Care Quality Commission

East Anglia Care Homes Limited

Sutherlands Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 24 and 25 September 2018. The first day was unannounced.

Our last full comprehensive inspection of this service was in May 2017. At that inspection we rated the home overall as Requires Improvement. At that inspection we identified a breach of legal requirements within the key question of Effective.

Following that inspection, we received a number of concerns regarding the quality of care being provided to people. Therefore, we conducted a focused inspection in October 2017 that concentrated on the Safe and Well Led areas only where we found four breaches of three regulations. This was because the provider had failed to ensure that: risks to people's safety had been adequately managed and that people received their medicines correctly; staff did not have the appropriate skills and knowledge to provide people with safe care; robust systems were not in place to assess and monitor the quality and safety of care provided to people. The home was therefore rated as Requires Improvement in both of these key questions.

During this latest inspection the registered manager demonstrated to us that improvements had been made and the home is now rated Good over all. The provider is no longer in breach of any of the regulations that we found at our inspection in October 2017. However, further improvements were needed in some areas as detailed below.

Sutherlands Nursing Home is a 'care home'. The provider advertises themselves as providing specialist care, including nursing care to people living with dementia. It is registered to provide residential and nursing care for up to 52 people and care. At the time of the inspection there were 40 people living in the 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 management of the home was led by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run.

People felt safe living in the home and systems were in place to protect them from the risk of abuse. Risks to people's safety and individual needs were clearly identified managed well. New systems to make improvements to this were implemented following our last inspection had become embedded. People received their medicines correctly and there were systems in place to safely store, manage and administer these.

There were enough staff to keep people safe and to meet their needs. New staff working at the home had been subject to the appropriate checks before their employment began. These checks were designed to

ensure staff were safe to work within care. Any incidents or accidents that had occurred had been reported, investigated and learnt from.

Staff had received training in a number of different areas to provide them with the skills and knowledge to support people effectively. Further training was to be provided to staff regarding dementia care to help them develop their skills further and gain confidence on how to assist people who may regularly become upset or distressed. Staff also received adequate support and guidance in their roles.

People received enough to eat and drink to meet their individual needs. Consent was usually obtained from people before any care was provided. Although staff did not always check with people before assisting them to move in their wheelchair. Where people could not consent, staff acted in line with the relevant legislation and only made decisions on people's behalf in their best interests.

We have made a recommendation to the provider in relation to the environment in the Minton Unit area of the home where people were living with dementia. Further improvements were needed to the design and decoration, that meet best practice guidelines.

People's healthcare was monitored and any needs met. Relationships had been developed with outside healthcare professionals who visited the home regularly in response to any concerns raised. The registered manager had established meetings with the local GP surgery which had led to improvements in communications and monitoring of peoples' healthcare needs.

People were offered choice and were involved in making decisions about their own care. The staff were kind and caring and treated people with dignity and respect. Staff supported people to maintain friendships and relationships. People's friends and family could visit when they wanted with no restriction to this.

People received stimulation from a range of activities that were on offer. This included one to one chats within people's rooms and trips to the local shops. This was being developed further in conjunction with the people living in the home and their relatives.

People and staff were able to raise concerns or complaints without fear which demonstrated an open culture. Any complaints or concerns raised had been appropriately investigated and dealt with.

Audits were in place to monitor the quality of the service people received. The registered manager reviewed the recorded accident and incidents. These were analysed to identify any patterns or trends and plans were put in place to reduce the risk of them happening again in the future. The registered manager was well regarded by people and their relatives who found them to be open, friendly and professional. Staff were happy working at the service, and felt supported by the registered manager and worked well as a team to deliver care to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Improvements had been made to accuracy of the assessed levels of staffing required. Arrangements to ensure that there was enough staff on duty had also improved by using a consistent team of temporary staff.

Improvements had been made to the assessments of risks to people.

The service was clean and staff demonstrated good infection control practices.

Safe practices where undertaken in the recruitment of staff. There were enough staff to keep people safe.

Is the service effective?

Good

The service was effective.

Improvements needed to be made in the environment to meet best practice guidance for people living with dementia.

