Sutton Veny House Limited

Sutton Veny House

Inspection report

Sutton Veny
Warminster
Wiltshire
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Tel: 01985840224

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Sutton Veny House is a nursing home for up to 28 people on four floors. There were 17 people at the service during our inspection. There was a passenger lift to access the upper floors. People had a communal lounge, dining room and there were extensive gardens. Within the grounds were six bungalows which staff provided emergency call out cover for.

People's experience of using this service and what we found
People were at risk of harm as the provider had failed to always assess and manage risks. Risk management plans were not robust and required monitoring was not carried out safely. There were not enough staff deployed to make sure people were safe day and night. Staff had not been recruited safely. People did not always receive their medicines as prescribed. Guidance was not available to support staff to know when to administer 'as required' medicines.

People's needs were not always assessed thoroughly so the service could not be sure they could meet them prior to admission. Guidance for staff to support people's healthcare was not up to date and was conflicting. Additional healthcare monitoring was not being carried out effectively. Mealtimes were hurried as there was not enough staff available and we observed undignified practice during mealtimes.

People told us the lack of staff available impacted on their dignity. People had to wait for long periods of time for staff to give them the support they needed. Whilst people and relatives thought the staff were kind and caring they said there were not enough of them. People had not been involved in their care and support. Care plans had been reviewed without their involvement. People were afraid to speak up and share their views, there was not an open and transparent culture at the service.

There was no registered manager at the service and since our last inspection there had been an inconsistency of leadership and periods of time without a manager. Quality monitoring was not robust and there had been no learning from incidents. Staff had not had meetings and all felt there was not enough of them to carry out their roles.

The environment was clean and free of odours. Staff used personal protective equipment appropriately.

Activities were available, and we saw people enjoyed activity such as pottery classes. Visitors were welcome at any time.

Staff followed the principles of the Mental Capacity Act (2005) and assessed capacity when needed. Where people lacked capacity staff followed best interest processes.

End of life care was provided, staff had completed care plans for people which recorded their wishes for care and support. People could see their GP weekly if they needed. Staff communicated with each other using

handover notes to share changes in people's needs.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection - The last rating for this service was Good (report published 16 November 2017.

Why we inspected
The inspection was prompted in part due to concerns received about staffing numbers and people being unsafe. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to unsafe staffing numbers, unsafe recruitment, failure to manage risks, unsafe medicines management and a lack of governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Sutton Veny House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by one inspector.

Service and service type
Sutton Veny House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. An interim manager had been appointed to manage the service until a permanent manager was appointed. We were told a new manager had accepted an offer of employment and would be starting in early 2020.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed all the information we had about the service prior to our inspection. This included whistleblowing concerns about people's safety. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and three relatives about their experiences of the care provided. We spoke with eight members of staff and the manager. We reviewed a range of records. This included nine people's care plans and multiple medication records. We looked at eight files in relation to recruitment. A variety of records relating to the management of the service, including health and safety checks were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, some operational reports and policies and procedures. We also contacted Healthwatch to see if they had any information about this home. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people's safety had not always been identified, assessed and managed safely which placed people at risk of harm. We received information of concern about a person with dementia leaving the service and being 'lost'. When we contacted the service, they told us a person with dementia had left the home without any staff knowing. The person was returned safely by a member of the public. This had happened at 1.20am.
- The service had not informed the local authority safeguarding team of this incident and had not notified us. Both of these actions have since been completed following our prompt.
- The regional manager informed us of the action taken by the provider to make sure this person remained safe. During our inspection we found the safety measures in place were not robust. The person was placed on half hourly monitoring by staff to check regularly where the person was. Records demonstrated these checks were not being carried out half hourly. Some staff were recording hourly and we also saw gaps in the recording in these records.
- In addition to half hourly monitoring the regional manager told us a sensor mat would be in use and checked regularly by staff to ensure it was working. We found during our inspection there was one occasion this mat was not working. This meant staff were not aware the person had moved. We saw the person was in their bathroom and notified staff of this shortfall.
- The person had exited the building via a side door. The staff had put a notice on the door to inform staff, relatives and visitors to make sure the door was locked. We found during our inspection the door was unlocked on two occasions. We suggested to the provider this door be fitted with an alarm to alert staff that it had been opened. Following our inspection, the provider informed us this action had been taken.
- One person had moved into the service on a four-week trial. The person was causing concern as they were mobile and restless and had dementia. They did not understand the risks posed by the environment.
- Whilst staff had assessed the risk of the person falling, no other risks had been assessed and there was limited guidance for staff to follow to keep this person safe. On the second day of our inspection we were told the person had slept in the lounge for their own safety, so they could be monitored by staff. A member of staff completed the person's care plan following our prompt. Staff had contacted the local authority to ask for an urgent review as they were not able to meet this person's needs.
- People who were at risk of malnutrition or choking had not had their needs assessed accurately. Staff used a tool to assess the risk of malnutrition which we saw had provided different scores for the same person. We asked a member of staff about this who was not sure why this was. Staff were providing three people with modified diets, one of which was a pureed diet. It was not evident that these people had been referred to the speech and language therapists (SALT) for assessment. We checked with the staff who confirmed a referral had not been carried out. Within their care plans it stated for two of these people they

