Mr Barry Potton

Sutton House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

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

We undertook this unannounced inspection on the 2 and 3 February 2016. There were 36 people using the service at the time of the inspection. At the last inspection on 14 January 2014, the registered provider was compliant in the areas we assessed.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. A member of staff had been the acting manager of the service since September 2015 and a new manager had been appointed and started their first day in the role on the day before the inspection. They will begin the process of registration with CQC.

We found people had access to community health care professionals and assessments of their health care needs were made. However, there were instances when staff did not monitor people's health care needs effectively and had not sought medical intervention in a timely way.

We found the quality monitoring system had not been implemented fully and had not been effective in highlighting areas to improve such as the care records and the environment. Action plans had not been produced in order to address shortfalls. Accidents had not been analysed to help find ways to reduce them.

We found there were times when there were insufficient staff deployed to meet people's needs.

The above issues meant the registered provider was not meeting the requirements of the law regarding assessing and delivering person-centred care, having an effective monitoring system and ensuring sufficient numbers of staff are deployed at all times. You can see what action we told the registered provider to take at the back of the full version of the report.

Care plans were produced so that staff had guidance in how to support people. We found these contained some personalised information but could be improved to ensure staff had full information on how people preferred to be cared for. People had risk assessments completed to help staff to minimise any areas of concern. We found some areas of risk had been overlooked. These points were mentioned to the new manager to address.

We have made a recommendation about the formulation of person-centred care plans.

People told us they liked the meals provided and they had plenty to eat and drink. On some occasions we saw people's weight had been recorded but we were unsure if action was taken when there was a loss identified or that this was followed up by further weight monitoring. We found some people were under the care of the dietician. The new manager told us they would address this with staff.

People generally received their medicines as prescribed and they were obtained, stored and recorded appropriately. However, on the day of inspection, the nurse administering medicines had lots of distractions which meant some people's medicines were late. We saw there was no impact on people because of this situation.

People told us staff were caring and kind. We saw staff were very busy and this impacted on the attention they were able to devote to people. We observed some areas of staff practice that could be improved and the new manager is to address this with staff.

We saw information relating to people's care and treatment was handled in a confidential way but personal records were not always stored securely.

We found staff knew how to safeguard people from the risk of abuse and had received training in how to recognise the signs and symptoms and how to pass on information of concern.

We found staff were recruited safely and had employment checks carried out before they started work in the service. Staff had access to training and supervision. A training analysis had just been carried out by a senior manager and they had planned a series of courses to ensure all staff had up to date certificates in essential training. We were unable to see the induction records of two new staff although one spoke with us and told us they had received mentoring from another member of staff and induction consisted of shadowing and working through booklets.

There was a complaints process that was on display and people told us they would raise concerns if required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were gaps in staffing levels which meant there was a risk people's care and treatment needs were not fully met.

Staff had completed safeguarding training and knew how to protect people from harm and how to raise concerns. People had risk assessments although we saw some areas of risk had been overlooked and were to be addressed by the new manager.

Medicines were obtained, stored and recorded appropriately and people generally received their medicines as prescribed. However, some recent staffing level issues had impacted on this.

Staff were recruited safely and employment checks were carried out before their start date.

Is the service effective?

Requires Improvement

The service was not always effective.

People received advice and treatment from a range of health professionals. However, there were some concerns with staff monitoring and meeting specific people's health care needs and seeking timely medical intervention.

People were provided with a nutritious diet and fluid intake to ensure their nutritional needs were met. People who used the service and staff told us the meal on the day of inspection fell short of the usual standard. Monitoring of people's weight needed closer attention.

When people were assessed as lacking capacity to make their own decisions, best interest meetings were held with relevant people to discuss options.

Staff had access to training, supervision and support to enable them to feel confident and skilled in their role. The training manager had undertaken an analysis of staff training needs and planned updates.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst we observed some very positive staff interactions with people who used the service, we also observed there were some areas of staff practice that could potentially impact on people's privacy and dignity. This is being addressed with staff.

