Mr Barry Potton

Sutton House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 6 and 7 June 2017 and was unannounced. At the last inspection in December 2016, we found breaches of regulations in multiple areas. These included ensuring a safe and clean environment, risk management, administration of medicines, consent, staff skills and training, promoting dignity and respect, the delivery of person-centred care and overall governance. The service was rated as Inadequate and placed in Special Measures. At this new inspection, we found improvements had been made in some areas, although we had continuing concerns about staffing numbers, gaps in dementia care and challenging behaviour training, stock control of some medicines, governance and notifying us of incidents.

Sutton House is registered to provide personal and nursing care to a maximum of 38 people. It is situated in the village of Sutton, close to local amenities. The home has three floors serviced by a passenger lift and stairs and has a range of single and shared bedrooms. There are several communal areas for people to use and a garden at the front and the side of the building. On the day of the inspection, there were 33 people using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We had concerns about staffing numbers. There was insufficient staff on duty, especially in the morning and early evenings when people required more attention. The staffing shortfalls had impacted on call bell response times and in some instances on the delivery of care, for example nail and hand care.

Some people had not received their medicines as prescribed. This had been due to not obtaining medicines in a timely way before stock ran out. There was also an issue with some recording of medicines which was mentioned to the registered manager to address.

There were concerns that not all staff had the required skills to meet people's needs. For example, there was a significant amount of staff that had not completed any dementia care training or how to manage people's behaviours that could be challenging. There were also clinical areas that nurses had not received training in such as wound care, re-catheterisation and the management of syringe drivers used to deliver medicines when people were at the end of their lives. Staff had received a supervised training session and a discussion about their competency in how to support people with swallowing difficulties and also a supervision session on challenging behaviours.

Although the management and oversight of the service had improved and more thorough audits were completed, there remained concerns in some areas. For example, we had not received several notifications of incidents which affected the welfare of people who used the service. These must be completed by

registered persons as they enable us to check how they are being managed and seek further action if required. We also asked the provider to complete a provider information return (PIR) but despite a reminder we have not received this. The PIR assists us when planning the inspection. Not all audits had identified areas to improve.

We are considering our regulatory response to the shortfalls in staffing numbers and training, medicines management and governance. We will report on this when it is completed.

There had been an issue with the assessment process for one person recently admitted to the service; full information had not been gathered before the person was admitted and their placement was in jeopardy. This had also been an issue at the last inspection. The registered manager told us they had difficulty obtaining the correct information. We have made a recommendation about the provider ensuring a protocol was developed and shared with commissioners which stipulated the documentation required to be in place prior to admission.

People had access to community health care professionals.

We found people's nutritional needs were met. There were choices and alternatives on the menus and people confirmed they liked the meals. We saw snacks and drinks were served in-between meals.

We observed staff approach had improved and saw they had built up good relationships with people. The atmosphere in the lounge and dining room at lunchtime was calm and relaxed which was a big improvement from the last inspection. Most staff showed they were caring towards people and respected their privacy and dignity. However, there was an impact on the care that staff provided to people as a result of staffing levels and the time they could devote to providing support. This impact affected call bell response times, choices for rising in the morning and the timings of meals for some people.

We found staff were recruited safely and full employment checks were in place before they started work in the service.

There had been improvements in risk assessments and care plans. These were much more detailed and provided staff with guidance on how to support people properly. Staff told us they liked the new care plans and they could find information more easily.

There had been improvements in how mental capacity legislation was adhered to. The registered manager had completed applications to the local authority when people lacked capacity and when their liberty was deprived. Staff were more aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We saw examples of staff gaining consent from people before carrying out tasks.

There was a range of activities for people to participate in and information was displayed on the notice board. Some people chose not to join in and this was respected.

People knew how to make a complaint and provided names of specific staff they would speak with to raise issues. Staff had policies and procedures to guide them when managing complaints and concerns.

Staff told us they felt supported in the service and could raise issues with the registered manager or senior management if required.

There had been significant improvements in the cleanliness and safety of the premises. The environment

was clean and tidy and issues raised at the last inspection such as broken radiator covers, clutter of equipment and accessible rooms with safety concerns such as sluices and hot pipes, had been addressed. There had been an issue with the lift breaking down with visitors inside but this had been addressed quickly and appropriate action taken.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There had been shortfalls in managing stock of medicine which meant some people had not always received their medicines as prescribed.