were at risk of choking, but no choking risk assessment had been carried out. We raised this with a nurse. Following our inspection, the provider supplied us with evidence that one person had been referred to SALT. However, the guidance supplied by SALT was not recorded in the person's care plan.

● Accidents and incidents were recorded on an online system. It was not clear what incidents had occurred at the service as there was no system in place to provide an overview. Staff first on the scene of an incident did not always complete the record and it was not always completed at the time of the incident. For example, a person fell on the morning of our inspection. We asked the see the report at 2.40pm and were told it had not been completed. This practice does not enable staff to record contemporaneously what happened.

● For the incident where a person had left the building without staff knowing we saw two incident forms had been completed. Both contained different information. We asked the regional manager and the manager to update us following our inspection with the correct information which they did.

● Systems were not in place to learn from any incidents or accidents. Staff did not have meetings to discuss any learning and information was not readily shared. One member of staff we spoke with did not know a person had got out of the home without staff knowing which meant they were not aware of the risks.

There was a failure to assess the risks to the health and safety of people living at the service and put into place robust safety measures. Whilst we saw no evidence of harm this was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● People were not always receiving their medicines as prescribed. People had medicines that had been prescribed 'as required' PRN. There were no person-centred 'as required' protocols in place to provide staff with guidance on how to safely administer this type of medicine. The manager told us they did not know why these had been removed and would put them in place without delay.

● Where people were prescribed multiple medicines for pain management or constipation there was no guidance in place to know what medicine to give and when. For example, people had been prescribed many medicines to treat constipation. It was not clear what order staff were to use each medicine and when to move onto another medicine.

● People had a medicines administration record (MAR) to record the medicines they had been prescribed. We saw there were gaps in the records for some medicines which meant it was not clear if people had been administered their medicine as prescribed. We raised this with the manager who told us they would review the MAR.

● Handwritten entries on people's MAR had not always been signed by a member of staff. National Institute for Health and Care Excellence (NICE) guidelines states that two members of staff should sign any handwritten entry or amendment on a MAR. This helps reduce the risk of transcribing errors.

● People had a topical medicines administration record (TMAR) to record the application of creams and lotions. These records were stored in people's rooms and completed by care staff. We found people's TMAR did not contain guidance for staff to know what cream to apply and when to apply it. Creams and lotions stored in people's rooms did not always have a date of opening recorded so staff would know when to discard it.

● People who had allergies were at risk. We found some people who had their allergies recorded on their medicines sheet but not on their MAR. In the event of a person going to hospital their MAR would go with them. Without all the information required recorded this put the person at risk.

Unsafe medicines management placed people at risk of harm. Whilst we found no evidence of harm this was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The provider had failed to provide safe numbers of suitably skilled staff to meet people's needs. Prior to our inspection we received concerns about staffing numbers at the service. During our inspection people, relatives and staff told us there were not enough staff available which meant people had to wait for long periods of time for care.

