Sutton Court Associates Limited

Homewood

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Homewood is a residential care home for people living with a learning disability and autistic people It is registered to provide personal care for up to six people; at the time of inspection six people were living at the service.

People's experience of using this service and what we found
People were not always protected from the risk of abuse. The provider had not ensured managers and staff had suitable training, skills and knowledge to support people whose behaviours may challenge themselves or others in the least restrictive or most person-centred way. A training programme had begun but this was still in the early stages and was yet to be cascaded to all staff.

People's communication and sensory needs were not always assessed and this meant that people's needs could not always be fully met.

People were not always supported by managers and staff who understood best practice in relation to learning disability and/or autism. Governance systems did not ensure people were always kept safe or that they received a high quality of care and support in line with their individual needs. Monitoring and assessments in relation to health and safety were not always undertaken or recorded.

Some people were not always supported to have maximum choice and control of their lives and guidance to staff did not always reflect how to support people in the least restrictive way possible and in their best interests.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.
Right support:
• Model of care and setting maximises people's choice, control and independence. The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. The model of care and setting did not maximise people's choice, control and independence. The support was task focused and staff did things for people rather than encourage their independence. Managers had recently undertaken training in this area and had begun to develop staff to shift the focus to a more active support approach. This training had not yet been fully embedded into practice.
Right care:

• Care is person-centred and promotes people's dignity, privacy and human rights. People were supported by staff who knew them well, however the provider had failed to ensure staff had received suitable induction or training. This meant people may not always receive person-centred care or support which promoted their dignity, privacy and human rights. Care and activities did not focus on developing people's strengths and aspirations. Managers explained that recent training had prompted them to begin looking at people's quality of life in order to identify and improve people's experience of care.
Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives. People were not supported by managers and staff who understood current best practice in relation to learning disability and/or autism. The provider had failed to ensure managers and staff received support to keep their knowledge and skills up to date. There were shortfalls in governance systems which did not ensure people remained safe, and lessons had not always been learned.

People gave mixed views of the service. Most people told us they were generally happy with the support they received and liked the managers and staff; they felt safe living at Homewood, but one person told us they like to "keep out of the way." They felt there was too much shouting in the house for them. Everyone told us they liked going to the shops and local amenities.
There were enough consistent staff who knew people well.

People told us they liked the food and often had their favourite meals.
People had access to health care and were encouraged to lead healthy lives.

Relatives told us they were pleased with the communication with the managers and staff and felt confident their views were listened too.

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

Rating at last inspection
The last rating for this service was good (published 11 July 2019).

Why we inspected
This inspection was prompted in part due to concerns about people's safety we identified in another of the provider's locations. We inspected in order to provide assurance people were safe and to check the service was applying the principles of Right support, right care, right culture.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report. Following the inspection, the provider had taken some actions to mitigate the risks. This is an ongoing process.

Ratings from previous comprehensive inspections for those key questions not inspected were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Homewood

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager covers some other services for the provider, Homewood also has a home manager who works exclusively at the service, providing day to day management.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and two relatives about their experience of the care provided. We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We checked that this was a suitable communication method and that people were happy to use it with us. We did this by reading their care and communication plans and speaking with staff or relatives and people. We used this communication tool with two people to tell us their experience. We spoke with six members of staff including the registered manager, the home manager and care workers. We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We contacted two professionals who regularly visit the service

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People were not always safe from abuse. Systems and processes to protect people from the risk of abuse were not operating effectively. For example, four incidents of people slapping/hitting each other occurred between May and October 2021 where the registered manager had failed to report to the local authority safeguarding team or to the Care Quality Commission (CQC). The incidents had repeated and action taken by the provider had been only partly effective, had the incidents been reported, external scrutiny may have led to support to reduce reoccurrence.
- People mostly told us they felt safe but one person told us some staff shouted, but it was not clear if this was about shouting at people or staff raising their voices to make themselves heard, one example was staff calling to people on the first floor from the bottom of the stairs. We reported this issue to the local authority safeguarding team for their consideration.
- People's emotional care needs had not been properly considered. For example, on eight occasions between February and October 2021 a person self-injured in the same way. Guidance for staff had not been recorded to show how the person should be supported to manage this or to seek support from relevant professionals such as the local authority leaning disability team. 'Right support, right care, right culture guidance' requires providers to ensure autistic people and people with a learning disability receive care which promotes and respects people's human rights. Staff were aware of how anxiety would prompt the person to self- injury and what to do if the person was upset because they knew them well but didn't have the knowledge or strategies to prevent or reduce reoccurrence.
- Support plans guided staff to take actions in response to managing incidents which included potential restrictive interventions. There were no strategies to help people to express their feelings in a more positive way. For example, one person's plan told staff to direct person to their room with one or two staff and to remain outside until the person was calm. It also said to "show the person authority when particularly challenging" however does not indicate what showing authority means. This meant that the term show authority could be interpreted differently. The registered manager agreed that this was open to interpretation and agreed to provide clear guidance for staff. Staff explained how they supported someone when they were emotionally distressed, they referred to going to their room or quiet area to enable a quite conversation, where they spoke with them and offered one to one staff attention until they felt better. The registered manager agreed that the guidance in the support plans did not reflect the supportive nature of the practice and told us they would address this. Similar concerns had been identified during a recent inspection of another of the provider's locations.