There was insufficient care staff on duty on some days, which had impacted on call bell response times and also on how care was delivered to people.

Staff were recruited safely and they knew how to protect people from the risk of harm and abuse. They also knew the actions to take if they witnessed any concerns.

Risk management had improved and an issue with the lift had been attended to.

There had been improvements in cleanliness and infection, prevention and control systems. We found the service clean and tidy.

Is the service effective?

Requires Improvement

The service was not effective.

There were some elements of staff training that had not been completed such as dementia care, managing people's behaviours that could be challenging and some clinical training for nurses. Not all staff will have the required skills to support people's assessed needs.

People had access to a range of health professionals when required. On two occasions staff could have been more observant regarding people's health care needs and acted without the need for prompts.

People's nutritional needs were met and the dining experience much more positive for them. Some dining support concerns regarding agency staff were raised with the registered manager to address.

The provider acted within mental capacity legislation and had made applications to the local authority when people lacked capacity and they were deprived of their liberty. Staff sought consent prior to carrying out tasks.

Is the service caring?

Requires Improvement

The service was not consistently caring.

There had been improvements in the way people's privacy and dignity was maintained. Their personal belongings were looked after properly.

Most of the staff interactions were positive and demonstrated a caring and patient approach. However, there remained some areas of staff practice, some of which were the result of insufficient staff, which required improvement for this domain to be rated good.

Confidentiality was respected and personal records held securely.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

One person was admitted to the service without full information of their needs. We have made a recommendation about this.

Care plans and risk assessments had improved and provided clearer guidance to staff in how to meet people's assessed needs. Staff told us they found it easier to locate information in care plans.

There was a range of activities for people to participate in which helped to provide them with social stimulation.

There was a complaints procedure and people felt able to complain to the staff or registered manager. One person said they preferred to complain to the provider so this is to be arranged for them.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered persons had not notified of us of several incidents that affected the welfare of people who used the service. This was a requirement and was important as notifications enabled

us to carry out this element of our regulatory functions.

We asked the provider to complete a provider information return (PIR) but despite a reminder, we did not receive this. The PIR is used when planning inspections and enables us to follow up issues and check on areas the provider states they have completed.

Although there were improvements in the quality assurance system, there remained concerns that some areas of shortfalls, for example staff training and stock control of medicines, had not been identified.

Sutton House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection took place on 6 and 7 June 2017 and was unannounced. The inspection team consisted of two adult social care inspectors on both days. An expert by experienced joined the inspection team on 6 June 2017. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The registered provider had been asked to provide a Provider Information Report (PIR) but we had not received it. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we spoke with the local authority safeguarding, and contracts and commissioning team, about their views of the service. We also received information from health and social care professionals who visited the service.

During the inspection, we observed how staff interacted with people who used the service throughout both days and especially at mealtimes. We spoke with four people who used the service and three people who were visiting their relatives. We spoke with the registered manager, the clinical lead (who is also the deputy manager), five care workers, two of whom were senior, the administrator, the cook and a person on duty as an activity co-ordinator.

We looked at specific care records relating to 12 people who used the service. We also looked at other important documentation relating to people who used the service. These included medication administration records (MARs) for 26 people and monitoring charts for food and fluid intake, weights, behaviour and pressure relief. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included recruitment files for three new staff, training records, the staff rota, menus, minutes of meetings with staff and people who used the service, quality assurance audits and maintenance of equipment records. We completed a tour of the environment.

Inadequate

Is the service safe?

Our findings

At the last inspection in December 2016, we found concerns with people not receiving their medicines as prescribed. This had been for various reasons such as stock control, staff finding people asleep or declining their morning medicines and recording this but not returning later, the management of 'when required' (PRN) medicines and record keeping.

During this current inspection, we continued to have concerns with how people's medicines were managed. For example, six people had not received part of their medicines due to no stock available in the service. For one person, this meant they were without pain relief for four days; when we checked their medication administration record (MAR), we saw they had received this every day, four times a day apart from the time when no stock was available. Another person had a medicine to help calm their anxious behaviour, four times a day. We saw the medicine was out of stock for two days meaning they did not receive any for eight doses. The same person also had no stock of pain relief for one day when the record showed they usually had this four times a day. Another person had not received a specialist medicine for 23 days, which was required twice a day. There was evidence staff had contacted the GP when there had been no stock for 13 days and was told they were awaiting information from the consultant. There was no record this was discussed with the GP prior to the medicine running out.