● Comments about staffing numbers included, "Enough staff on duty most of the time, sometimes there is not enough on the weekends", "There is a lack of carers sometimes", "There is not enough staff here, no time to sit and chat" and "Sometimes there has only been one carer here at night." One person told us, "There is not enough staff on duty, especially when I am wet, I am told to wait and wait, this happens every day."

● Prior to our visit we were told by the regional manager staffing numbers were calculated based on people's needs. The regional manager told us the staffing numbers were safe. During our inspection we were told by people and staff they believed staffing numbers were provided based on the number of people living at the service, not their needs.

● Our observation during our inspection was there was not enough staff available to safely meet people's needs. Staff were caring for people over four floors. The building had many corridors so there was a lot of ground for staff to cover. For 17 people there were four staff in the morning and three in the afternoon. There was also a registered nurse on duty all day. This was not safe. Many people needed two care staff to help them with personal care and to re-position. We observed staff struggled to support people to eat effectively during mealtimes. We saw there were no staff available to help external activity providers carry out their planned activity.

● Staffing rotas demonstrated in November and December there were eight shifts that two care staff were working in a morning which put people at risk of harm. We were told there were times when staff were not able to work at very short notice. Agency staff were not able to cover the shift at short notice.

● We were told there had been a turnover of staff with many staff leaving since our last inspection. This had placed strain on existing staff to train new staff. Staff raised concerns that new staff were not given sufficient time to learn about the role before being placed on the rotas. This placed people at risk of harm.

The provider failed to deploy adequate numbers of suitably qualified staff. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had been employed without the required pre-employment checks being carried out. We found in seven of the recruitment files we checked there was not a clear record of the member of staff's full employment history. For example, one member of staff had their employment listed without any dates recorded for when they worked at each job. Another had no employment history recorded. This impacted on the ability to check references from previous employers for accuracy.

● References had not always been obtained from employers directly. For example, one member of staff had declared they had worked in a care home. The provider had not contacted the employer for a reference but a colleague who worked alongside them. This reference was not from the employer.

● We discussed these shortfalls with the manager who told us staff at their head office carried out the necessary recruitment checks and stored some records. We observed records held electronically for three members of staff and saw there were shortfalls.

The provider had failed to carry out the required checks on staff prior to starting employment. This put people at risk of being supported by staff who were unsuitable. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The home was clean and smelt fresh. We observed staff using personal protective equipment when

providing care. There were ample supplies of gloves and aprons available to staff.

● Prior to our inspection the kitchen had been inspected by the local authority environmental health officer. They had been told they had very good standards of hygiene. Following our inspection the provider informed us that a '5' rating had been awarded.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People were not being cared for by staff who had been adequately inducted and trained. Staff had not always been provided with induction when they started at the home. Staff told us some new staff had been counted in the numbers without any time off the rota to learn the providers policies and procedures. One member of staff said, "There is not enough time for staff to have a good induction, new staff are counted in the numbers, it is hard for them [new staff] and hard for us."
- Some staff had been recruited through an agency. These staff had not been given an induction from the provider. Whilst they had completed training with the agency they had not completed the provider's own training.
- Training records demonstrated that staff needed updates in training such as moving and handling, safeguarding, health and safety and first aid. We were not able to see records of any training in areas such as diabetes, end of life or medicines management. We asked the provider to send us records of medicines training following our inspection but these were not supplied.
- Staff told us they had been able to have a supervision with their supervisor but found it was not always effective. One member of staff told us they discussed the same things in all supervisions, so they did not find the process helpful. The provider had identified supervision had not routinely taken place but had not put in robust actions to correct this shortfall.

The provider had failed to make sure staff received appropriate training to enable them to carry out their duties. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs had not always been effectively assessed. Staff could not demonstrate they had taken into account all information gathered as part of pre-admission assessments for one person. The impact of this was that the service were not able to meet this person's needs.
- People's care and support was not delivered following an accurate or comprehensive assessment. Whilst the provider used nationally recognised tools to assess areas such as malnutrition and pressure ulcer development we were not confident they were accurate. We saw for some people there were different scores within their assessment. We asked a member of staff who was not sure why this was. In addition, when people had lost weight this had not been used to inform the review of assessments of malnutrition or development of pressure ulcers.
- Assessments for areas such as pain had not been carried out. This was a concern for people who had

dementia or were frail and not able to communicate their pain.

