Mr Barry Potton

Sutton House Nursing 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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Sutton House Nursing Home is registered to provide personal and nursing care for 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 is a large sitting room set out into two separate areas, a small quiet sitting room and a dining room. There is a garden at the front and the side of the building and parking for several cars.

At the time of the inspection, the service did not have a registered manager. 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. The service had a manager in post who had made an application with CQC to be registered; this was still being processed.

Sutton House Nursing Home was inspected in February 2016 and concerns were found regarding how people received personalised care, the number of staff on duty and how the quality of the service provided to people was managed through good governance. We issued requirement notices and received an action plan regarding the timescales the registered provider was to become compliant in these areas. An inspection to follow up the requirement notices was completed in July 2016 and we found improvements had been made in how people received personalised care and staffing numbers. However, although some improvements had been made to monitoring quality, there remained concerns about governance. We issued a warning notice for the registered provider to be compliant in this area by 19 August 2016. We also imposed urgent conditions on the registered provider's registration to make sure guidance in how to manage accidents and injuries was available and all staff knew how to provide support should accidents and incidents occur.

We carried out this full comprehensive inspection to assess the service as a whole and also to follow up the warning notice and make sure the conditions of registration had been met. We found improvements in policies and procedures regarding how to manage accidents and incidents, and staff were knowledgeable about what action to take should someone have a fall. As a result we have decided to remove these conditions from the registered provider's registration.

However, we found continued concerns with governance and oversight of the service and additional concerns in risk management, personalised care, infection prevention and control, medicines management, ensuring dignity and respect, staff training and the need for consent. As a result of inspection findings, the overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant

improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the registered provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

There were persistent concerns regarding quality monitoring and overall governance of the service. Some audits and checks had been completed but these had not been effective in identifying the shortfalls we found during the inspection. Some shortfalls which had been identified in previous audits had not been addressed in a timely way.

In three of the care files we looked at, we found the people had not had sufficient assessment of their needs prior to admission. One of the people was assessed by the local authority as requiring 24 hour specialist dementia care and although Sutton House Nursing Home did not provide this level of service, the person was admitted and will require an alternative placement.

We found not all people who used the service had risk assessments that identified areas of concern and steps the staff needed to take to minimise incidents occurring. Some incidents had occurred and staff were unsure of how to manage them.

We saw some people's care plans lacked important information in order to provide staff with guidance in how to meet people's needs in an individual way.

We found some people had not received their medicines as prescribed. This was due to a variety of reasons such as stock management and administration procedures.

There were times when the application of legislation such as the Mental Capacity Act 2005, used to protect people when they lacked capacity, was inconsistent. Not everyone had an assessment to determine capacity and a best interest meeting to discuss decisions, when care restrictions were in place such as lap straps and bed rails. The manager had taken action and sent in applications to the local authority when people's liberty had been deprived; some of the applications had been authorised but several people were awaiting assessment by the local authority.

We saw some positive interactions between staff and people who used the service and a caring approach. However, some areas of interaction and how staff looked after and stored people's dentures and toothbrushes required improvement to ensure privacy and dignity was maintained. Also we saw records were held securely and conversations with health professionals were held in the nurses office; however, the size of the nurses office posed a risk that confidential discussions, held during reviews with a group of people, could be overheard as the door had to be left open to accommodate more than two chairs.

There was a lack of signage around the service to remind people of where their bedrooms, toilets and

communal rooms were.

Not all staff had received the level of training required to meet the current needs of people who used the service. This meant some people may be at risk of not receiving appropriate care and support.

Staff were recruited safely and there were enough staff on duty. However, how staff were deployed at certain times of the day or how shifts were organised, for example at mealtimes, meant people did not always receive support in a timely way. We have made a recommendation about this.

Some areas of the service posed a risk to infection prevention and control. Items of equipment had not been cleaned and stored properly, areas of the service required cleaning and there was a lack of hand hygiene guidance in communal hand washing areas.

We found some areas of the service and equipment such as radiators posed a risk to people. People who used the service had access to areas that were hazardous such as the boiler room, sluice rooms, store rooms and they also had access to potential harmful products stored in a communal toilet.

People told us they liked the meals provided and we saw there were menus which detailed choices and alternatives. Special meals were provided for people with individual dietary needs and swallowing difficulties.

People had access to activities to provide them with stimulation.

Staff had received training in how to safeguard people from the risk of abuse. They knew the signs to look out for and what to do if they had concerns.

Staff told us they felt supported by the manager and could express their views. The staff supervision and appraisal process had commenced which the manager said would be used to establish training and development needs.

We saw there was a complaints procedure and people felt able to raise concerns. They told us they were confident the manager would address complaints.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People had not always received their medicines as prescribed.

People were not always protected from the risk of infections as parts of the service and equipment required cleaning.

Individual risk was not always assessed, monitored or managed effectively to ensure people remained safe.

Staff were recruited appropriately and in sufficient numbers but how staff were deployed, especially at mealtimes, meant some people were left unattended. We have made a recommendation about this.

Staff knew how to protect people from the risk of abuse and how to report any concerns.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was an inconsistency in the application of mental capacity legislation and recording the decisions made on their behalf. This meant not all people who lacked capacity and had restrictions in place had documentation to evidence assessments and meetings were held, and the decisions made were in their best interest using the least restrictive option.