We also found recording issues such as a lack of guidance for staff in when to administer 'when required' (PRN) medicine for two people who had anxious and distressed behaviour. We saw in some instances staff used pre-dated MARs (used for one month's recording of administration) over several months leading to confusion about dates. One person had 13 MARS for five separate medicines. There were lots of duplication and crossings out; these were very confusing and could potentially cause errors. Medicines were stored and disposed of appropriately.

Not ensuring the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are considering our regulatory response and will report on it when it is completed.

We had concerns about the numbers of staff on duty, especially on the first floor where people who used the service had complex health care needs. The rotas indicated there was one nurse and between six and seven care staff during the day and at night there was one nurse and three care staff. The registered manager was also a nurse and worked Monday to Friday. The clinical lead was included in the nurse rota and we were told they would be on duty as an additional nurse one day a week, to enable them to complete administration and supervision tasks. The four weeks of rota we checked showed these additional hours only occurred on two out of the four weeks. The nurse and team leader or senior carer completed medicines throughout the day and carried out nursing tasks or senior care tasks such as meeting with health care professionals, which took them away from hands-on care tasks. There was a range of ancillary staff so care staff could focus on caring tasks.

Staff told us when they were fully staffed with three carers on both floors and one carer on the ground floor

receiving people as they came down for breakfast, everyone received care as per their plans. However, in a two-week period, the rotas showed there were six care staff on duty five of the days and the planned rota for the following two weeks showed six care workers each day. On the first floor there were 19 people who used the service, eight of whom required two staff to move and handle them safely using a hoist and four people required full assistance to eat their meals. Eleven people on this floor preferred to be washed, dressed and up, whilst the remainder preferred to stay in bed or were nursed in bed as part of their care and support plan. A member of staff said, "Staff shortages have a knock on effect, people get up later, have breakfast later then don't eat lunch." We observed this in practice and also that people in the sitting room did not a mid-morning drink until 11:20.

A visiting professional told us how they looked around the ground floor to be let out of the building but could not locate a member of staff; they had to go up in the lift to the first floor to find staff. As one person was funded for a one to one support for twelve hours a day, there was a concern that this was not in place. Another visiting professional said, "I personally have concerns with the time that it takes to gain entry into the home, staff do not appear to be visible on the main floor on entry and exit. We visit daily to administer insulin and locating a staff member to assist in obtaining clinical equipment needed is frustrating and time consuming. At times it's difficult to establish the allocated senior carer for the residential side."

People who used the service described how the amount of staff had impacted on their care. They reported long delays in staff answering call bells or staff would answer the bell, say they would return soon but this stretched to a long wait. We observed one person was brought to the dining room for their cooked breakfast at 11:00 and then was served lunch at 12:15; they hardly ate any lunch but had really enjoyed their breakfast. We spoke with staff about how this could be adjusted for the person whilst still having their cooked breakfast. We also observed another person brought into the dining room for breakfast at 09:30. They were left with their breakfast and no staff entered the dining room again until 09:55. The person had fallen asleep at the dining table and staff supported them to the lounge. During a check of the environment, one person asked the registered manager if the staff were coming to get them up; the time was 10:00; they were told staff would be with them soon. We later noted the person was still in bed at lunchtime and we observed they had difficulty drinking their mid-morning cup of tea and ended up spilling it on the bed-clothes.

Comments from people who used the service included, "Sometimes there are shortages but we are well looked after and they usually answer call bells within minutes" and "No [when asked if there was sufficient staff on duty], the call bell is answered in two to three minutes but they say they will come back and it's a long wait; five or ten minutes but sometimes an hour."

Visitors said, "No [enough staff], they didn't come down to breakfast until yesterday" and "No [enough staff], sometimes they say staff take a long time to come to the call bell. They said it was an hour the other morning – first thing in the morning is terrible. Also they said the staff come in and turn the alarm off and say they will be back in a few minutes". Their relative, the person who used the service added, "Nurses minutes are different to my minutes."

Not having sufficient staff on duty at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are considering our regulatory response and will report on it when it is completed.