Staff were provided with training, supervision and a yearly appraisal to maintain and develop their skills.

People's rights were respected and care was provided with consent or in people's best interests. Staff understood the principles of the Mental Capacity Act 2005.

People had access to enough food and drink to meet their needs. They were able to see healthcare professionals when needed to help them maintain their health.

Is the service caring?

Good

The service was caring.

Staff were kind and caring to people living at the home.

Peoples independence was promoted, and their right to privacy

and dignity respected

People were actively involved in making decisions about their own care where they could do this.

Is the service responsive?

Good

The service was responsive.

Improvements had been made to identifying people's preferences in how they received their care. Staff provided support that was less task focussed and more person centred.

A complaints policy and procedure was in place. Issues raised were acted upon to improve the service.

The home supported people who were at the end of their lives following a recognised pathway, which they were accredited to provide.

Is the service well-led?

Good

The service was well-led.

The recruitment of a new manager had an immediate and positive impact, people and their relatives had found the service was improving.

Systems to monitor the quality and safety of the home had been established and implement. Feedback from this was used to drive up the quality of care and support provided by the home.

Care Quality Commission

Sutherlands 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 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.

We inspected this service in line with our methodology where we return to re-inspect services rated as Requires Improvement within 12 months of the report being published on our website. The inspection took place on 24 and 25 September 2018. The first day was unannounced which meant the provider did not know we were planning to inspect the home.

On 24 September 2018, the inspection team consisted of two inspectors, a specialist advisor in nursing and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 25 September 2018, two inspectors and an inspector who specialised in medicines management visited the home.

Prior to the inspection, we reviewed information we held about the service to inform our planning of the inspection. This included notifications that the provider must send us by law and any concerns and/or positive feedback received about the quality of care provided at Sutherlands Nursing Home. We also gained feedback from the Local Authority quality assurance team and a healthcare professional.

During the inspection, we spoke with six people and two of their relatives to gain their views about the quality of care received. We spent time observing care in the lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We spoke with five members of nursing, care and kitchen staff. We also spoke with the clinical lead, registered manager and the providers regional operations manager.

We looked at several records that were kept in relation to the care that people received. This included six people's care records and several people's medicine records. We also looked at staff training, recruitment and supervision records and paperwork in relation to how the provider monitored the quality of care

provided to people living at the home.

Good

Is the service safe?

Our findings

Following our focussed inspection of this domain in October 2017, we rated Safe as Requires Improvement. At this inspection we found improvements had been made and have rated Safe as Good.

At that inspection, we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not taken appropriate action to manage risks to people's safety, pressure area and wound care. There were also shortfalls in the safe management of people's medicines.

We also found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the assessed level of staffing to meet people's needs was not provided. Peoples needs were not met in a timely was that promoted their safety.

At this inspection we found that improvements had been made and therefore, the provider was no longer in breach of those regulations.

People told us that they received their medicines regularly and on time. Relatives we spoke with confirmed this. One person told us, "I have my medication two hours before breakfast, they bring it to me with a cup of tea, while I'm still in bed, they're never missed."

A Care Quality Commission medicines inspector looked at how the service managed people's medicines and how information in medication records and care notes supported the safe handling of their medicines. Records showed overall that people living at the service received their medicines as prescribed. Audits were in place to enable staff to monitor medicine stocks and their records to help identify areas for improvement. We saw a system available for reporting and investigating medicine incidents or errors, to help prevent them from happening again. Medicines were stored securely for the protection of people living at the service and within appropriate temperature ranges.

We observed the latter part of the morning medicine round and noted that people received their medicines on time by staff that followed safe procedures. Staff who handled and gave people their medicines had received training and had their competence assessed regularly to ensure they managed people's medicines safely. Supporting information was available for staff to refer to when handling and giving people their medicines. There was personal identification and information about known allergies and medicine sensitivities.

An electronic system for the management of medicines had recently been implemented and we saw that this was work in progress. Information about how people prefer to have their medicines given to them and written information about medicines prescribed for people on a when-required basis, had not yet been put into the electronic system. Additional charts for the application of medicated skin patches and body maps for the application of external medicines such as creams and ointments also required implementation. The registered manager gave us assurances that full implementation of the system was a priority and that

additional charts for the application of skin patches would be implemented by the end of the day of inspection to ensure safety. Further checks we made later that day confirmed that this had been completed.