The provider failed to ensure people were safe from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We reported these incidents to the local authority for consideration by the safeguarding team and informed the registered manager that we had done this. The registered manager acknowledged these concerns and told us actions they planned to take including a review of incident management and safeguarding systems to ensure they were effective. The registered manager submitted the required statutory notifications to CQC immediately following the inspection.
● The provider had recently started a training programme for the registered manager and home manager to learn about Positive Behaviour Support (PBS). The home manager had started to cascade some learning to the staff team and some staff had received some awareness training about the principles of PBS.
● Some lessons had been learned following an inspection at another of the provider's services. For example, the registered manager had started to record in more detail their analysis of incidents including actions taken and lessons learnt.
● Staff told us that the home manager talked with them following incidents and encouraged them to look for ways to support people more effectively. These debriefing sessions were an opportunity to reflect and discuss in depth what happened, what areas of support were effective, and to acknowledge feelings. The home manager began to record these sessions for future reference to review changes in approach and identify their effectiveness. The home manager told us the recent learning about PBS would support this practice, giving them a wider understanding of appropriate ways to support people.

Assessing risk, safety monitoring and management
● Risk assessments did not always contain adequate information to provide staff with information to mitigate risks. For example, risk assessments used terms such as, 'redirect' or 'reassure' but gave limited details on how to do those things, support plans did contain more detail but was not always clear. Staff did know what these terms meant for each person and they were different for each person.
● Individual activities for people only had any risk assessment if people became anxious and had not assessed the risk of the activity itself. For example, a person has a trampoline in the garden, and there was not a risk assessment in relation to the safe use of this equipment. The registered manager showed us an archived assessment. Staff told us a second person had also used the trampoline, but the risk was not recorded for the second person. The registered manager told us the trampoline was no longer in use, but it remained in the garden and could therefore still pose a risk.
● Risks associated with the use of a wheelchair for one person and the staff pushing the wheelchair had not been considered and recorded. This was a new change of need and the registered manager told us they would carry out a risk assessment. Wheelchair safety checks were in place. We saw no evidence that people had come to harm.
● Risks to people from fire had not always been assessed effectively. A fire evacuation plan to be carried out in the event of an emergency at night included a single staff member supporting people to evacuate the service. This had not been tested to ensure this was effective or practicable. Following the inspection, the registered manager demonstrated to us they had carried out a fire drill to test the process. West Sussex fire safety service had visited and not raised concerns about the night time evacuation.
● The registered manager assured us shortly after the inspection the more detailed archived risk assessments and support plans were in the process of being updated and available to staff. Staff confirmed this. This meant that new staff had access to the information to support people with previously identified risks. This is an area that requires improvement.

Staffing and recruitment
● Staff were mostly recruited safely and in line with best practice. Records showed applications forms were completed and included employment histories. Suitable checks such as references and Disclosure and Barring Service (DBS) were obtained prior to employment. Records showed one DBS check outcome should

have had a risk assessment in place. The registered manager told us the detail of the risk and how the information had been assessed but agreed that it needed to be recorded.
● There were sufficient staff to meet people's needs. We observed staff were prompt in supporting people who needed assistance. People gave varied views of staff. Some told us staff were kind to them and how they always had time to chat; we saw this in practice.
● Through the inspection we observed staff interacting with people. People were relaxed with staff and generally spoke positively about the service and the staff. One person pointing out an individual staff in an adjoining room and smiling and making thumbs up gesture said "good"
● Relatives told us they felt their loved ones were safe. One said, "The staff are just brilliant."

Using medicines safely
● Medicines were received, stored, administered and disposed of safely.
● We observed two staff members administering medicines to people, this was completed with care and attention. The staff members were knowledgeable about the medicines they were administering and demonstrated an understanding of the person's needs and preferences.
● Only staff who had been trained to administer medicines were permitted to do so; the rota confirmed there were always trained staff available to carry out this task. Staff had checks on their competency in practice.
● Guidance was available for staff on when to offer 'as required' (PRN) medicines and what these medicines were for. People received medicine in line with this guidance.
● People's medicines to prescribed to support anxiety were reviewed and where possible had been reduced.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

Is the service effective?