Following the inspection the registered manager told us recruitment was underway and staffing numbers were to be increased. We will check this out at the next inspection.

At the last inspection, we had concerns with how risk was managed within the service. This related to

people's individual risk assessments and the delivery of care that would minimise risk, and also areas of the environment which posed a risk. We found improvements had been made in both these areas. People's individual risk assessments had been updated and included clearer guidance for staff in how to manage difficult and challenging situations. For example, people who had a risk of choking or inhaling food and fluids had full details in risk assessments and care plans about how this was to be minimised. Staff had received training and in discussions told us they felt confident in supporting people at risk.

In the environment, the loose metal radiator covers had been boxed in so were inaccessible to people. The sluices, which had very hot water outlets, had been made inaccessible and the boiler room was locked. Harmful products were stored securely, areas had been de-cluttered, bedrail protectors were fitted properly and airflow mattresses were set at the correct level for each person.

At the last inspection, we had concerns about the cleanliness of the service and how the prevention of infection was managed. During this current inspection, we found significant improvements had been made. All areas of the service were clean and tidy, chairs with damaged fabric that was difficult to keep clean had been replaced and new carpets had been fitted in the lounge and corridors upstairs, where the bedrooms were situated. New fly screens had been fitted to the kitchen doors and foot operated clinical waste bins had been purchased to replace broken ones.

We found staff recruitment processes were robust and full employment checks were carried out before new staff started work in the service. These included, application forms to explore gaps, obtaining references, holding an interview to assess skills, and completing disclosure and barring service (DBS) checks. The DBS checks identified those people who had been excluded from working with adults at risk and helped employers make safer recruitment decisions. There was a check made with the nursing and midwifery council (NMC) to ensure nurses were registered and had no restrictions on their practice.

Staff had received training in how to safeguard people from the risk of harm and abuse. In discussions, staff were clear about the actions they had to take if they witnessed abuse or poor practice.

Equipment used in the service was checked and maintained. There had been a recent incident with the lift when visitors had been locked inside. Maintenance personnel had been trained to release the door and this happened quickly. The local authority visited the service to check continuity plans regarding the lift and was happy with the measures put in place. The lift has since been attended to.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in December 2016, we had concerns with staff training in specific areas. For example, how staff supported people who were anxious or distressed and which led to behaviours that were challenging. Also we were concerned that staff lacked guidance in how to support people who were at risk of choking and inhaling food and fluids. We had placed a condition on the provider's registration that supervision and training was to be completed by 31 January 2017.

During this current inspection, we found risk assessments and care plan information had improved in these areas. Staff had received a supervision session/competency check in both areas of challenging behaviour and managing choking/inhalation of food and fluids. Records and staff discussions confirmed this. However, we found formal MAPA training in how to manage behaviours that were challenging had not been completed for all staff that provided direct care and support to people. (MAPA means management of actual or potential aggression). There remained a large number of staff who had not completed dementia care training. According to the most up to date training record, out of 31 nursing and care staff, 17 had completed MAPA training and 14 had completed an understanding dementia course. There had been a basic awareness session on dementia care included in a one day 'mandatory' training course in February 2016. As this day covered approximately 19 topics, the sessions were brief. There were people who used the service who were living with dementia and some had behaviours which caused them anxiety and distress, therefore it was important staff had the training and skills to support them.

A visiting professional told us staff were unable to manage one person's needs and they were looking for an alternative placement for them. Other health professionals said, "Some staff are not confident when supporting people with dementia which can, in some instances, escalate patient's behaviours."

There were also shortfalls in nurse training in areas such as wound care, syringe drivers and re-catheterisation, which was identified at the last inspection. We saw there had been improvements in first aid training. The administrator told us they updated the training record when they were given the completed training certificates and the one provided on the day of inspection was up to date.

Not ensuring staff had the required training and development was a persistent breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are considering our regulatory response and will report on it when it is completed.

We asked the registered manager and provider to review the training record. Following the inspection, we received a 'projected training/development plan'. This included a full range of training to take place in June, July and August 2017. We will continue to monitor this information. Staff told us they felt supported by the registered manager and had received at least one supervision session since the last inspection. Staff appraisals were underway. The clinical lead told us they spent as much time as possible working alongside nurses and care staff in order to observe care practices and assess staff skills. They had also worked night shifts with the nurses to establish how their time was spent. They said, "Working in this way with staff means that issues such as staff attitude, approach or lack of skills can be addressed immediately with additional

supervision, competency checks and further training."