People told us that they felt safe living at Sutherlands Nursing Home, relatives we spoke with confirmed this. One relative told us, I come here at all times and I have never had any concerns about the way they [staff] treat her. Staff always communicate with me, and they always ask me how she has been when I visit."

Improvements had been made to the way in which risks to people's safety were managed. This included identifying and managing risks in relation to wound management, pressure areas, falls, choking and malnutrition. For example, detailed assessments in relation to people's healthcare needs had been completed, and were regularly reviewed. People's skin integrity and their risk of pressure ulcers were assessed using a recognised clinical scoring tool. This took into consideration the persons build, weight, skin type. Also detailed were potential areas of risk, such as age, continence and mobility. Where it had been identified that a person was at risk, equipment was implemented to reduce these risks. For example, pressure relieving cushions or mattresses. Records also clearly identified the settings to be used for this equipment. Staff we spoke to were able to tell us how they could obtain input from the community tissue viability nurse if they felt additional expertise was required.

The provider had recently implemented an electronic care records system to store and input information about the care people needed, and their well-being. We saw this information was updated regularly, and reviews took place following an incident or a change in a person's needs. This system and information was also used by the provider regional operations manager, and the registered manager as part of their monitoring and oversight of the quality and safety of the home. This meant that we were confident that there were systems in place to manage people's risks.

Risks to the premises had been managed well. Fire exits were clear to aid any evacuation from the premises that may be required. There were personal emergency evacuation plans in place for each person to make sure they were assisted safely whenever there was a need to evacuate the premises. Any hot surfaces such as exposed pipes that had been deemed as a hazard had been covered to reduce the risk of people acquiring burns. Lifting equipment such as hoists had been serviced in line with relevant legislation. Checks of water temperatures were in place to help reduce the risk of legionella. Records of fire safety checks, water temperatures, refrigerator and food temperature checks had been completed. This helped ensure that the service was a safe place to live, visit and work in.

At our last inspection in October 2017, we found that staff who supported people living with dementia in the Minton unit of the home, did not have the skills and experience required to safely respond to potential risks from this condition. Where people's behaviour presented a risk of harm to themselves or others, staff were not able to intervene safely. At this inspection we found that improvements had been made. All staff had undergone basic training in supporting people living with dementia, and some staff had completed a two-day specialist training course in this area. Arrangements had been made for all staff who supported people living in the Minton Unit, to complete this training in the coming weeks. During our observations in this area of the home, we saw that staff were confident in their interventions when people became confused or disorientated.

At our last inspection, we found that the providers own assessments of the number of staff required to meet people's needs and keep them safe had not been provided. These assessed levels of staff did not accurately reflect the amount of staff that were needed. People's needs had not always been met in a timely way because of this. At this inspection we found that improvements had been made, and the assessed number of staff had been deployed. Our observations showed the accuracy of the assessed levels of staff required

had improved, and we found this was reflected in the amount of staff provided. In addition to this, the number of people living at the home had reduced. This was because the registered manager and provider felt that their priority was to drive forward improvements in the home identified as being needed at previous inspections. They felt that this could be achieved more quickly by focussing on improving the skills and experience of existing and newly recruited staff, before filling vacancies and increasing the need for a greater number of staff.

Staff that we spoke with told us that they felt there was enough staff on duty to keep people safe and meet their needs in a timely way. They also told us that the decision to use temporary agency staff to cover care staff vacancies, annual leave and sickness, had been a positive move. The registered manager told us that they had reviewed rotas and the deployment of staff during the day, to ensure that there were enough staff available to be responsive at all times. For example, they had changed the way in which staff took their breaks, meaning staff took these at times that had been identified as quieter.