A relative felt they did not always have the opportunity to discuss things that mattered to them. The new manager was looking into this.

Confidential information was not always held securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed and plans of care produced but they lacked personalised information that would guide staff in how to fully meet their needs.

When people required additional monitoring, the records completed by staff were inconsistent.

There was a complaints policy and procedure to guide people who wished to raise a concern, and instructed staff in how to manage them.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although there was a quality monitoring system, this had not been fully implemented for some time and had not been wholly effective in highlighting shortfalls and taking action to address them.

Staff told us they felt able to raise concerns. A new manager had just started employment at the service and support was being provided by a senior management team until their induction was fully completed.

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 unannounced inspection took place on 2 and 3 February 2016 and was carried out by two adult social care inspectors on the first day and one adult social care inspector on the second day.

Before the inspection, we asked the registered provider to complete a 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, there had been electronic difficulties and the registered provider had not received the PIR in time to complete it and return it prior to the inspection. We looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed.

Prior to the inspection, we spoke with the local safeguarding team and the local authority contracts and commissioning team regarding their views of the service. We also received information from five health care professionals. There were no outstanding concerns from any of these agencies.

During the inspection we observed how staff interacted with people who used the service throughout the days and at mealtimes. We spoke with four people who used the service and several relatives. We spoke with the director of nursing, the training manager, the new manager, the acting manager, a nurse, five care staff, an activity co-ordinator, domestic staff and a cook. Following the inspection we spoke with the registered provider.

We looked at nine care files which belonged to people who used the service. We also looked at other

important documentation relating to them such as accidents and incidents and the medication administration records (MARs) for 26 people. 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, the training record, the staff rota, supervision logs, minutes of meetings with staff, relatives and people who used the service, quality assurance audits, complaints management and maintenance of equipment records. We looked around the service to make sure it was clean and tidy.

Requires Improvement

Is the service safe?

Our findings

Some people who used the service and their relatives commented about insufficient staffing numbers and the impact this could have on them. Comments included, "They put me to bed at 11pm, I'd prefer 10pm but there are other people to see to", "Sometimes they come straight away when you ring the bell but at other times you have to wait. I nearly fell when going to the toilet as I'm supposed to wait" and "It's not too long when you press the bell [for staff]." A relative said, "There's not really enough staff on. Sometimes he's in bed at 5pm and he used to be a really sociable person". When we asked the relative why the person went to bed so early, we were told this could be because he was safer in bed when there were not so many staff around. Another relative said, "She had to wait for the toilet yesterday and asked three times; she was getting distressed. Staff said they'd be there in a minute but it didn't happen." On the second day of inspection we observed a person in the lounge shout out to each member of staff who passed the doorway. All of the staff said they would return 'in a minute' but we noted it was 30 minutes before staff actually returned to speak to the person and meet their needs.

On the day of inspection there were 36 people who used the service, 23 of whom required nursing care. The staffing rotas indicated there was one nurse, a senior care worker and five care workers on duty in the morning; this changed to one nurse, a senior care worker and two carers in the afternoon and evening. There was a nurse and two care workers at night. As the night shift started at 7.30pm, this meant there were three staff on duty from this point until 7am. There were separate staff for catering, domestic, laundry and maintenance tasks. There were two activity co-ordinators; one was on shift each day between the hours of 12 noon and 7pm. An activity co-ordinator spoken with told us they could be available for caring tasks when required.

We looked to see if the staffing structure had any impact on people who used the service. We found there were times during the day when there were insufficient staff on duty to meet people's needs. We saw the nurse did not complete the morning medicines round until 11am and on one of the days of the inspection, this was 1pm. The nurse told us there had been lots of distractions and interruptions which occurred daily and meant the medicines round took longer than it should. This meant medicine regimes prescribed by GPs had to be amended and on some occasions had meant that people missed a dose of their medicine. Another area of note that could potentially be an impact of staffing numbers was an increase in falls and incidents in the afternoon and early evening when less staff were on shift. We checked accidents and incident records for a three month period and found 23 out of 36 accidents had occurred between 1.30 and 8pm. We observed the lunchtime experience and noted there were insufficient staff to support people appropriately; in one instance, a person's care plan stated they required assistance to eat their meals as they had a risk of choking. However, we observed this person was not assisted during their meal.