During the inspection, we found improvements in the application of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called DoLS. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found assessments of capacity had been completed and when people lacked capacity and DoLS were required, appropriate applications had been submitted to the local authority; according to records held in the service, 10 people had DoLS authorised by the local authority and a number of other people were awaiting authorisation.

We found staff's knowledge about MCA, DoLS and the need for consent had improved and in discussions, they were able to provide examples of how they gained consent prior to carrying out care tasks. During the inspection, we observed staff used their knowledge about people who used the service and how they communicated agreement to care and support; we saw they provided choices to people and gained consent.

We found people had access to a range of health care professionals. These included, GPs, consultants via out patient's appointments, district nurses, speech and language therapists, dieticians, emergency care practitioners, opticians and chiropodists. In discussions, with care staff, they were knowledgeable about the signs and symptoms of urinary tract infections, how to manage catheter care, how to support people with swallowing difficulties and how to prevent pressure ulcers from occurring. However, we noted several people had hand contractures as a result of them having a stroke. Staff described how they supported people to keep their nails filed and the palm of their hand clean and dry but we had concerns about the care of one person's hand contracture. We asked the nurse to address this straight away which they did; the GP was contacted and prescribed antibiotics for the person. The registered manager told us they would ensure the full care of people's hand contractures was detailed in care plans.

A visiting professional told us that on one occasion, there had been a delay in contacting a GP for a person who looked unwell when they visited. A visiting health professional called the GP, who saw the person and diagnosed a chest infection. This had been mentioned to the registered manager and staff were to be more vigilant in identifying health concerns so action could be taken quickly. Another health professional said, "On a positive note we receive very few referrals for pressure damage, moisture lesion and wound care in general."

We found people's nutritional needs were met and the lunchtime experience for people in the dining room was much improved; lunchtime on both inspection days was calm, unhurried and people received the support they required. However, the lunchtime experience for people who ate their meals in their bedrooms required improvement. For example, we observed two people were assisted to eat their meals in their bedrooms by agency staff; the staff did not know the people well and the pace they used to support the person was inappropriate. We mentioned this to senior staff and the registered manager and they addressed this with the agency worker. We also saw one person was given their meal but the meat was not cut up for them and they picked up a large piece of gammon with their fingers and started to eat it. We noted their meal was placed on a table by the side of the bed so it was possible a member of staff was due

to return to assist them. However, the meal could have been served when the member of staff was ready to assist. This was mentioned to senior staff to address.

Care records indicated people were screened to see if there were any nutritional needs and we saw referrals to dieticians and speech and language therapists had been completed when required. Staff recorded people's weights, and according to records held in the service, these were stable. Some people had been prescribed food supplements to enhance their calorie intake and we saw people were offered snacks in-between meals. People who used the service told us they had enough to eat and drink and liked the meals. Comments included, "I normally go to the dining room. The food is ok; there is plenty to consume and appropriate choices" and "The food is beautiful; I love the salads. The cheese and onion quiche they make is beautiful. They know I'm not a big eater."

Menus provided people with choices and we observed alternatives were given to people if they did not like the options on offer. A new pictorial menu board had been purchased and provided bright and colourful information about the meals on offer. The cook told us they continued to receive information from care staff about people's individual needs such as special diets, where they preferred to eat their meal, whether they were able to choose from the menu and how they preferred their drinks. The cook also said they visited people who used the service to find out their likes and dislikes.

Requires Improvement

Is the service caring?

Our findings

At the last inspection in December 2016, we had concerns about how people's privacy and dignity was maintained. At this current inspection, we found improvements in the way people were supported, the way their privacy and dignity was maintained and in the way their personal belongings were looked after.

We observed positive interactions between staff and people who used the service. Staff were attentive to people in the dining room at lunch time and provided people with choices of where to sit and alternatives to eat when they decided they did not want the main options. Staff were patient when talking to people, asking them questions and waiting for answers; they asked if people wanted to wear clothes protectors. They reassured people there was time to have lunch before their relatives arrived. The dining experience was much more organised and was a social time for people. We heard several people comment on how nice the meal was and staff checked everyone to see that they had everything they needed. We saw staff change a cup of tea that had gone cold and brought a fresh one. The cook noted one person's food kept falling off their fork so they gave the person a spoon instead which they managed well. Staff were engaged with people who used the service during lunch rather than each other, as observed at the last inspection.