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutritional needs, likes and dislikes were recorded on a form when they moved into the home and shared with the kitchen staff. There was not an effective system in place to make sure this information was reviewed. Forms had not been updated though some people had lived at the service for many years.
● Menus were planned seasonally which meant they changed regularly and people had a copy of the menus in their rooms.
● People's views on the food was mixed. Comments included, "The food could be better, it is very predictable and not to my taste", "Food is atrocious for what we pay" and "Food is good and there is enough of it."
● Mealtimes were hurried as there were not enough staff to support people's needs.
● Staff took meals to people in their rooms on trays. Staff transported meals upstairs on a rack which was not heated. This meant hot meals were standing whilst they were served. If staff were delayed with a person, it meant other people had to wait for their meal. The food was cooling down during this delay. We observed staff brought the hot food upstairs at 12.30pm. They served the last meal from the rack at 12.46pm. This meal had sat for 15 minutes on the rack.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Referrals had been made to some healthcare professionals such as local GP's. Staff told us the GP visited every week and would see people if they needed. The manager told us they would make sure people who needed it were referred to the speech and language therapists following our inspection.
● The manager was aware of the support available to people using the care home liaison team who provided guidance for people with dementia or mental health issues.
● Staff used handover sheets to share information with each other. This recorded daily changes and any health concerns.

Adapting service, design, decoration to meet people's needs
● Sutton Veny House was an old building which had been adapted to provide a nursing home. Due to the layout it was not suitable for people with dementia who were very mobile. Staff recognised this limitation however; a person had been admitted with this need. Staff were struggling to keep this person safe.
● Areas of the home were in need of repair. For example, some flooring was threadbare and in need of replacing and one wall was water stained where there had been a leak.
● There was no signage available to help people find their rooms or any communal room. The environment could be very confusing for people with dementia.
● People were able to personalise their rooms which they had done. Some people had brought in their own furniture and put up pictures and photographs.
● The building had its own substantial gardens.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests

and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- Staff were working to the principles of the MCA. Staff had assessed people's capacity and used best interest decision making to support people where they lacked capacity. People's records demonstrated staff considered the least restrictive options.
- Where needed an application to the local authority for a DoLS had been applied for. Those that had been authorised were recorded with any conditions being met.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People's dignity had been compromised due to the lack of staff available to meet people's needs. People told us they had to wait for long periods of time to have the help they needed. Comments from people included, "There is not always enough staff, I have to wait for the toilet longer than I would like", and "I rang the bell for help, I waited, and waited and waited and waited, then the staff came and told me I would have to wait."
- We observed a member of staff support two people to eat at the same time. This was not dignified. Whilst the support given was kind and caring this is not best practice. Another person had their meal blended all together. The staff member supporting them to eat did not know what was in the bowl. This meant they would not be able to tell the person what they were eating while supporting them to eat. They would not be able to check the person wanted to have that meal.
- People's notes and personal information was not securely stored at all times. We observed people's files were moved around the home with the person. This meant files with personal information were stored in areas where unauthorised people could access it. For example, when one person went to the lounge their file was placed on a chair. There was no staff around to observe this. I told a member of staff where the file was who said it should be in the drawer in the lounge. But this drawer was not locked.
- People had not been asked if they preferred a male or female care worker to provider their personal care. We had received concerns about shifts where there were only male care workers on duty.
- Communal bathrooms were being used to store equipment. We saw pieces of equipment in most of the communal bathrooms. Whilst this could be removed if people wanted a bath or shower the rooms did not look inviting. For example, in one bathroom we saw a hoist, two commode chairs and one walking frame being stored.
- Despite the concerns about numbers of staff, people and relatives told us staff were caring and kind.
- Staff told us even though they were short of staff they enjoyed their work at Sutton Veny House. Comments included, "I love it here, I like to see it when people laugh" and "It is like a little family here."
- People could have visitors when they wished without restrictions.