There were gaps in training which meant not all staff had the skills, knowledge and experience to care for people living with dementia and when they required physical interventions.

People liked the meals provided to them and menus indicated choices and alternatives. Improvements were required in staff interventions at meal times to ensure people received timely support and assistance to eat their meals.

People's health needs were met and they had access to community health professionals for advice and treatment.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although we saw some positive and caring interventions between staff and people who used the service, staff could be more proactive in ensuring privacy and dignity was promoted at all times.

Staff did not consistently care for people's belongings such as toiletries and oral hygiene equipment, especially in shared en-suites.

There was a lack of information to help guide people around the service such as notices for the sitting rooms, dining rooms, bedrooms and toilets.

People's care files and staff records were held securely.

Is the service responsive?

Inadequate

The service was not responsive.

People's assessments did not always contain full information about their needs in order to plan care. In one instance, a person was admitted when there was doubt about the service being able to fully meet their needs.

Some people's care plans and risk assessments lacked important information to guide staff in how to care for people in ways that were safe or in ways they preferred. The delivery of care had at times not met people's individual needs.

People had access to activities to help stimulate and occupy them.

There was a complaints procedure and people felt able to raise concerns when required.

Is the service well-led?

Inadequate

The service was not well-led

There was a persistent concern with governance. The quality monitoring system in place has not been sufficiently robust to identify shortfalls so that these could be addressed in a timely way.

There were times when the service was not organised well.

The manager was described as caring to people who used the service, supportive to the staff team and keen to improve the quality of care provided. However, there were times when the body language of some staff could be interpreted in a less than positive way.	

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 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 1, 2 and 7 December 2016 and was unannounced on the first day. The inspection team consisted of two adult social care inspectors for two days and one inspection manager for one day.

There had been some technical difficulties regarding the service receiving the Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. However, we checked our systems for any notifications that had been sent in 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 about their views of the service. We also asked the health commissioners for their views.

During the inspection we observed how staff interacted with people who used the service throughout the days and at mealtimes. 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.

We spoke with seven people who used the service and five people who were visiting their relatives. We spoke with the registered manager, two nurses, a team leader, three care workers, one of which was a senior, one laundry assistant, two domestic workers and maintenance personnel. We also spoke with three health professionals, an ambulance crew and two social care professionals.

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 32 medication administration records (MARs) and monitoring charts for food, fluid, weights and pressure relief. 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 three staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records.

Inadequate

Is the service safe?

Our findings

We found the service was not safe. We found several people who used the service had recorded behaviours which could be distressing for them and challenging for the staff and other service users; some of the challenging behaviour occurred during personal care tasks. There were no risk and behaviour management plans which provided staff with clear guidance in how to manage the behaviours in order to keep people safe and protect them from harm. We saw seven incident reports for one person that indicated a range of behaviour including assaulting and being verbally abusive to staff, shouting at other people who used the service and visitors, damaging property and throwing food. We observed additional incidents of the person removing their safety strap and foot plates from their wheelchair. These incidents occurred frequently and staff needed clear and consistent guidance in how to manage them to ensure the person and other people remained safe. One person who used the service told us that one of the people living with dementia had gone into their room and threatened to hit them. Another person told us they felt safe but said, "When he's not kicking about I do [referring to another person who used the service]." We observed one person who used the service spoke in a disparaging way to another person, which caused them distress and to retaliate. Another person told us they preferred not to be in the main sitting room as they were frightened of some people who used the service. The care plans did not reflect these issues and how staff were to manage them.

One person had a risk assessment which indicated they were at risk of choking and aspiration pneumonia but there were no control measures on the risk assessment to guide staff in how to minimise the risk of this occurring. We found that pressure relieving mattresses for two people who used the service were set at an incorrect level and not in accordance with their recorded weight. There was no information recorded in care plans to identity what the correct required pressure mattress settings should be for them or for any other service user who required pressure-relieving mattresses. This posed a risk of people developing pressure ulcers. We found a bedrail protector for one person had not been correctly applied which was an entrapment risk. We saw one person who used a wheelchair repeatedly unfastened the lap strap. We spoke to a member of staff about this and they said, "[Person's name] is not safe to be left without a lap strap, he should have a staff member with him at all times."

Not appropriately assessing risk, doing all that was reasonably practicably to mitigate such risks and having systems in place to monitor and identify risk was a breach of Regulation 12 (2) (a) (b) and a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are considering our regulatory response and will report on it when it is completed.

We found people had not always received their medicines as prescribed. This had been for various reasons such as management of stock and staff finding people asleep or declining their morning medicines and recording this but not returning later. As these medicines could be taken throughout the whole day there was the opportunity for staff to approach people at a later time to administer medicines and space them appropriately; this had not happened. We saw one person had received a medicine, prescribed 'when required' (PRN) for increased anxieties, every night but when cross-referenced with their daily notes there were very few episodes of their behaviour which was recorded as agitated. The registered manager told us

the reason the person was calm and free from anxiety was due to the continued use of the medicine. However, the staff had not consulted with the prescriber to enable them to review the person's medicine regime and alter treatment to a more regular dose if, in their judgement it was required. There were other examples when the medicine was given to people and the reasons were clearly documented.