However, despite the improvements noted in staff interaction with the majority of people who used the service, there was an issue with staffing levels which had impacted on people's choices and levels of support. This included times of rising for some people leading to a late breakfast and affecting the timeliness and enjoyment of lunch. There was also an issue of concern regarding two people who used the service and the pace of assistance provided to them at lunchtime from an agency member of staff. Mid-morning drinks were served late. Some people required attention regarding nail care. Some people had commented negatively on call bell response times. These issues were discussed with the registered manager to address.

We saw staff sat and spoke to people in the sitting room, got down to their level and made eye contact. Staff were appropriately tactile, putting their arms round people to reassure them or stroking their back to comfort them. There was a joking banter between staff and some people who used the service and relatives told us staff made them feel welcome and offered them refreshments.

At the last inspection, we noted one person who was living with dementia, experienced disinhibited behaviour and they did not have an appropriate care plan for staff to support them when this occurred. Staff had now placed a blanket nearby to use when the person needed it. However, we saw the person looked much calmer and more relaxed and did not require this intervention during the two days of the inspection. We observed the provider had purchased a screen to use for when people were transferred using a hoist.

There was a calm and relaxed atmosphere in the service which was an improvement from the last inspection. The registered manager had taped over the loud door bell and only had the shorter, quieter doorbell in use.

People's personal toiletries in shared en suites had been separated and placed in baskets to prevent them

being mixed up and toothbrushes were appropriately stored. All communal products had been removed from toilets and bathrooms and discarded.

At the last inspection, there was an issue with how information was provided to people who used the service with a lack of signage and inaccurate notice boards. At this inspection, we found significant improvements. The notice board provided people with accurate information of activities for the next four weeks and pictures of Hull in previous eras. A new pictorial menu board had been purchased for the dining room. The cook changed this daily to reflect the meals on the menu. New signage had been purchased for the rest of the service, which included signs for toilets and bathrooms, the dining room and sitting room. People had new name plates on the wall at the side of their bedroom doors, which helped them to locate their bedroom.

People told us staff were caring and respected their privacy and dignity. Comments included, "They are quite good; I have no problem with any of them [staff]", "I think the staff are brilliant; they are not just carers, they are friends" and "They are generally caring and okay at looking after me – it works." One person mentioned they would like staff to make sure information was passed on so they didn't need to repeat requests. Visitors said, "They are generally caring and treat him with respect", "The care is brilliant and they keep me informed", "I'm very happy with care – it's perfect" and "Most of them are alright. We have gotten to know each other and there is lots of friendly banter." The person also said staff always seemed to be in a rush.

We observed staff knock on people's bedroom doors before entering and doors were closed when personal care was carried out. Staff described how they promoted people's privacy and dignity and gave examples such as knowing people's preferences, likes and dislikes, closing doors and curtains during personal care and providing choices so people could make their own decisions.

We saw personal care records were stored securely in filing cabinets in the nurse's office which was locked when not in use. Medication administration records were held in the treatment room which was locked. Staff personnel files were secured in the manager's office. The manager told us the computers were password protected to help keep access to a minimum and electronic records secure. The administrator managed any monies deposited in the service for safekeeping. They had a system to ensure financial records were held securely.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in December 2016, there were shortfalls in the assessment and care planning processes for people who used the service. This had led to staff not having appropriate levels of information about people's needs and full guidance in how to meet them. The impact was that people's needs were not fully met.

During this current inspection, we found that improvements had been made in planning people's care. However, there remained a concern that full information was not obtained when one person was recently admitted to the service. The registered manager told us they visited the person in hospital and spoke to staff and checked records to gain information but said they were not provided with full details of their care and support needs. The person's local authority assessment of their needs was not available prior to admission but the social worker told us they did provide verbal information. The impact for the person was that their initial needs could not be met in the service and they experienced a very unsettled period of time with support from a range of health and social care professionals. The person may have to move to an alternative placement more suited to their needs. The registered manager has discussed the shortfall in information with health colleagues.