Supporting people to express their views and be involved in making decisions about their care

- People told us they were not involved in their care. One person said they had a review with a social worker but not with staff from the home. People were not able to routinely share their views on what was working for them and what needed changing. Care plans were evaluated by staff on a computer, there was no evidence that people were involved.

● People told us they were afraid to speak out about the lack of staffing and the impact this had. When we were talking with people they were very concerned about sharing their concerns openly.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People had a care plan that was personalised and reviewed by staff. Some care plans were detailed with good guidance for staff to follow. However, some were conflicting and lacked guidance.

● One person's care plan stated they had to be observed every 15 minutes as they were at risk of falls. Further on in the care plan it stated hourly checks would be adequate. Another person had a care plan which stated they had pain relief prescribed when they needed it, but their medicines administration record had pain relief prescribed four times per day. For another person we saw their nutrition care plan stated they ate their food independently. We also saw in their care plan they needed staff to cut up their food and prompting to eat. We observed this person eat on both days of our inspection and saw staff supported them to eat.

● Where people required additional monitoring, this was not being recorded so there were gaps in people's records. For example, people who required their food intake to be monitored did not have records to demonstrate what they had eaten. People who required fluid monitoring did not always have targets for staff to know what they needed. Some people had only consumed 300 or 400 mls of fluid on some days. Nurses did discuss this in handover and said they would refer the people to the GP.

● Monitoring forms were duplicated and confusing. People who needed their whereabouts monitored had two records being completed. Following our inspection the provider informed us staff kept one daytime record and one night time record. We saw that this duplication had caused confusion amongst staff who were recording on one record but not the other. This did not give us assurances people's risks were being managed effectively which was a concern due to one person leaving the building during the night without staff knowing.

The provider had failed to provide care records that were fit for purpose. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People had some activities which they could participate in. People told us they enjoyed the pottery classes and musical events. One person said, "I enjoy the pottery and the singing but there could be more going on."

● Whilst there was some activity for people to participate in there was a lot of time spent with nothing going on. People told us they would like more to do.

● Due to the staffing constraints we observed staff did not have time to sit with people and talk to them. Staff told us sometimes they had time to do this in the afternoon but not often.

● Some people preferred to stay in their rooms which was respected by staff. We were concerned these people were at risk of social isolation. Staff did not have time to spend with them outside of personal care activity.

Improving care quality in response to complaints or concerns

● People were not supported to make a complaint when they wanted to. People and relatives, we spoke with were not confident they could make a complaint without being victimised. Whilst the provider shared with us two complaints that had been made it was evident during our inspection more people were not happy with their care.

● We saw the provider had a complaints procedure which was shared with people when they moved into the service. We were told this could be provided in different formats for people who may need larger font.

End of life care and support

● People were able to stay at the service until the end of their lives if they wished. In addition, people were able to use Sutton Veny House for palliative care. During our inspection we saw one person had been admitted for palliative care. They had only been at the service for a short period of time so we were not able to see if their care was responsive to their needs.

● Staff worked with local healthcare professionals to make sure people had the right medicines and equipment to be comfortable.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs had been identified and assessed. How to support people with communication was in their care plans. For example, people who needed glasses or hearing aids to communicate had this recorded for staff to know how best to communicate.