Several people who used the service were prescribed medicines to be taken PRN or as a variable dose so a decision would need to be made by staff administering the medicines to them. These included medicines such as painkillers and laxatives or, as mentioned in the previous paragraph, to help with anxiety and agitation. We found two people had PRN protocols in place which gave clear guidance to staff in when to administer the medicine, the frequency of doses and timing in between. However, other people did not have clear guidance for staff on when to administer PRN medicines or those with a variable dose. For example, guidance was required regarding the length of time between doses, at what stage of anxiety to administer medicines for the optimum effect, what signs to look out for that people's behaviour was becoming more anxious or agitated, how people expressed pain, when one or two doses of pain relief were required and the timing and amounts of laxatives for individual people. This meant that there was a risk that people could be administered more medication than recommended over a given time. It is important that this information is recorded and readily available to ensure people are given their medicines safely, consistently and in line with their individual needs and preferences. Medicines, including those requiring stricter controls, were stored appropriately. Recording in some instances could be improved. For example with the definition of codes when medicines were omitted, gaps on the medication administration records (MARs) and in the use of MARs for more than one month's supply of medicines which led to confusing records.

Not ensuring the proper and safe management of medicines and having systems in place to monitor this was a breach of Regulation 12 (2) (g) and Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are considering our regulatory response and will report on it when it is completed.

We found there were areas of the environment which posed a risk to people who used the service and improvements were needed to make them safe. For example, several radiators had loose metal covers which had sharp edges. The doors to store rooms, sluices, the hair dresser's room, the linen room and the boiler room were left unlocked and in each there were hazards such as hot water, very hot pipes, chemicals and equipment which could pose a risk for people if accessed by them. Some bathrooms were unlocked and used as store rooms for items such as a floor polisher, sitting scales, commode chairs and wheelchairs; this made them cluttered and could pose a risk to people wanting to use the facilities. A downstairs toilet which was used frequently by people who used the service had potentially harmful products accessible on the shelves. A television aerial socket on the wall in one person's bedroom was loose with the back exposed. In one person's bedroom, the metal corner brace on one wall was exposed with plaster having fallen off. The same bedroom had a hard plastic document holder inside the wardrobe door which had pieces broken off and had sharp edges.

Not ensuring the environment was safe and free from the risk of harm and having systems in place to monitor this was a breach of Regulation 12 (2) (d) (e) and Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are considering our regulatory response and will report on it when it is completed.

There were areas of the environment and some equipment which posed a risk of infection. For example, nebulisers had not been cleaned properly before storing them on the floor in the treatment room. The suction machine was dusty and the trolley it was held on was splashed with dried liquid. One person's mask for receiving oxygen had not been cleaned after use and an oxygen mask and tubing were compromised

and found attached to the oxygen cylinders stored in a cupboard labelled for use by domestic staff. Some en-suites in shared bedrooms had only one towel for use by both occupants, which could pose a risk of cross contamination. There were five splashes of blood on the floor of a shared en-suite which could not be accounted for. Some under sink areas in en-suites were in need of repainting and difficult to keep clean. The vents at the top of radiators in some people's bedrooms were very dusty and items had dropped down into them. The sluice rooms required cleaning behind the machines and sinks; a system of checking commode and slipper pans following cleaning in the sluice machine was needed to ensure they were completely clean.

Some chairs and a table required cleaning in the main sitting room, the carpet was badly stained and the plastic cover for a pressure cushion was ripped exposing the sponge underneath which made it difficult to keep clean. The plastic covering on three bedrail protectors was perished making them difficult to clean; some bedrail protectors were stored under beds which harboured dust. Also the plastic chairs in the hairdresser room were split and the stuffing visible making them difficult to clean. The fly screen used to prevent flies from entering the kitchen by one of the doors had a large rip down the middle and was coming away at the sides. The cutlery tray positioned on the kitchen hatch ready for use, contained some utensils that had not been cleaned properly. Staff were observed wheeling laundry about the service in skips that were not tied or covered. There were no hand wash signs throughout the service to provide staff with good hand hygiene techniques and some clinical waste bins were not foot-operated which could lead to cross contamination.

Not assessing the risk of and preventing, detecting and controlling the spread of infections and having systems in place to monitor this was a breach of Regulation 12 (2) (h) and Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are considering our regulatory response and will report on it when it is completed.

By the third day of the inspection most of the issues affecting the environment and cleanliness had been addressed and staff had been reminded about the need to ensure access to unsafe areas was restricted. The registered provider told us other issues had been added to the redecoration and refurbishment plan. We saw equipment used within the home was serviced and checks were carried out by maintenance personnel on areas such as bedrails, hot water outlets, the nurse call and fire alarm points. People who used the service had personal evacuation plans for use in emergency situations.

There were sufficient numbers of staff employed to meet people's needs. However, how the staff were deployed at specific times of the day, for example at mealtimes, or how the mealtimes were managed, led to disorganisation and not every person receiving the care and support they required. On the first two days of the inspection, we observed some people had to wait between half an hour to an hour for their lunch, once seated. We also observed one person, during lunch, asking to go to the toilet for half an hour before staff were able to take them; this could impact on people's dignity. This issues mentioned to the manager to review and address. Staff told us there were sufficient numbers on each shift but this could be disrupted when short-notice absences occurred. They said improvements have been made by reorganising the administration of medicines to people which had reduced the time this had taken. A health professional told us they had noted an increase in staffing levels recently and said they were aware staff were also allocated to each floor to provide care. Another professional told us they sometimes had difficulty finding staff when needed, whilst another said, "Good staffing ratios."