We recommend the registered provider develops a protocol regarding the criteria for admission which details the documentation that needs to be in place prior to people being admitted to the service, and that this is shared with commissioners.

We saw two other assessments completed by the registered manager for people recently admitted to the service. These were completed thoroughly and both people's assessment by the local authority had been obtained prior to their admission. This enabled the registered manager and staff team to start to plan and deliver care to them as soon as they were admitted.

We found care plans for people were much more detailed and included clear guidance for staff in how to support people's needs in the way they preferred. For example, a care plan to support a person with pressure damage prior to admission described the frequency of positional changes, the correct setting of the airflow mattress and physiotherapy exercises. We found this guidance was followed by staff in practice and there had been no further pressure damage. Care plans for people with swallowing difficulties were detailed and covered how the person should be seated and what observations and actions staff were to take during supporting them to eat and drink. A care plan for a person with diabetes provided clear guidance of blood monitoring, insulin therapy and the involvement of a diabetic specialist nurse.

Care plans detailed how staff were to support people with behaviours which were challenging to themselves, other people and staff. The clinical lead said, "The positive behaviour support plans were sadly lacking and needed more detail and guidance for staff. These are being worked on, based on observations, records made, and discussions with staff to identify triggers and the support required." We saw a comment in a person's records, following a visit from mental health professionals, which stated their care plan could not be improved on. The clinical lead also told us there was a new system of care planning which collates

information together and staff encourage visiting professionals to record in them to assist communication.

Risk assessments had also improved and showed the action staff were to take to help minimise risk. The risk assessments included areas such as swallowing and choking difficulties, anxious or distressed behaviour, moving and handling, nutrition, falls, and fragile skin.

Staff told us that information sharing between staff, and also people's care plans, had improved. They said they found information in care plans easier to locate. Comments included, "Information is shared on handovers; I've seen so many improvements" and "The new care plans are fantastic, so much better and so much easier to follow and find information."

People who used the service told us they were happy with the care and there were some activities for them to participate in if they choose to. Comments included, "Yes, if I want anything, I press my buzzer and they do come", "I get visitors every day" and "I have no desire to change anything." Some people told us they preferred their own company and did not like to join in activities. They said this was respected.

During the inspection, the activity co-ordinator was unavailable on the first day but we saw care staff supported people with hand and nail care in the sitting room and organised a sing a long in the afternoon. There was a designated member of staff for activities on the second day. The activity planner included bingo sessions, games, craft work, painting and colouring, quizzes and ball games to help movement. There was monthly reminiscence therapy, 'Days Gone By', and musicians and singers visited to entertain people. There were also clothes parties for people to purchase items. Domestic staff were organising a summer fair for July and the money raised was to go towards outings. The newsletter stated that those people who were unable to go on the outings would be offered an alternative therapy such as a massage. The notice board in the corridor showed pictures of people who used the service enjoying a recent visit from a company who brought exotic animals such as iguanas.

The registered manager told us how they had made links with local clergy who had photographs of Sutton House from previous eras and these were to be displayed in the service. Church services were held regularly for people who used the service.

There was a hen house in the garden and people who used the service liked to visit them; we saw four eggs were incubating in a corner of one of the rooms which had caused some interest.

The registered provide had a complaints policy and procedure. This described timescales for acknowledging complaints, investigating them and responding to the complainant. The procedure provided details of how to escalate complaints to other agencies. There were forms for people to fill in to detail their complaint and the action staff took to resolve it. Staff knew how to manage complaints. The newsletters reminded people that the manager was available with an 'open-door policy' if people wished to raise any concerns. People told us staff listened to them and would address any concerns they had. Comments included, "There are no complaints I can think of; I would tell whoever was on duty", "I would see [registered manager's name]. I complained once about something and everyone was told and it; it hasn't happened since" and "I'm not sure who I would tell but I think any of the staff; I've never had to complain." A relative told us, "I would see [registered manager's name], the boss; the door is always open and you can go and talk to her." One person told us they would prefer to raise concerns with the provider; the registered manager told us they would arrange this for them.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in December 2016, we had concerns about the general oversight of the service, the thoroughness of the quality monitoring system and the management structure. At this current inspection, we found some issues had been improved; however there remained concerns in other areas including medicines management, staffing levels and training.