We received mixed feedback from people about whether there was enough staff to meet their needs in a timely way. One person told us, "I've got a buzzer here and when I press it I know they'll come if I need help." All the people told us that at certain times they would have to wait. One person told us, "It's particularly bad between 8 and 10 am." We spoke to the registered manager about this. They told us that they too had identified that more staff were required and that people had raised the same concerns with them. Since coming into post after our last inspection, they had worked with the provider to assess and increase the number of staff on duty. Those assessments had led to an increase of staff from nine members to eleven on duty during peak times such as the morning. Our observations of staff responsiveness to call bells, requests for help and providing people's care in accordance with their preferences was that significant improvements had been made since our last inspection.

The provider and manager had made the required checks on new staff before they were contracted to work at the service. This included a check to ensure they had not been barred from providing care to vulnerable people and references from past employers assured them staff had good character.

The manager had reported any incidents of alleged abuse to the Local Authority safeguarding team, and had notified the Care Quality Commission (CQC). Staff we spoke with knew how to keep people safe and were aware of their roles and responsibilities in reporting any concerns or incidents. They told us, this could be to their manager or to external safeguarding agencies such as the police or the local safeguarding authority. Staff had undertaken training in the safeguarding of adults, and could tell us how to recognise indicators of abuse.

We found all areas of the home to be clean and we saw the equipment people used was also clean. People told us that they felt the home was clean. One person said, "It's clean, they seem very thorough. My room is cleaned every day and I'm happy with that." The home employed domestic staff in addition to care staff, whose focus was to ensure that the home remained clean and odour free. Staff used good infection control practice. They could tell us what precautions they took to reduce the spread of infection and we saw this in their practice where they wore gloves and aprons when assisting people with personal care.

Staff we spoke with were clear that they needed to report any incidents or accidents that occurred to a senior member of staff, for example falls or medicine errors. We saw that current records considered previous risk assessments. This information was identified so incidents in a person's history could be used to reduce further occurrences. We saw in one person's records, information had been used from assessments that had been completed when living at another home where they had several falls. Records showed that for this person, in the six months they had lived at Sutherlands Nursing Home, they had not fallen. Staff told us

that they completed detailed records after any incident. These incidents were always reviewed by the registered manager. They were also discussed at meetings, to identify if any lessons could be learned.

Good

Is the service effective?

Our findings

Following our last comprehensive inspection in May 2017, we rated Effective as Requires Improvement. At this inspection we found that improvements had been made. However, we have made a recommendation that the provider ensures that the environment in areas of the home supporting people living with dementia meets best practice guidance. We have rated Effective as Good.

At that inspection, we found that the provider was in repeated breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We identified the legal framework of the Mental Capacity Act 2005 not been correctly implemented. It was unclear as to how decisions were being made in people's best interests where they may lack capacity, including when people were deemed to need to have medicines administered covertly. At this inspection we found the required improvements had been made and the provider is no longer in breach of this regulation.

Some people living in the home lacked capacity to consent to and make decisions about their own care. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Most people and their relatives told us that staff sought consent before providing care. However, we observed that staff did not always seek people's consent before assisting them to move in a wheelchair on two occasions. One person told us that they were not always asked to consent to receiving care. They told us, "It depends, they might knock before coming into my room, they don't actually ask. When they hoist me, they tell me they're going to do it rather than ask me." We discussed this with the registered manager, who assured us that staff received training and guidance in the importance of seeking people's consent at all times, and that they would revisit this with all staff.

All of the staff we spoke with had a good understanding about the MCA and DoLS. Where people could not make a decision, staff offered them visual choices and prompts such as what to wear or eat to help the person make a decision for themselves. Where it was in doubt, the registered manager had assessed people's ability to make certain decisions about their own care. This included areas such as medicines management, the provision of personal care and if people had pressure sensor mats in place. Where the person lacked the capacity to consent to the care being offered, a best interest decision had been made. This involved relevant parties such as a healthcare professional and relative.

The manager had assessed if anyone living in the home was being deprived of their liberty. Where they were,

an application had been made to the Local Authority for this to be authorised. The manager ensured that where people were being deprived of their liberty, the least restrictive option was being used.