Staff confirmed there were some issues with numbers of staff on duty. Comments from staff included, "There is not enough staff; they are rushed off their feet and there are lots of turns [pressure relief for people] for them to do", "Staff work really hard; we are rushed and there is less time for service users", "We need staff to look after the distractions when the nurse in doing the medicines" and "Sometimes it's alright but lately we've lacked staff" and "There's lots of pressure when staff ring in sick at short notice; on Sunday three

people rang in sick but we managed to get some carers to come in." One member of staff told us they had not had time to have any lunch on the day we spoke with them and two other staff said, "Yesterday was bad; we were short staffed and staff didn't get their breaks."

Not having the right amount of staff available at all times to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The new manager told us staffing was to be increased straight away and they had been assured a budget for this from the registered provider. The new manager also told us they would complete an assessment of people's dependency levels to assist with the planning of staffing numbers.

Care records indicated risk assessments were completed for specific areas such as mobility, falls, moving and handling, tissue viability, nutrition and the use of bed rails. We found there were some areas of risk that were not assessed, for example, specific people's seating positions and some behaviour which could be challenging to others. We also found there were some risk assessments that were not adhered to by staff. For example, one person had a risk of choking and required staff assistance when eating but we observed they were unattended at lunchtime eating their meal. We mentioned this to the new manager and they stated they would check all risk assessments to make sure they were accurate and up to date and staff were aware of them.

We found medicines were obtained and stored appropriately but, due to the length of time the nurse took to carry out the medicines round in the morning, there had been instances when people had not received them in a timely way. The nurse told us that on most occasions, they were able to stagger the medicines throughout the day so people received the correct amount but there had been a few occasions when this had not been possible. The new manager is also a qualified nurse and will address the issue of timeliness regarding medicines administration to people in the mornings.

We found staff were recruited safely. Employment reviews were carried out prior to new staff starting at the service which included references, gaps in work history and disclosure and barring (DBS) checks to ensure they were safe to work with vulnerable adults.

There were policies and procedures to guide staff when safeguarding people from the risk of abuse. Most staff, apart from newly recruited personnel, had completed safeguarding training and knew how to make a referral to the local authority safeguarding team when they had any concerns. There was a system in place to manage people's personal allowance when this was held for safekeeping in the service. The local authority safeguarding team told us they were currently investigating a concern about a delay in treatment for one person.

We found the service was clean and equipment used was serviced and maintained; we saw some equipment was stored in bathrooms. This was mentioned to staff to address. Staff had completed training in infection prevention and control and cleaning schedules were available for domestic and maintenance personnel. The laundry had appropriate equipment and supplies to ensure soiled linen was washed correctly. We saw there was personal protective equipment such as aprons, gloves, hand wash and sanitizer and colour-coded mops and buckets to assist staff in maintaining good infection prevention and control. We observed care staff mixed up the colour-coded mops and buckets and this was mentioned to the new manager during feedback to address.

Requires Improvement

Is the service effective?

Our findings

People told us they were able to access health professionals when needed. They also said they enjoyed the meals provided by the service. Comments included, "I see my GP and the chiropodist; I'm waiting for a medicine course to finish and then I'm going to the dentist", "I'm looked after, thanks; I've no concerns", "I have bad legs and the nurse sees to them; I get to see the doctor when I need to", "Medical people come here when they are needed and I have regular pills and potions", "The food is nice and they provide a variety of juices; yesterday was an off day" and "Yes, we get plenty to eat and drink. Yesterday the fish fingers were so hard, I could hardly eat them." We saw the meal on the first day of the inspection was an alternative to the published menu, as the meat order failed to arrive in time. The presentation was not as good as expected but people and their relatives told us this was an exception to the rule and the meals were usually well-prepared.