Registered persons, that is the provider and manager, are required to send the Care Quality Commission (CQC) notifications of incidents that affect the welfare of people who used the service. We found several instances when this had not been done. These related to allegations of physical incidents between people who used the service, an allegation of missing money and an allegation made by the hospital when a person was admitted for treatment. The registered manager had discussed these issues with the local safeguarding team and in the instance of missing money, with the police. It was important for CQC to be made aware of incidents which affected the welfare of people who used the service in order for us to complete our regulatory duties.

Failing to notify CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are considering our regulatory response and will report on it when it is completed.

There had been improvements in the way audits were completed which meant issues were being identified sooner. The audits completed were care plans, medicines, the environment for cleanliness, decoration and repairs, wound care, pressure-relieving equipment, accidents and incidents, and food safety arrangements. However, we found shortfalls in medicines stock control and how medication administration records were maintained. These had not been identified in audits of medicines management. There had not been an audit of staff training completion, so shortfalls had not been addressed.

At the last inspection, we were unclear how the registered manager's dependency level tool assisted them in calculating the correct staffing numbers. There had not been any change in the use of the tool, which identified the level of people's dependency with regards to the care and support they required but there was no scoring system to analyse how this was used to calculate staffing numbers. There were also no criteria for looking at people's comments about call bell waiting times and staff's views. Therefore it was difficult for the registered manager to assess if staffing levels were correct; we found there was insufficient staff at specific times of the day. Following the last inspection, there was an action plan that recorded the shortfalls, whose responsibility for addressing them, timescales for completion and whether these had been completed. Most of these actions had been completed apart from training elements which was identified as 'on-going'.

In February 2017, we requested the provider complete a Provider Information Return (PIR). The PIR provided information about what the provider does well and what improvements were planned. In March 2017, the provider was sent a reminder about the PIR. The CQC has not received a PIR to date. The PIR is important for the inspection process and helps to identify areas we need to follow up and assess whether they have been completed. We spoke with the provider about this and they advised that in future they would allocate the receipt and action of the PIR to a senior manager within the company. Not completing the PIR showed us

there continued to be issues with provider oversight of the service.

Not ensuring good governance was a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We are considering our regulatory response and will report on it when it is completed.

Despite the continued breach in governance, improvements have been noted. For example, there had been an assessment of the dining experience for people and a check of their bedrooms to ensure key worker tasks had been completed and their belongings looked after properly. This was an improvement since the last inspection. The clinical lead said, "Audits are in place and are picking up things which are being acted on, for example, behaviour plans, timely referrals to the mental health team. I think people are less anxious and more settled."

The registered manager told us they received supportive visits from a senior manager and we saw reports from a discussion and a visit for two days in May 2017 when a range of issues were discussed including staffing numbers. The registered manager told us they felt supported and the employment of the clinical lead and more senior staff care staff had made a big difference. The clinical lead supported with on-call arrangements out of hours which helped the registered manager have a break from this responsibility. They described the provider and senior manager as approachable and available when required.

At the last inspection, we placed a condition on the provider's registration to ensure that risk assessments and care plans for people at risk of swallowing difficulties and challenges regarding behaviour were completed. These had been completed. All staff had received a supervision session which helped to check their competency in these areas.

There had been improvements in the fabric of the service. For example, new carpets had been provided in the sitting room and corridors on the two floors were the bedrooms were situated. Areas had been redecorated and this had made a difference to the internal appearance of the service.

Staff meetings had taken place and there had been meetings for people who used the service and their relatives. The registered manager told us the activity co-ordinator visited people separately if they chose not to attend meetings. We saw from records there had been four meetings for people and their relatives since the last inspection. The meetings evidenced people were provided with information, for example the last inspection report was discussed, and they enabled people to express their views. There had been two questionnaires to people regarding care staff, food and activities since the last inspection.

There had been improvements in the way daily notes and monitoring charts such as food and fluid intake and positional changes, were completed.

Staff told us communication within the service had improved. Handover sheets identified issues for the next nurse or senior to address. They also identified that care allocation of tasks had been completed so the shifts could be managed more effectively. The registered manager told us her management style was to make sure she was visible to staff and people who used the service and frequently supported people with care tasks if required. She said this enabled her to monitor staff practices and be there for advice and guidance when required.