During the inspection we viewed the premises to judge whether it was suitable for the people who lived there. The home had several communal and lounge areas for people to use. One lounge was used for activities but the others were quiet areas where people could spend time if they wished. There was one dining room in use and another two available on the ground floor. Minton Unit, which provided accommodation for people living with advanced dementia, was located on the first floor, and had a communal lounge/diner area.

On Minton Unit we saw that bedroom doors and the communal lounge had signage to aid orientation for people living with dementia. However, no pictures were on people's doors that were meaningful to them which is good practice to aid people living with dementia to orientate themselves to their own room. There were some pictures on the walls that people could look at for interest. Other areas of best practice support such as rummage or fiddle items for people to pick up to provide them with sensory stimulation were not provided. We observed that people often wandered around the Minton Unit, running their fingers around the edge of tables or chairs. We also saw people fiddled with door locks and handles, which is often an interest of people living with dementia. However, no specialist equipment that could be of stimulation to people interested in this was provided. The use of colour could be improved in some areas to help people be more independent such as colour contrasting toilet seats, plates or doors.

The registered manager told us they had plans to improve the environment further, and that monies raised through fundraising events had been set aside to do this. We have therefore made a recommendation that the provider consults best practice guidance in relation to developing the environment further for people living with dementia and provides signage, equipment and decoration in line with this.

People's bedrooms looked comfortable and well equipped with storage for clothes and a television if they wanted this. People who lived on the ground floor of the home could freely access a pleasant outside garden area. Hand rails were in place for people to use whilst they were walking around the home. Corridors and entrance ways had been designed with extra width which helped people who used wheelchairs or walking aids move around the home with ease.

Before moving into the home, an assessment of people's needs had been completed covering their physical, mental and social needs. The registered manager and clinical lead had widespread experience and knowledge of best practice in relation to providing care for people living with dementia and people requiring nursing care. The registered manager and regional operations manager had reviewed policies and procedures since coming into post which reflected best practice guidelines issued by professional bodies such as the National Institute for Health and Care Excellence.

Staff who were new to the home completed induction training that was based on the Care Certificate. This is a recognised qualification within the social care sector. Staff also told us they were supported to complete other qualifications in health and social care if they wished to do this. The registered manager had assessed the competency of new staff before they started working with people on their own. The staff told us that they regularly worked alongside senior staff to provide support and guidance in relation to their practice. Staff could explain to us how their competency was checked, and reported that these checks had increased since the arrival of the registered manager. Staff also told us that they received regular supervision sessions, where they discussed their performance and planned their skills development with the registered manager.

All of the staff we spoke with told us they felt the training they received was good and provided them with

the skills and knowledge they needed to provide good quality care. Staff told us they had also completed face to face training in some areas, which they felt was more beneficial than on line based training. At our focussed inspection in October 2017, we identified concerns in relation to the level of training staff received when supporting people living with dementia. The registered manager told us that all staff now completed a two-day training course in dementia care. This was delivered in a class room style setting, staff who had already completed this told us that they found this to be beneficial. The registered manager told us all staff had either completed this, or had places booked to undertake this by the end of November 2018. Records we checked in relation to staff training showed that staff had up to date training in a number of areas including but not limited to fire safety, food hygiene, safeguarding adults and moving and handling.

People and their relatives told us, they were satisfied with the food and drink provided. One person told us, "Lovely, no complaints at all. The food is very good and we get plenty of it." People told us that on occasions the quality of food provided had been variable, and that choice had been limited. However, people reported that the arrival of a new head chef had brought improvements and food was consistently better, and that choice was more varied. We spoke with the head chef, who showed us the results of a recent consultation with people about what they would like to see included on menus. They had proposed a seasonal menu and included additions to the variety of snacks and alternative options that could be provided. All the staff we spoke with had a good knowledge of people's food likes and dislikes and any cultural or allergy needs they had in relation to food. They also expressed to us the importance of ensuring people had enough food and drink to keep them healthy.