Relatives said, "She has complex needs and generally I feel she is well looked after", "Yes, they are looking after her well", "The food is good; she has eaten more here than anywhere else" and "I do like the home and I'm sure he is looked after well. It is proper home cooked food and he gets plenty to eat and drink; he's looking better than he did and is back to being able to feed himself with prompting."

Care files indicated people had access to a range of community health care professionals such as GPs, community nurses, including psychiatric nurses, dieticians, speech and language therapists, a psychologist, emergency care practitioners, chiropodists and opticians. People were also supported to attend outpatient's clinics. A health professional told us it was generally a good service with staff having the wellbeing of their clients at heart. They also said the staff followed instructions and kept them informed of changes in people's needs but said this could be improved at times.

However, we found some concerns regarding the assessment, monitoring and supervision of specific people's health care needs. For example, one person had behaviours which could be challenging to others. Their care file had instructions from a community psychiatric nurse for staff to administer specific medicine for pain relief. We found this instruction had only been followed on one occasion. We spoke to the person and they told us they had back pain. The same person was prescribed a medicine to reduce their anxiety prior to care tasks but often declined to take it; staff had not referred this back to the GP for consideration for the medicines to be given covertly. This was mentioned to the new manager to complete a pain assessment and to check if pain relief and any covert medication were required. We found some people had lost weight but we were unsure if any action had been taken to follow this up; dieticians were providing treatment for some people. There were no records to evidence those people with weight loss were weighed more frequently. We found blood pressure readings for some people were very low and if correct would have required follow up; this had not been completed. We saw staff were not always ensuring people had foot rests in place when they sat in recliner chairs which meant their feet were not supported. We saw two people struggled with their seating position at lunchtime. We saw one person did not receive the required level of supervision during mealtimes in line with their risk assessment. The local safeguarding team are currently investigating an allegation that one person's health care needs were not monitored effectively leading to them not receiving medical attention in a timely way. The daily notes for the person indicated there were

missed opportunities for carrying out observations which may have prompted more timely intervention.

Not ensuring people's health care needs were appropriately assessed and met was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These points were mentioned to the new manager and the registered provider's director of nursing during feedback. Following the inspection, we received information that measures were being taken to address all these issues.

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. We saw assessments of capacity had taken place and best interest meetings held for specific people and particular issues, for example, a person who attempted to leave the building unescorted which placed them at risk of harm, a decision for a person to remain living at Sutton House and day to day care decisions for another person. However, we asked the new manager for assessments of capacity and best interest decisions for areas such as the use of equipment that restricted people's movement, for example bedrails and kirton chairs. We found these could not be located. The new manager told us they would address this. In discussions with staff, they had an understanding of MCA and the need for people to consent to care provided. One staff said, "We must gain consent and explain what we want to do."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the registered provider was working within the principles of the MCA on some occasions. We saw applications for DoLS had been made for some people but they had yet to be assessed and authorised. There were potentially more people who met the criteria for DoLS. We found staff were using holding techniques to support one person during personal care tasks, as their behaviour could be challenging for staff at this time. A DoLS application had been made for this person but not authorised yet. The registered provider had arranged for a consultant to review people's assessments and care plans to ensure the least restrictive practice with regards to MCA and DoLS. We found most staff had completed basic training in MCA and DoLS, however, the consultant was to provide additional training to designated staff in application completion and processing and monitoring systems. The new manager is to keep the Care Quality Commission informed of DoLS authorisations.