We recommend the registered provider reviews and improves the deployment of staff at peak times such as meal times. We will assess this again at the next inspection.

Staff had received training in how to safeguard people from the risk of abuse; records confirmed training had taken place. In discussions, they were able to accurately describe the different types of abuse and demonstrated an understanding of safeguarding and the action to take should they witness abuse or harm. Staff told us they did not use any physical interventions whilst providing personal care to people and used distraction techniques instead. However, it was difficult to confirm this as recording regarding how staff managed people's behaviours which could be challenging was not clear.

Although some people, as mentioned in the first paragraph of this section, told us they did not feel completely safe, other people were happy and felt safe living in the service. They said there were sufficient staff to attend to them. Comments included, "Oh yes, I do feel safe", "I definitely feel safe", "When you ring the bell, they do come quickly; sometimes it can be slow if they are doing other things" and "When you ring the bell, they are here in a jiffy." Visitors had positive comments about the safety of people in the service and staffing numbers. Their comments included, "I know my dad is protected and safe; I've never had any fear over safety", "My mother has no problem with safety and she said she feels secure here", "More staff have been appointed recently" and "When she complains of pain she is given analgesia."

We found that new staff were recruited safely with full employment checks being carried out before they started work in the service. These included application forms to look at gaps in work history, obtaining references, holding an interview and checking with the disclosure and barring service (DBS) to see if there was any reason why the member of staff could not work in care settings. There was a check made with the nursing and midwifery council (NMC) to ensure nurses were registered and had no restrictions on their practice.

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are 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 were being met. We found the people who required DoLS had an application submitted; ten people had these authorised by the local authority and a number of other people were awaiting authorisation.

We found there was inconsistency regarding the application of MCA with regards to assessing people's capacity and holding meetings to make decisions in people's best interest. For example, we saw some people had assessments to determine capacity and best interest meetings to make important decisions when they lacked capacity. One person had a document which stated the person was to remain at the service and care staff in conjunction with family and GP would make decisions about their care needs. However, records showed the person was to have medicines covertly and was signed by the manager but the sections for consultation with the person's GP and family were blank.

Some people had restrictions such as lap straps, bedrails, sensor mats and physical intervention care plans but not all these people had assessments of capacity and best interest decisions recorded to ensure these were in their best interest and the least restrictive option for their safety. This meant some people may be restricted unlawfully.

Not ensuring best practice regarding gaining consent in line with MCA principles is a breach of Regulation 11 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are considering our regulatory response and will report on it when it is completed.

In discussions, staff described how they sought consent by asking people and looking for non-verbal cues to indicate they agreed to care provided to them.

At the last inspection in July 2016 we imposed an urgent condition on the registered provider's registration to ensure staff's skills were appraised in relation to how they managed accidents such as falls and health concerns such as people having seizures. We found staff had received instruction in how to manage falls and seizures and what observations were to be carried out by the person in charge of the shift to make sure people were safe. Policies and procedures had been updated to provide staff with on-going guidance and information. In discussions, staff accurately described the specific actions they would take and records showed us appropriate observations had been carried out when required.

We saw staff had access to training, supervision and appraisal. However, some people who used the service

had a generic care plan for physical interventions. These stated all staff were to be MAPA trained (MAPA means management of actual or potential aggression) but the training records indicated that out of 34 care staff, only 11 had completed the training. In discussions, staff told us they needed more training in how to manage challenging situations. One person who used the service was assessed by the local authority as requiring '24 specialist dementia care' but out of 34 care staff, 18 had completed dementia care training. There had been a basic awareness session on dementia care included in a one day 'mandatory' training course. As this day covered approximately 19 topics, the sessions were brief. Out of 34 care staff, 26 had completed the mandatory training day. The training record indicated shortfalls in first aid and fire safety, and not all nurses had completed wound care and syringe driver training. The manager told us there may be some inaccuracies regarding the training record as not all courses may have been included in it. The shortfalls in training in specific areas meant all staff may not have the skills to deal with incidents that could be challenging or support people living with dementia. This could place people who used the service at risk of ineffective care and support, or place them, visitors and staff at risk of harm or injury.

Not ensuring staff had appropriate training, knowledge and skills was a breach of Regulation 12 (2) (c) and Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are considering our regulatory response and will report on it when it is completed.

Records indicated staff had supervision meetings with their line manager and discussed issues such as changes to policies and procedures, training needs, roles and expectations and the importance of documentation. The appraisal process had started and several staff had received one, which highlighted their skills and what training was required for development.

We saw people received treatment from community health care professionals such as GPs, district nurses, speech and language therapists, dieticians, emergency care practitioners, opticians and chiropodists. Staff described to us how they would monitor people if their health was deteriorating and when they would refer to community health professionals for advice and treatment for them. We observed one person's toe was pressing against the end of their bed, which could pose a risk of pressure damage. The manager told us they would address this. Comments from health professionals included, "Generally, the home is very effective in managing health conditions and refer to the appropriate areas for advice" and "Residents are referred to district nursing who implement a plan with support from carers."