We observed the lunchtime meal in the main dining room. This was a pleasant and social experience for people. A choice of two main meals was on offer. Alternatives were given and provided to people if they did not like the main meals. Where people could not make a decision about what to eat, the staff showed them both meals to help them make their own choice. People received assistance to eat when required. Staff did not rush people and regularly checked with them as to whether they were enjoying the meal. People who chose to eat their meals in their rooms received this in a timely manner. People had access to a choice of drinks which were regularly topped up, and people who preferred to stay in their rooms had jugs or drinks left within reach.

The head chef was aware of which people required their foods to contain extra calories to help them build up or maintain their weight. They told us that they had completed specialist qualifications in catering for older people who may require fortification of their food, or to have meals provided in different textures or consistencies. They explained they would add extra calories in the form or cream or butter to certain foods. Snacks such as biscuits, cakes and fruit were available as part of the regular drinks trolley that went around the home several times per day. Where people were at risk of not drinking much, their intake had been recorded and this was monitored by staff, so that action could be taken if required.

The staff told us they worked well as a team to deliver effective care to people. They also worked well with other healthcare professionals when required. Records showed they followed healthcare professional's guidance when given. When people came to live in the home, the registered manager worked closely with organisations such as hospitals and local authorities to ensure the persons move in to the home was as smooth as possible.

The registered manager told us that the GP visited regularly to check on people's healthcare needs. Staff told us they understood the importance of ensuring people received good healthcare and described how they would report any concerns to the senior staff or clinical lead. Records showed that staff requested assistance from specialist healthcare professionals when needed such as physiotherapists, dieticians or the speech and language therapist.

People and their relatives said they had access to healthcare professionals as and when required. One person told us, "The doctor comes in twice a week, Tuesdays and Fridays, but if you need to see a doctor other than those days, you can." They also said, staff were proactive in seeking medical attention should a person feel unwell and supported people to get to appointments. A relative told us, "My [relation] needed to see the dentist the other week so I took her in a taxi, the manager had a carer come along too, just in case we needed help while we were out. I didn't ask her to do that, she suggested it would be a good idea and I agreed."

Good

Is the service caring?

Our findings

Following our last comprehensive inspection in May 2017, we rated Caring as Good. At this inspection we have continued to rate this key question as Good.

People we spoke with all told us they felt well cared for and that staff were kind and caring. One person told us, "The staff are very caring, they look after me, whatever I need they help me. It's not just the nurses, the cook's really friendly and so are the cleaners." Throughout our inspection, we saw positive interactions between the staff and the people living in the home. Staff responded to people in a calm and reassuring manner. A person we spoke with said, "The [staff] are lovely, they are respectful, I have never heard any of them loose their temper or anything like that. We seem to get on well."

On the ground floor area of the home, we saw that people's requests for support were quickly responded to. Staff asked people how they could help in a polite respectful manner and reassured them that nothing was too much trouble. We observed that staff approached people in a warm and friendly manner, greeting people and asking them how they were. One person said, "They [staff] know me, we chat when there's time, they've got to know me and I've got to know them." Staff knew people's preferences and personal histories well.

On the Minton Unit on the first floor, we observed that although staff were kind and caring towards people, care staff were not always proactive in initiating conversations with people, or interacting with them when there was opportunity to do so. This meant that although people were safe and comfortable, there were periods of missed opportunities where they experienced little interaction or activity. However, we did see that when the activity co-ordinator arrived and started playing board games, people were keen to join in and showed enjoyment by participating, smiling and interacting. We spoke to the registered manager about this, they told us they had identified this as an area of development, and that this had been a driver in arranging for all staff to complete advanced training in dementia support. They told us they were to further promote this by mentoring and supervising staff so they could gain further confidence when working on the Minton Unit.

We saw some people had been involved in the planning of their care. For example, people's preferences about their likes or dislikes were included in care plans. People's choices about what time they got up or went to bed had been discussed with them. Where people were not able to participate in those conversations, we could see that their relatives had been asked on their behalf. One person told us, "I have quite a lot of support from my [relation], and we have talked with the manager a number of times. They seem happy with how things are. That's good because I do want to do as much for myself as I can."