We found one choice was prepared for the main meal at lunchtime although catering staff confirmed alternatives could be provided and we saw these were listed on the menus. They also confirmed special diets, fortified meals, adapted cutlery and plate guards were available for those people who required them. We observed the lunchtime experience and found this could be improved to ensure people's nutritional needs were met more effectively. There was a lack of organisation which meant not all people received the full support they required. We saw meals were delivered on trays to those people who preferred to remain in their bedroom. However, we noted the hot dessert was served at the same time which meant it would be cold before it was eaten. A nutritional risk assessment was completed for people, their weight was monitored in line with this and dietician referrals made when required. There were some occasions when weight loss had been recorded but we were unsure about the action taken. The new manager told us they would follow this up and they also confirmed they would reorganise the lunchtime staffing arrangements to better suit people's needs.

On the first day of the inspection we met the registered provider's training manager. They had recently visited the service and completed a staff training analysis; they had planned a series of training days to ensure all staff had up to date certificates in essential training. Staff confirmed they had completed training

and had ideas about the additional training they required; they were to raise these in discussion with the training manager. There was also additional training planned, for example, dignity in care, person-centred care and effective record keeping. The training manager told us they were also to revisit dementia awareness with staff and holding techniques which were used for one person. A community psychiatric nurse had given guidance and advice regarding the person's initial support and there were instructions in their care plan but not all staff were confident when supporting the person. We were told formal supervisions were underway by the new manager and training manager to ensure staff felt supported; some supervisions were behind schedule. New staff shadowed more experienced staff and worked through an induction pack; we were unable to locate induction and supervision records for two of the new staff whose records we checked. However, one of the new staff, a nurse, told us they had a mentor for support and advice which they had found helpful. The training manager told us they would address supervisions and induction records.

There had been measures taken to ensure the environment supported people living with dementia. For example, all toilet doors were painted red to easily identify them, there were photographs of people who used the service on their bedrooms doors, there were grab rails and equipment to aid mobility and signage around the service. We noted there was no menu on the notice board in the dining room; this would assist people when making choices for their meals.

Requires Improvement

Is the service caring?

Our findings

People told us staff were caring and kind, their privacy was maintained and they could make choices about aspects of their lives. Comments from people who used the service included, "The staff are nice. [Member of staff's name] is my keyworker and she's nice; she goes shopping for me", "Oh yes, [privacy is respected] they knock on the doors, shut curtains for dressing and keep me covered", "I am happy and looked after; I have no concerns", "laundry is done properly; some items go missing, for example, socks but they reappeared this morning", "I like spending time in my bedroom; I have my plants, television and DVDs", "No-one questions when I want to go to bed or get up. I can stay in my bedroom but I choose to come out into the lounge" and "I prefer to stay in my bedroom and my bed; they come and check on me. I can't think of anything they can improve for me."

Relatives said, "It has taken a while for her to settle but now she is ok", "I have seen staff working well with people", "Staff are helpful", "They keep us informed and involve us", "We are welcomed and offered a cup of tea" and "Staff are kindly but very busy. Sometimes he has not had a shave; he likes a wet shave but I've brought him an electric one so it is quicker. I am happy with the care. He is happier here than other places; it's more relaxed here." Relatives told us they were able to have meals provided for a nominal fee. Relatives also told us they had witnessed staff observe people's privacy and dignity. They said, "Oh yes, they ask me to wait outside whilst they do any personal care. There is a privacy curtain between the two beds" and "We feel part of her care and come daily."

Two visitors told us staff approach when advising them of their individual relative's care needs could be improved so they didn't feel as though they had been 'told off'. One of the relatives had been upset by this and when we passed on the details to the new manager, they arranged a meeting with them to sort out the problem and ensure they felt included in the person's care.

We observed some positive interactions between staff and the people who used the service. For example, we overheard a member of staff try to reassure a person when they thought there was a dog in their bedroom. On another occasion, we observed staff were very attentive to one person who had asked to go to the toilet but who declined to put their slippers on. The member of staff quickly went to get socks instead and patiently explained the need to protect her feet, gently supported the person to stand, reassured her throughout, escorted her to the toilet and reminded them they would wait outside for them, which they did. Catering staff were observed giving out mid-morning drinks; they asked people what they wanted, served a selection of biscuits on plates, provided yoghurts for some people and positioned tables to put drinks on. The interaction was pleasant and friendly.