We found people's nutritional needs were met. Menus provided people with choices and we observed alternatives were given to people if they did not like the options on offer. The cook told us they received information from care staff about people's individual needs such as special diets, where they preferred to eat their meal, whether they were able to choose from the menu, how they preferred their drinks and likes and dislikes. Care records indicated people were screened to see if there were any nutritional needs and we saw referrals to dieticians and speech and language therapists had been completed when required. Some people had been prescribed food supplements to enhance their calorie intake. People who used the service told us they liked the meals. Comments included, "[Name of cook] is lovely. The food is lovely too", "

During the inspection we found some staff practice issues which were addressed with the manager. These included two different places of recording people's food and fluid intake which caused confusion and the risk of inaccurate recording. We saw catering staff plating up pureed meals for lunch and putting them in the hot trolley at 10.45. As some people who required assistance to eat their meals didn't have them until after 13.00, this meant there was the risk of the meal becoming dried out. We also observed staff taking trays of meals to people who chose to remain in their bedroom. The hot dessert was served at the same time as the main meal which meant it would be cold by the time it was eaten. Two people were observed eating their meals on unsuitable low tables which meant they had to lean forward and stretch to gain access to the

plate. This was despite there being several appropriate tables for this purpose seen stored in the dining room. We saw one person required more observation to ensure they were supervised during meal times so staff were aware of their nutritional intake and could record this accurately.

Requires Improvement

Is the service caring?

Our findings

We observed some positive interventions between most staff and the people they supported. However, we found improvements were required to ensure every person was treated in a way that respected their privacy and maintained their dignity. During the inspection, we observed incidents and a lack of care support that impacted on people's dignity. We saw one person was transferred from an ambulance trolley, via a hoist, to a chair in the dining room in front of another person who used the service and their relative; there was no privacy screen used to maintain the person's dignity. Another person was administered an insulin injection during lunch in the dining room in view of other people eating their meal. Another person who was living with dementia, and experienced disinhibited behaviour, had no appropriate care plan for staff to support the person when this occurred. Several people who used the service had dirty and long finger nails.

There was a lack of care and respect for some people's toothbrushes, which were seen in shared bedroom en-suites mixed together and on one occasion the toothbrush holder also contained one person's dentures. A soap holder in one person's bedroom held soap with a toothbrush lying next to it and another person had their dentures and soap together on the soap holder. In shared en-suites, people's toiletries were mixed together on one shelf and not labelled making it difficult to establish which products belonged to specific people. A deceased person's toiletries were found in one shared en-suite among the two occupants own toiletries. We found packs of unlabelled continence pads in one of the downstairs toilets. The inference being that these were used for any person who required them rather than as prescribed for specific people and stored in their bedrooms until needed.

The dining experience on two consecutive days of the inspection was chaotic and poorly managed, which resulted in some people having to wait excessive amounts of time for their meal whilst other people in close proximity had their meals. Although we observed some positive interactions from specific staff, such as showing people plates of food to aid choices and joking banter during support, this was not consistent across all staff and support provided. For example, some conversation between staff and the people they were supporting to eat their meal was minimal and consisted of overloud speech and sentences such as, "What's up [person's name]" and "You alright [person's name]." Staff were observed talking to each other instead. We observed one person ate very little lunch and the care staff took their plate away without any check with them to ensure they had received enough to eat.

We found people were not always provided with accurate information. The activity board in the main sitting room had incorrect information about activities on the first day of the inspection. It referred to 'summer fayre' and 'sitting in the garden' but the first day of the inspection was 1 December 2016. There was a lack of signage about the service such as pictorial signs to help people locate their way to toilets, the dining room or the lounge. There were no signs on bedroom doors reminding people of how to locate their bedroom. There were pictorial menus to assist people living with dementia in making choice for their meals. However, we found some of the pictures of the meals were unidentifiable as the food was covered in gravy; some of the plates in the pictures had splashes of food on the side which did not make them look appetising.

We found at specific times there was a potential for confidentiality to be compromised and some members

of staff approach needed to be improved. For example, a review was held in the nurse's room during the inspection and the size of the room meant the door could not be closed and the conversation could be overheard. During a discussion between an inspector and social care professional in the room, staff walked in without knocking, saw it was occupied but came in anyway, completed a task and left without apologising for the interruption. One member of staff was overheard referring to people who required assistance to eat their meals as 'feeders'. This showed us the member of staff identified people as 'tasks to be carried out' rather than as individuals. One member of staff's approach when speaking to a relative was observed as abrupt and not all comments from visitors to the service referred to staff's attitude in a positive way.

Not ensuring all people who used the service were treated with dignity and their privacy respected was a breach of Regulation 10 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are considering our regulatory response and will report on it when it is completed.

In discussions with staff, they gave us examples of how they would promote people's privacy and dignity. These included knocking on doors before entering, closing doors and curtains during personal care and keeping people covered, and taking people to a private area if they become ill. We saw most people who used the service had a bedroom for single occupancy which afforded them privacy. Those bedrooms for shared occupancy had privacy screens to use when required. Bedroom, bathroom and toilet doors all had privacy locks. We observed one member of staff engaging really well with the person they were assisting to eat their lunch and another member of staff demonstrated very kind and caring interventions with a person who used the service.