Relatives of people we spoke with told us that they had been encouraged to be involved in reviews of their family member's care and support. They confirmed that staff were good at keeping them updated on their relative's health, care and support needs. People could see their visitors whenever they liked. The registered manager told us they ensured people could speak with family members who lived a distance away, by facilitating skype or facetime calls. They had also assisted one person to arrange regular visits to see a family

member who lived in another part of the country.

Staff could tell us how they supported people to maintain their independence and knew about people's individual preferences. One person said, "There's a lot I do for myself, because that's what I want." We observed during the lunchtime meal that staff encouraged people to be independent with gentle prompts and reminders. Throughout the inspection we observed staff actively involving people in making decisions about their care. This included areas such as where to reside within the home, what to eat and drink and what activities they wanted to be involved in.

We observed staff treating people with respect and being discreet in relation to their personal care needs. People were appropriately dressed, assisted, and prompted with any personal care they needed in private. Doors were also closed when providing people with personal care and conversations with people were held quietly so that their privacy was respected. Staff positively engaged with people throughout the day and enquired whether they had everything they needed. People and their relatives said they were able to visit the service without any restrictions.

Good

Is the service responsive?

Our findings

Following our last comprehensive inspection in May 2017, we rated Responsive as Requires Improvement. We found the provider had not ensured that staff consistently provided care to meet people's individual needs and preferences. People's care records were not fully completed and did not reflect people's preferences. At this inspection we found that improvements had been made and have rated Responsive as Good.

People told us that an initial assessment of their care and support needs was carried out prior to them coming to live at the service. This ensured as much as possible that the service had identified what the person needed and had planned how to meet identified needs. People said they felt they were treated as individuals. Relatives we spoke to were positive about how their family members needs were assessed and met. Our conversations with staff demonstrated they knew the people they provided care to well. They were able to tell us about people's personalities, their likes and dislikes and what their occupation had been.

The provider had recently invested in a new electronic system to store and record plans of people's care, as well as daily notes about their welfare and health. During the implementation of this, the registered manager had, along with people who wished to and could, reviewed all the care plans to ensure they were accurate and reflective of people's needs. This new system had been well received by staff as it enabled them, particularly nursing staff with a responsibility for clinical overview of people's health needs, to review often complex and large amounts of information about how a person's needs were being met.

The care records we viewed were sufficiently detailed to instruct staff and contained person-centred information. 'Person centred' means care which is based around the needs of the individual. Examples included assistance with mobility, personal care, day and night time routines, nutrition and pressure area care. Care plans included information about people's preferences, including how they wanted to be addressed and what was important to them. Also included was the person's family history, life history and medical history. This helped staff to get to know the person and provide individualised care which was responsive to the person's needs.

Guidelines were in place for staff regarding assisting and prompting people with their personal care needs along with details of people's daily routines. Daily records showed that people made choices about their care to ensure that their care and support needs were met. We saw that people were receiving the care and support which was right for them and specific to their assessed needs. For example, in relation to any weight loss, or their skin integrity. Plans were in place for staff to fully meet these needs.

The provider employed two staff members whose sole focus was the provision of activities for people to enjoy. People were told of what activities were on offer and asked if they wanted to participate. There was a programme of activities in place. People told us, they had been asked what activities they would like to do. People were able to join in group activities such as bingo or flower arranging. Activity staff also supported people on a one to one basis, for example, taking people to visit the local shops. People who chose to stay in their rooms rather than spend time in communal areas also benefited from individual time allocated to

them for visits from activity staff.

People and their relatives told us they knew how to complain. The complaints policy was displayed on the notice board, and a copy of this was given to people should they require it. The policy included timescales and the response they should expect. For example, it described how their complaint would be acknowledged and what would happen next. People and relatives we spoke with told us that the registered manager and staff at the service dealt with any concerns they had raised to their satisfaction.

People who were at the end of their life had the relevant healthcare professionals involved in their care such as GPs and district nurses. The home was an accredited provider of the six steps pathway, which is a framework used to ensure high quality care for people who are at the end of their lives. Emergency health care plans were documented in people's care files. Where a person or their relatives and other professionals had judged it was in the best interests for a person not to be resuscitated the necessary documents were in place and up to date. People had been asked about the care they wanted at the end of their life and we saw this was documented in their care plans.