However, we observed some incidents where staff practice could impact on privacy, dignity and choice. For example, staff directed the visiting dentist to treat people in the dining room rather than the treatment room as a medicines audit was being carried out there. The dental treatment consisted of a consultation and impressions being taken of a person's mouth. On another occasion we observed a member of staff's approach to a person living with dementia could be improved. On other occasions we observed staff spoke very loudly when it was not necessary. We overheard staff refer to the task of supporting people to the toilet

in a way that did not reflect good person-centred practice. We saw staff gave out pastries to people using their fingers and no gloves and did not place them on a napkin or plate. We observed a person was not provided with a choice of where they wanted to eat their lunch and was not given a proper explanation that they were being taken to the dining room. We observed one person who used the service was shouting out from their bedroom; we had to prompt staff to go in and see if they were ok. Staff were busy and there were periods when people sought attention but this was delayed. This had the potential to impact on dignity. We saw some people who required a hoist for transferring had their own sling whilst other people shared these. These points were raised with the director of nursing and the new manager during feedback so they could address with staff.

In discussions, staff were clear about how they promoted privacy and dignity. They described how they would close privacy curtains and doors, and keep people covered during personal care. They also described how conversations with health professionals such as GPs and district nurses would be held in private. The acting manager said, "The main focus here is to give a high standard of quality care to people, maintain their privacy and dignity and to provide assistance when needed. I feel we meet this; the staff are caring."

Care files mentioned what people preferred to be called and their assessments prompted staff to maintain privacy and dignity.

The new manager was aware of the need for confidentiality with regards to people's records and daily conversations about personal issues. People's care files and medication records were held in the treatment room which was lockable when not in use. However, we observed instances when the room was not locked and two of the drawers where care files were stored had the front missing. We also saw some personal care records were stored in folders and envelopes in the hairdresser's room which meant they were not secure. These boxes were meant to be archived. This was mentioned to the new manager to address. Staff records were held securely in lockable cupboards in the new manager's office. The new manager confirmed the computers were password protected to aid security. Following the inspection we received an action plan which included a refurbishment of office areas, new storage for care files and a redesign of the clinical area and nurse's station.

Requires Improvement

Is the service responsive?

Our findings

Most people we spoke with told us they would be able to raise complaints. Comments included, "Yes, I would definitely tell them [staff]", "Yes, I would tell someone but I don't like complaining though as it upsets me", "Yes, I would complain and tell the girls; they listen to you always" and "Absolutely, I would feel able to raise concerns. I would tell the person in charge." One relative told us they felt they could not raise issues as well as they used to when the previous manager was in post. They said, "Whilst there is no-one here [registered manager], the systems have gone down. I brought things up with [previous manager's name] and she addressed them."

People told us there were activities to participate in which they enjoyed. A relative told us, "He is interacting more; I want him to come out of his room and be in the lounge more." One relative told us the noise levels in the service could be an issue and we observed this during the first day of the inspection. We observed there were two different door bells, one which was a long continuous sound until answered and a second one that had a short burst of ring tone. The door bells and call bells were rung at intervals throughout the day. Staff spoke loudly to people and to each other. Music played continuously until an activity took place which then increased the noise levels. We saw it was difficult for people to find a quiet place to sit apart from their bedrooms. We noted it was a bit quieter on the second day of the inspection. There was a small sitting room with space for two or three chairs which was occupied on both days of the inspection by one person.

People had assessments of their needs completed prior to admission. These contained a range of information, for example, how staff would need to support the person to maintain a safe environment, how the person communicated their needs, nutritional concerns, mobility, continence, sleep pattern, preferences for gender of carer, personal hygiene and dressing. There were also risk assessments to identify specific areas of concern, for example, skin integrity, falls, moving and handling, nutrition and the use of bed rails. There was also information in most people's files about their life history, family relationship details, their interests and hobbies, and what was important to them.