● However, alternative methods such as pictorial information were not widely in use at the service to support people to communicate. For example, menus we saw were text and not pictorial. We did see one person who used pictorial communication sheets in their room. When they were in the dining room there was no pictorial information available to help them communicate.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- At our last inspection we identified the culture at the service was not open, inclusive and empowering. The registered manager had not demonstrated leadership that supported staff. After that inspection the registered manager left, and the service has been unable to recruit and keep a registered manager.
- At the time of our inspection there was no registered manager. The provider informed us following our inspection that a new manager had been recruited and would be starting in early 2020. Comments about the management included, "I don't know who the manager is, we have not had a proper manager for ages" and "If feels very unsettled at the moment, we need a manager."
- An interim manager had been appointed and was managing the service day to day. The regional manager visited the service monthly to carry out operational audits. There was an inconsistency with the leadership at the service. New management had changed how staff worked which had led to confusion amongst staff. The lack of team meetings had contributed to poor communication at the service. One member of staff told us the provider was secretive and did not share information with staff about what was happening.
- Changes had been introduced without consultation with staff. For example, activities had been changed to happen in the afternoons, staff were not clear why. The home did not have a receptionist or administrator which impacted on nurses having to answer the telephone. Staff told us they used to have a person to help answer the phone, but they had left. It was not clear why they were not replaced.
- People, staff and relatives told us they had raised concerns with the provider about the lack of staff available. They told us the provider did not listen and had not responded to their concerns. Comments included, "Head office don't understand staffing, we want to give people more time, residents pick up on us not having enough staff", "There is a high turnover of staff here and some carers are working too many hours", "It is very poor here, there is not enough staff on duty and this affects my mood" and "Staff are worked to the bone, there are only two carers on duty sometimes. I have told the provider this."
- People, relatives or staff had not had the opportunity to attend any meetings held at the service to share their views or give any feedback about the service or events held at the service. Staff had not had any team meetings where they could get together and discuss views.
- People, relatives and staff had concerns about giving feedback about the service for fear of being victimised. There was a real fear that the provider would take action against any person who criticised the service. This demonstrated the culture at the service had not improved. People were frightened to tell the provider about their concerns we have reported on throughout this report. Where people had shared concerns, they told us there had been no action taken. One person told us, "Talking does not do anything, it

is like talking to a brick wall."

● Following our inspection, the provider told us they had not received any concerns from people, relatives or staff. They told us staff had a grievance procedure they could use if they wanted to raise concerns. They also told us people were able to complain using the complaints procedure. People were also able to give feedback to staff.

● Quality monitoring was not effective in identifying shortfalls and driving improvement. The interim manager had completed some audits, but these were not robust and had not identified the issues we had found. For example, the recent medicines audit rated the service as 100% compliant. We had found medicines required improvement. A safeguarding audit has rated the service as 76% as new staff had not been given the safeguarding training they needed. Since this time, we could only see two members of staff had been given safeguarding training.

● Management did not always have an oversight of people's needs to make sure suitable risk assessments were in place. One person was known by staff to use the stairs, this information had not been shared with the manager. There was no risk assessment in place to keep this person safe. This same person had lost weight in the previous three months. This had not been identified so effective monitoring could take place.

● Due to the ineffective audits and lack of staff meetings there was no evidence any opportunity existed for there to be any continuous improvement.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● This inspection was prompted in part by an incident which required a notification. The provider did not notify us or the local authority until we prompted them to do so. We were made aware of this incident by a concern raised by a whistleblower.

● Accident and incident forms were not being completed contemporaneously which meant staff were filling in records long after the events. There was a risk information recorded might not be accurate.

● We reviewed one incident where we saw two different incident reports. Both had different information about the same incident. This did not enable the service to reflect and review the incident so learning could take place. We asked the manager to review the reports and update us following our inspection which they have done.

The failure to assess, monitor and mitigate risks and failure to assess, monitor and improve the quality and safety of the service provided placed people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● We saw evidence of one incident which the provider had discussed with the person's relative. They had informed them of the incident and kept them updated with action taken.

Working in partnership with others

● Staff worked with local GP surgeries and the local support services. For example, if a person was experiencing distress the service knew to refer to the care home liaison team.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to carry out the required checks on staff prior to starting employment.

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 provider failed to deploy adequate numbers of suitably qualified staff. The provider had failed to make sure staff received appropriate training to enable them to carry out their duties

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to make sure risks had been assessed and safety measures put into place to keep people safe from harm. Medicines were not managed safely.

The enforcement action we took:

We served the provider with a warning notice

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 provider had failed to provide care records that were fit for purpose and make sure records were completed contemporaneously. The provider had failed to assess, monitor and mitigate risks and failure to assess, monitor and improve the quality and safety of the service provided placed people at risk of harm.

The enforcement action we took:

We served the provider with a warning notice