Good

Is the service well-led?

Our findings

During our last inspection of this area in October 2017, we found that the provider had not ensured that there was robust quality assurance in place to assess, monitor and improve the quality and safety of care that people received. There had not been a registered manager in post at the home for more than three years. This resulted in a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and a registered manager had been in post since November 2017. The quality of care provided had improved and was robustly monitored, the management of the home was stable. Therefore, the provider was no longer in breach of this regulation.

The service now had a manager that was registered with the Care Quality Commission (CQC). They had worked with the regional operations manager in implementing systems to monitor and mitigate the risks relating to the health and welfare of people. We found that these were effective at improving the quality of care that people received. There was an established auditing programme to monitor service provision. Audits were carried out both weekly and monthly in areas such as medicines, care plans, health and safety, infection control, fire safety, and equipment.

People and their relatives told us they felt that the service was well managed and that the registered manager was very visible. One person living at the service told us, "[Registered manager] is always around…….She says hello and is always happy to chat." Some people living in the home were encouraged to be, and were actively involved in the running of the home. This included participating in staff recruitment interviews, leading resident's meetings and having catch up and feedback sessions with them. The registered manager regularly invited people to meet for coffee, or afternoon tea, where people could talk with her about their experiences of living at Sutherlands Nursing Home.

Staff told us the registered manager was supportive and approachable. They told us that she had made significant improvements to working practices since starting in post. Staff we spoke with said that morale was good and they worked well as a team. The registered manager had an 'open door' policy, and staff were comfortable to go to the office and talk about anything that was of concern to them. The provider's regional operations manager visited the service regularly to assess the quality of care. Their role was to visit the service to review all aspects of the care provision, and identify any areas for improvement. This included conducting spot checks and audits of the quality of provision.

The regional operations manager had compiled a service improvement plan which they monitored progress of with the registered manager. They worked jointly with them to develop a plan for the implementation of these improvements. This included areas such as redecoration and refurbishment, new equipment, staff development and staff recruitment. The registered manager told us that there was a focus on ensure the development of the service would ensure that improvements in quality were sustainable.

Staff recorded accidents and incidents within the service. Each event had been analysed and measures were in place to reduce the risk of re-occurrence, this helped to ensure the wellbeing of each person. The registered manager reviewed this information to look for any trends or patterns, for example, what time of

day the event happened or if it took place in a particular location. We saw that incidents and accidents had been recorded and followed up with appropriate agencies or individuals, for example the falls team.

Maintenance checks were completed regularly by staff and records kept. There were cleaning schedules to help make sure the premises and equipment were clean and safe to use. The registered manager carried out their own annual internal quality audits, including health and safety audits, in line with their own policies and procedures. The registered manager monitored these checks, and took actions to address any shortfalls.

Staff meetings were held to give staff an opportunity to raise any issues with the service. The registered manager told us that they hoped to increase the frequency of these as improvements and new systems of work within the home became embedded. Staff told us the management team listened and acted on what they said. Staff told us communication was good and they worked well as a team to ensure that people received the care they needed. Our observations and discussions with people, staff, and relatives, showed that there was an open and positive culture between people, staff and managers.

Staff told us they had been provided with information about whistleblowing. Whistleblowing is a way in which staff can raise any concerns to the management or recognised bodies, such as the CQC. All the staff we spoke with were confident if they raised a concern it would be investigated appropriately by the registered manager in line with the provider's procedure.

The registered manager told us that staff were encouraged to discuss any areas of concern or their developmental needs during supervision. Where required, feedback was given to staff in a constructive and motivating manner. This ensured staff were aware of the action they needed to take.

The registered manager understood their responsibilities in recording and notifying incidents to the Local Authority and the CQC. All services that provide health and social care to people are required to inform CQC of events that happen in the service so we can check appropriate action was taken. The registered manager notified CQC in line with guidance.

It is a legal requirement of all services that have been inspected by CQC and awarded a rating, to display the rating at the premises and on the service's website, if they have one. Ratings must be displayed legibly and conspicuously to enable the public and people who use the service to see them. We saw that the previously awarded rating was displayed.