Care plans were produced from the assessment information. We found the care plans contained some detailed information, for example, each person had a form which indicated how they were to be moved and handled safely. However, other areas of the care plan were generic and did not contain sufficient personalised information to give staff guidance in how to fully meet people's needs in the way they preferred. Staff spoken with knew how to care for people but there was a risk of care being overlooked if not planned for fully. This was mentioned to the director of nursing and new manager during feedback. Following the inspection, we received an action plan which detailed that all care plans were to be audited and everyone's moving and handling needs reviewed during the second week of February 2016. A company had also been contacted regarding a supply of high risk pendants for some people who used the service to more effectively manage their falls risk and safety.

We saw people who required closer monitoring in specific areas had charts for staff to complete. This enabled managers to check if there were any concerns, for example, with fluid and nutritional intake, pressure relief and behaviours which could be challenging. We found the completion of monitoring charts

was inconsistent and could be improved in some areas. For example, with pressure relief charts, staff did not always indicate the required frequency so it was difficult to audit if what was recorded was actually in line with risk management. Sometimes staff referred to the person being 'repositioned' but did not state which side this was. Diet and fluid charts were inconsistently completed and fluid intake was not calculated or analysed for any concerns. The new manager told us they would address these issues with staff.

We saw bedrooms were personalised to varying degrees. People were able to bring in photographs, ornaments and pictures to make their bedroom look homely.

We saw there was a range of activities for people to participate in if they chose to. There were two activity co-ordinators who, between them, worked from 12noon until 7pm seven days a week. The activity co-ordinators maintained a file which included a programme of daily events – this was also displayed on the notice board in the main lounge and we were told it could be subject to change if people wanted to do something else. We observed group activities and one to one sessions took place with people to ensure there was social stimulation and involvement. One person used doll therapy and we saw they gained comfort from this. We observed an activity where pictures of famous faces were shown to people who used the service, they were asked if anyone knew who they were and then discussed them. There was also a sing-a-long session which people really enjoyed. We observed one person sitting in the quiet lounge was listening to the quiz activity and contributing in their own way by repeating names. They were clapping along to songs and singing. However, staff didn't notice and they were not invited to participate in the main lounge.

The range of activities included, painting and craft work, bingo, dominoes and other games, play your cards right, ball games, pampering sessions, reminiscence and seasonal crafts such as making Easter bonnets and Christmas decorations. The activity file showed some people had participated in outings to local parks and shops and a zoo in Doncaster. The activity co-ordinator told us they ensured people who remained in their bedrooms had one to one attention which could be sitting and chatting to them or hand and nail care. They also confirmed the file contained dates of people's birthdays and staff celebrated with them with cards, banners and a cake.

There was a summer house in the garden which had been purchased from the 'residents fund' and people enjoyed using this in warmer weather. They also enjoyed the well-stocked aquarium in the entrance area.

There was a complaints procedure which was displayed in the service. This described how people could make a complaint and how to escalate it if required. The staff had access to a complaints policy and procedure to guide them in how to manage complaints. This included letters for acknowledgement and forms to record the details of the complaint, investigation and outcome.

We recommend that the service seek advice and guidance from a reputable source, about the formulation of person-centred care plans.

Requires Improvement

Is the service well-led?

Our findings

The previous registered manager left the service in September 2015 and an acting manager was appointed. People who used the service and their relatives were aware the previous manager had left the service and they knew who had been temporarily in charge until recruitment of a new manager was completed. In the interim there had been visits, to support the acting manager, from the senior management team which consisted of the registered provider, the company's director of nursing and the training manager. The new manager started employment at the service the day prior to the inspection. The director of nursing and training manager told us they were to continue visits over the next few weeks to improve systems and to oversee the service until induction of the new manager was fully completed. The registered provider held a meeting to introduce the new manager to the staff team.

Staff told us the service was busy but had a nice atmosphere. We found there was an open culture and staff were able to raise concerns with the registered provider and management team. Some staff said when the senior management team visited it would be nice for all staff to be introduced to them. The acting manager told us they had received supervision from the training manager and there were records of support and monitoring visits to the service undertaken by the director of nursing. The registered provider told us they completed visits to the service and the senior management team was available for support as required.