People who used the service told us they were able to make their own choices and decisions, and staff were caring and kind to them. Comments included, "The staff are not bad at all", "The staff do look after us", "They tell you off when you have been doing anything daft; I don't mean they shout at you", "The staff are brilliant ; they are all nice day and night staff", "You can have a lie-in if you're not feeling well; I can't grumble about them [staff]", "Oh I like them [staff]; they are really nice and friendly", "The staff are ok; they knock on the door before coming in. I can get up and go to bed when I choose. I prefer to stay in my room; it's my choice" and "I think the staff are fantastic. I get up sometimes but decided to stay in bed this morning as I had a bad night." One person said, "They don't like being called at night though. I had a right do dah with some; they seem miserable." This was mentioned to the manager to address.

Relatives commented positively on staff approach, although there was some inconsistency in this approach indicated in the statements. Comments included, "Staff have always been lovely and caring", "The staff are lovely considering their difficult job. When I visit I find them very helpful and friendly", "They always promote dignity; very caring and treat them with respect", "This is a very good home with hard working staff whose aim is to achieve a happy, relaxed atmosphere for their clients", "Some staff have a better, more considerate approach", "Generally yes (staff caring and kind), some more so than others" and "Some staff seem more aware of help needed than others."

There were mainly positive comments about staff approach from health and social care professionals, although there were some comments from them regarding how this could be improved. Positive comments included, "I have noted from reviews with families that they speak well of the care from the staff", "The staff appear to be caring, friendly and look out for the needs of residents", "Residents are encouraged to be independent" and "Talking to people who live here, who don't have capacity, they believe that they are staying in a good hotel." Areas to improve included, "Sometimes staff ignore people, they are not acknowledged", "I observed one member of staff speaking aggressively to a patient and not listening to patients requests" and "There is never anywhere private to hold reviews. I've had to wait ages for other

people to move away; it's not very nice for them." These comments were passed on to the manager to address with staff and to investigate an alternative room to hold reviews.

We saw personal care records were stored securely in the nurse's office which was locked when not in use. Medication administration records were held in the treatment room which was locked. Staff personnel files were secured in the manager's office. The manager told us the computers were password protected to help keep access to a minimum and electronic records secure.

Inadequate

Is the service responsive?

Our findings

We looked at the assessments for three people admitted to the service since the last full comprehensive inspection. We found the assessments did not contain sufficient information to safely plan care. For example, the assessment for one person was not signed or dated and had limited information about their care and support needs in relation to their mobility, dexterity, their mental health, current and past medical conditions and the impact this had on them. For the second person, the assessment stated they had had a stroke but there was no information about which side of the body the stroke had affected and whether there was weakness or paralysis of limbs. The assessment stated the person required a full hoist and sling but there was no type of sling identified. It also stated they needed a 'supported chair' as they leaned to the side, but it did not indicate which side or how the person was to be supported with additional pillows and how these were to be positioned. The third person was assessed by the local authority as requiring 24hour specialised dementia care due to behaviours which could be challenging. Whilst Sutton House Nursing Home provides care to people who have developed dementia whilst living in the service, staff are not able to provide specialist dementia care. There are people who use the service who have complex health care needs and limited mobility, which places them in a vulnerable position.

Risk assessments did not always contain the measures staff were to use to help minimise risk. For example, we observed one person had disinhibited behaviour but when this question was asked on their risk assessment form, staff had ticked 'no' and had not developed a plan to minimise risk and provide support. Another person had an incident when they had lunged forward and overbalanced when seated in a hoist sling. Whilst staff were present and prevented an accident, we were unable to locate the risk management plan to reflect this and to minimise future occurrences.

The assessment and risk assessment stages were important as they helped to determine if a person's needs could be met in the service and also as an indicator of the level of support required. There were comments from staff around the need for more information about people's needs prior to their admission to the service.

We found there was an inconsistency with care plans. Some care plans were detailed and contained lots of guidance for staff in how to support the person, but others lacked important information in how to deliver care safely to people. Two people had no plans at all for the management of behaviour which was challenging and had caused, them, other people who used the service and, on occasions staff, anxiety and distress. Some care plans said, "Staff to encourage position changes" (but didn't state how often), "To rest on their bed when pressure areas reddened" (but didn't state how long for), "Staff to assist into the shower using relevant aid" (but didn't specify what this was) and "During shower time requires assistance from three staff" (but didn't state how this was to be carried out).

There were other comments recorded in care plans such as, "Reassure during washing and changing clothes", "Physical intervention plan implemented", "Encourage position changes", "Use verbal diversion", "Use diversion techniques", "Two staff to support during personal care" and "Reassure when agitated." The 'how' and 'when' this support was to be carried out were missing from some of the care plans.

There was a generic behaviour management plan for personal care for several people, which was to be used if physical interventions were required. The care plans were not personalised and did not describe what specific physical interventions were actually required for each individual service user; pictorial information on positioning of people's limbs and staff support would provide additional guidance to the written form. When we spoke with staff about this, they described the approaches and sentences they used to distract one specific person during personal care and how effective this was for them. As the information was not written down in personalised plans, there was a risk that other staff may not be aware of what worked for the person and may inadvertently cause more distress and anxiety. In discussions, staff demonstrated knowledge about other people's specific needs, however again some of these were not written down in care plans.

We found supplementary daily records relating to food and fluid intake and pressure relief did not provide clear guidance for staff. There were no instructions on the supplementary records for each individual person to guide staff in the frequency of pressure relief or the amount of fluid intake staff were to support the person to aim for each day. We saw there were gaps in recording of pressure relief of four and a half hours, five hours, six hours and seven hours for one specific person who used the service. And for another person a gap of nine hours was recorded. In both instances, their care plan stated that when lying in bed or when sitting out in a chair, four hourly pressure relief was required.