There was a quality monitoring system in place but we saw it had only been partially implemented since the previous registered manager left the service. We found the organisation of staff deployment could be improved, especially at mealtimes, and there was a lack of oversight regarding documentation and some staff skills and practices. The 'manager's monthly audit' had not been completed since November 2015. The last form dated 27 November 2015 indicated that an audit for areas such as care plan reviews, people's weights, risk assessments, meetings and complaints had taken place but did not identify the results and any issues to be addressed. A monthly pressure ulcer audit had not been completed since November 2015. There had not been an analysis of accidents to help look for trends and to see if they could be prevented. There was a food safety tick box check completed in November 2015, which found there were no actions to correct. We saw one medicines audit, which was completed the day prior to the inspection by the new manager; they had identified some recording and practice issues such as the treatment room door unlocked and they told us these would be discussed with staff.

The acting manager told us an environmental audit had not been completed since the previous registered manager left the service. We could not locate any environmental audits. We observed areas of the service were looking tired and in need of refreshing. Following the inspection we received information from the registered provider that a review of the refurbishment/redecoration plan will take place at the beginning of March 2016.

The quality monitoring systems had not identified that some areas had not been addressed and some concerns had not been followed up. For example, the 'manager's monthly audit' in November 2015 had not identified that some risk assessments were missing from care files, care plans lacked some person-centred information, those people with weight loss had not been weighed weekly, low blood pressure readings were

not investigated, correct wound care documentation was not in place and the environment was tired in places.

Not having an effective governance system in place was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw staff meetings had taken place for catering, domestic, care and nursing staff. The minutes for the meeting in November 2015 stated that new wound care documents were to be introduced but we saw during the inspection this had not been implemented and nursing staff were using daily diary notes which did not prompt them to record full details. The meetings exchanged information and provided staff with the opportunity to express their views. There were minutes of a meeting held with relatives in May 2015, which was open and honest and discussed a recent complaint and asked for their views.

We found there had not been any questionnaires completed in 2015. This was confirmed in discussion with the acting manager and administrator. There had been questionnaires and a quality review the previous year in November 2014. The new manager told us they would initiate the quality review as soon as they are settled into their role.

We found some minor organisational issues that required attention. For example, there was only one phone line into the service which made it difficult if the nurses needed to follow up health care issues when it was in use. Staff spoken with said that a mobile phone for the nurse in charge would resolve the issue and enable them to keep in touch with staff on the ground floor when they were on the upper floor. Also we observed domestic staff approach the nurse on duty for a key to a storage cupboard on the ground floor. The nurse handed over the full set of keys and confirmed this was a regular occurrence and they would have to seek out the domestic staff to retrieve them. Copies of appropriate keys would resolve the issue. These points were mentioned to the director of nursing and the new manager during feedback to address.

We found there were communication systems in place to ensure information was cascaded to staff. These included a shift handover and records were made at each one referring to any accidents, wound care dressings and appointments. We checked some of these documents and found some staff described issues more fully than others. Also some anomalies were not followed up, for example, there were records of very low blood pressure readings but these were not questioned. There was also an unprofessional comment about a member of staff which did not belong on the handover record. This was mentioned in feedback during the inspection.

The acting manager and new manager were aware of their responsibilities in notifying the Care Quality Commission and other agencies of incidents which affected the safety and welfare of people who used the service. We have received notifications in a timely way.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who use services had not been consistently provided with care that was person-centred and which was appropriate to meet their assessed needs. Regulation 9 (1) (a) (b) (3) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have effective systems and processes to ensure the service provided was safe, effective, caring, responsive or well-led. Regulation 17 (1) (2) (a)(b)(c)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not deployed sufficient numbers of suitably qualified, competent, skilled and experienced staff at all times to make sure they can meet people's care and treatment needs. Regulation 18 (1) (c).