We found some people could have received more individualised care. For example, one person's spouse had recently died and their care plan had not been updated to reflect the emotional care and support staff were to provide. The person was observed asking staff repeatedly for information about the funeral; staff gave inaccurate information about the time of the funeral and the inspectors intervened and wrote the information down for them to refer to when required. A visitor told us their relative's sight was deteriorating to the point where they had very limited sight. The manager confirmed the person had not been referred to community services for listening books or sight aids; they ensured a referral would be completed as soon as possible. We observed staff asked one person if they wanted rice pudding for dessert. The person stated they did not like rice pudding so the member of staff went to find an alternative. In the meantime, another member of staff placed a bowl of rice pudding in front of the person and walked away without comment; this was a trigger which caused the person anxiety and frustration. During lunch, one person was observed asking to go to the toilet for 30 minutes but staff did not respond to this and take action.

The mealtime experience on two consecutive days of the inspection demonstrated some people were not provided with care that was tailored to their individual needs. For example, staff took everyone from the main sitting room into the dining room at the same time. As some people required assistance from staff to eat their meals, they were left waiting until staff had served people, taken meals upstairs or returned people to the table who had chosen to leave. For some people this meant a wait of a half an hour to an hour. The risk assessment and care plan for one person stated they required observation with their diet. We saw staff provide them with breakfast but then left the room and the person got up and left the table having eaten very little. When we checked the daily recording, staff had written the person had eaten well.

Generally the design of the premises and equipment used was appropriate and responsive to people's needs. For example, corridors were wide and had grab rails. There were raised toilet seats, support handles and assisted baths in bathrooms, specialised beds and mattresses, and hoists, walking frames and other moving and handling items. There was a passenger lift for the upper floors. However, there was an issue with access when admission by ambulance trolley was required. There was a portable ramp for the front door, which could be put in place for people using wheelchairs to access but staff told us the ramp couldn't be used for the ambulance trolleys. Access was via the dining room and people were transferred there. We spoke with the manager about how this could be improved and people transferred in a more appropriate

area.

Not ensuring care was personalised to meet people's individual needs was a breach of Regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are considering our regulatory response and will report on it when it is completed.

Despite some of the areas to improve, we observed occasions when staff did deliver care that was person-centred and people who used the service confirmed this in discussions. For example, people told us they were able to remain in their bedrooms if this was their choice; when this happened we observed staff checking on people to make sure they were alright and didn't need anything. One person who used the service told us staff ensured they completed exercises designed by a health professional. Some people had specialised chairs tailored for their needs. One person told us they preferred to stay in their wheelchair most of the day but would ask to transfer to a more comfy chair when they chose to. Records showed some people rested on their beds in the afternoon or had alternate days on bed rest to help prevent skin deterioration. We saw staff getting down to people's level to ask them what they wanted for breakfast. We observed staff manage a difficult situation in the main sitting room in a calm way.

Visiting health professionals told us of occasions when staff had been responsive to people's needs. They said, "Will generally action any changes. I have asked for referrals to be made and when I have followed up these have been actioned" and "Carers report changing status of residents in a timely way." One visiting professional told us about an occasion when staff were unprepared for a review and they found the process was disorganised.

We observed there were activities provided mainly by designated activity coordinators. These included quizzes, sing-a-longs, art and craft work, hand and nail care, board games, movement games, entertainers and occasional trips out.

There was a complaints procedure on display in the service. The procedure described timescales for acknowledgement, investigation and resolution. It also provided information of where people could escalate complaints if they were unhappy with the outcome of an investigation. There were forms for people to fill in to detail their complaint and the action staff took to resolve it. Staff knew how to manage complaints. People who used the service and their relatives told us they would feel able to raise concerns knowing they would be addressed and named either the manager or other staff they would speak to. The manager told us they had not received any formal complaints since they have been in post, which was February 2016.

Inadequate

Is the service well-led?

Our findings

At the last inspection in July 2016, which was a focussed inspection to follow up requirement notices, we found the manager had made improvements in carrying out some audits but there was a lack of oversight in ensuring specific incidents and accidents were managed well. We issued a warning notice as we had on-going concerns about the effectiveness of some parts of the quality monitoring system. Since that inspection, the registered provider had ensured policies and procedures for managing accidents were updated and the manager had appraised staff and checked skills in that area.

We found some audits and checks had been carried out but these had not been effective in identifying the shortfalls we highlighted during the inspection. For example, in relation to risk management, infection prevention and control, medicines management and care files. Audits had not been completed to check requirements in staff training and deployment, recording, assessing need, planning care, and in some instances the delivery of care. As mentioned in other areas of the report, some people who used the service did not have risk assessments for distressing and challenging behaviours. Some areas of the service, and equipment used, required cleaning. Some people had not received their medicines as prescribed due to stock ,management and administration practices. Staff had not received appropriate training in specific areas to enable them to support people safely. The deployment of staff especially at mealtimes was not effective in ensuring people received the care and support they required in a timely way. There was no system to check that monitoring charts were accurately recorded. We found the recording of food and fluid for one person was inaccurate and did not match their daily notes. Staff had recorded they had eaten and drunk well but the food monitoring chart suggested the opposite.
Some people's initial assessments had not included important information. In one instance, a person had been assessed by the local authority of requiring 24hour specialist dementia care; they were admitted to the service but their needs could not be met as the service did not provide specialist dementia care.
Observations of care practices and support had not been carried out, especially at mealtimes and managing behaviour. These would have assured the manager the staff team had appropriate skills to support people to eat their meals and to manage distressing behaviour. The quality assurance system needs to be much more organised and structured to ensure shortfalls are identified so they can be addressed and the quality of the service provided to people improved.

Some shortfalls had been identified in audits but not acted on in a timely manner and some areas of concern were highlighted but we found they had occurred again. For example, in a thorough environmental audit carried out in February 2016 just after the last full comprehensive inspection, it was noted the boiler room door was wedged open and it was used to store wheelchairs. We found the door unlocked, on occasions throughout the inspection it was open, and still used as a store room for wheelchairs. The audit also identified mattresses needed reviewing for the appropriate use and weight capacity; we found two mattresses had to be adjusted as they were at an incorrect setting. The audit identified issues with the sluice rooms; we found these had not been addressed. Some radiators were reported as having loose covers; we found these had not been attended to. We found there was a lack of storage space in the service which meant alcoves on the first and second floors were cluttered with equipment. This had been identified in an environmental audit carried out by the manager on 1 November 2016 and they told us they were to speak to

maintenance personnel to box in the area.

Whilst the registered provider had made progress with the refurbishment and redecoration plan, for example the dining room looked really bright, clean and fresh, other areas of the service needed attention. These included the main sitting room, especially the carpet which was badly stained and the lighting which was low level and not appropriate for people living with dementia. Two bathrooms had a wallpaper border removed as if redecoration was about to be started leaving unsightly plaster exposed, several en-suite rooms needed decorating and attention under sinks and some bedrooms were in need also of redecorating. Skirting boards and doors in corridors upstairs had been painted but in the process the carpets had been splashed with paint. The registered provider told us they were addressing this with the company who completed the work. They also told us a new boiler system had been a priority in 2016 which meant other refurbishment had been delayed.

We saw that the numbers of accidents and incidents had been collated and some measures taken by the manager to increase staff in the early evening, but there was no full analysis and action plan produced to help to minimise incidents especially with people's changing and at times challenging behaviour.

The manager showed us a tool used to calculate the staffing levels required. We saw that whilst the tool enabled the manager to look at the dependency levels of people who used the service, there was no formula or score system for determining the number of staff required, especially at specific times of the day. We could not be sure the numbers of staffing were accurate and in line with people's needs.

The manager told us they had worked more than 60 hours a week for the last few months since a clinical lead employed in July 2016 had been unavailable. This amount of hours was extremely tiring for the manager and needs to be reviewed by the senior management team.

Not ensuring there was an effective system of governance and quality monitoring in place was a persistent breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are considering our regulatory response and will report on it when it is completed.

Following the inspection, the registered provider told us they had appointed a new clinical lead who was due to start work in mid-January 2017. This would help to relieve the workload for the manager. The director of nursing had visited the service on a number of occasions to offer support and supervision to the manager. There had also been supported visits from the training manager and registered provider. The manager told us they felt supported by the senior management team and they were able to contact them when required for advice and guidance. They said the registered provider was available and had 'never turned her down' when equipment had been requested. The manager stated they were able to contact the director of nursing for support who always returned her phone calls and enabled her to talk things over. The manager told us they tried to lead by example, listen to people and think about things first before reacting.

The registered provider's director of nursing told us there was an audit tool available to observe the mealtime experience for people; during the inspection, they made sure the manager had this in order to observe meal times and staff practice.

We found the manager had acted promptly and appropriately following a specific safeguarding alert which questioned the practice of a specific member of staff. The manager initiated supervision and a competency check on their practice.

There were mixed comments from health and social care professionals. Some stated, "I find the

management here very good" and "Improvements with current management." Other comments from different professionals described shortfalls in the way the service was organised. For example, the comments included, "It is organised chaos", "Never enough staff" and "It's always like this. One professional commented on the lack of organisation with regards to reviews of care for people who used the service.

Staff were complimentary about the manager and stated they received support from them. Comments from staff included, "We are all dedicated and love our jobs", "We have more staff and equipment now than ever before", "They [manager] has an open-door policy, is approachable and you can talk to her about things", "She [manager] is absolutely brilliant", "[Manager's name] asks us if we are ok" and [Manager's name] is approachable, quiet and likes things done efficiently." Staff told us the administration of medicines had been reorganised which had been an improvement.

There were generally positive comments from people's relatives about the manager's approach and supportive attitude. Comments included, "Our family are happy with all aspects of how things are managed" and "The current manager has an open-door policy which appears to work well. She listens to concerns and acts upon them. She demonstrates a caring attitude and is very hard working." We did observe some incidents when the body language of some staff could have been interpreted in a less than positive way; this was mentioned to the manager to address.

We saw staff meetings had taken place where people were able to express their views about the service. Relatives confirmed they attended meetings and had completed a survey about the service.

We saw staff were given an employee handbook which provided information about roles and expectations. This helped staff to know what was expected of them and also what they could expect from their employer. It also provided information about the values of the organisation, relevant policies and procedures and ways of working.