Our findings

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

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff support: induction, training, skills and experience

- People were not always supported by staff who had the induction, training, skills and experience to deliver care in line with the standards and current guidance.
- Staff did not consistently display respectful language. One staff used the term, "kicking off" when describing a person who had become emotionally distressed. Then went on to talk about the person with genuine regards, demonstrating an understanding of them as an individual.
- Records contained terms such as "accessing the community" when meaning "going shopping or doing a leisure activity." A person was recorded as being "territorial" when wanting to spend time in a shared area of the house alone. These terms demonstrate a lack of understanding of maintaining people's dignity and are not person centred. When brought to the registered manager's attention they agreed and told us they would address this culture.
- People's communication and /or sensory needs were not assessed. For example, people with limited verbal communication did not have any additional methods of communication identified in their plans or in place for them to use. Understanding people's communication and/or sensory needs is fundamental to planning and delivering good quality person-centred care. For example, the lack of alternative communication tools meant that people may became distressed when they did not fully understand what was expected of them. Following the inspection a staff member told us the service has developed some visual communication support tools for people, For example one person has photographs of places they like to visit to aid choice.
- Staff had not always completed training or always had the relevant knowledge to meet people's needs. For example, records showed that some staff had not completed training about autism or how to support people with a learning disability according to current best practice. One staff member told us, "The home takes care of adults with a learning disability and mental health" then corrected themselves to say not mental health but autism. They added, "But similar in the way we support them." This demonstrated a lack of understanding of the needs of the people they supported.
- The service used an Electronic Care Monitoring system (ECM). When people's plans were transferred to the ECM details were omitted. Plans in current use and available to staff did not consider people holistically and focused on perceived negative behaviours people could display.
- Managers had not fully considered people's strengths or focused on what they could do, to enable people to have a fulfilling and meaningful life.

The provider failed to ensure staff received appropriate training and support to enable them to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were told that recent Positive Behaviour Support training (PBS) had identified the need to actively support people, for staff to encourage and work alongside people to do more for themselves. To promote people's well-being by giving more opportunities for people to experience a sense of achievement. Staff confirmed the home manager had started this practice and led by example.
● We observed staff giving a person time to talk about their favourite subject. Other staff we spoke with told us that another person asked to see information on the internet to aid choice, we saw this happening during the inspection.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff took account of people's dietary requirements and ensured people were offered choices in line with those needs. For example, one person had recently been referred to a speech and language therapist, due to their difficulty with eating.
● People told us they enjoyed the meals and had plenty to eat. One person said," I like the food, I like to eat hot pot."
● Some people were supported to make their own drinks. People were offered a choice of drinks regularly.
● Staff mainly prepared and cooked most meals. One person told us "I hate cooking, the staff do it for me." Other people had limited involvement with meal preparation; staff and people told us this was something they were had started to do more.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
●People had access to healthcare professionals and the service generally worked in collaboration to ensure their needs were met. Staff monitored people to identify any changes in their health. Records confirmed people had been supported to meet with a variety of healthcare professionals.
● Professionals gave varied feedback, one told us, "The manager was helpful in accommodating my visit request and was able to provide information about what was happening with the person I was planning to see." Another said, in reference to explaining a person's clinical plan, "They (staff) don't always take on information well and you have to break this down significantly."

Adapting service, design, decoration to meet people's needs
● People were supported to personalise their rooms and this included choices about the decoration.
● Some adaptations to the environment had been made to accommodate people's mobility needs, a removable ramp was available for a person to access the front door.
● People appeared relaxed in the service and some people spent time in communal areas and their rooms. A second, quitter sitting room on the ground floor was being used by one person to look at magazines and they told us they liked to look at cars from the window. Staff told us how much people enjoyed time in the garden in the summer months.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Staff understood the MCA legislation and DoLS guidance.
- People had received mental capacity assessments and these included details of the help people might need to make decisions. There was clear information about the processes to follow to ensure where people lacked the capacity to make decisions these were made with them and in their best interests.
- People had an authorised DoLS and the registered manager had a system to follow up with the local authority when it was due to expire. Records showed where a person had conditions these were being met. For example, one person's medicines were to be reviewed by their GP or psychiatrist and this had been completed.

Inadequate

Is the service well-led?

Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider had failed to keep the culture of the service under review and ensure people were supported in line with the principles of 'Right support, right care, right culture'. They could not be assured people were supported in a person-centred way where the culture had a focus on continuous learning and improvement.

- The provider had failed to ensure that training appropriate to meet people's needs was delivered to all staff and had not checked staff understanding of the training they had received. For example, understanding autism, learning disability, effective communication and sensory processing training had not been provided to all staff and staff competency had not established.
- The provider had failed to recognise that language used when recording information about people was not respectful or person centred.
- Information to enable monitoring of the service was unreliable. Record keeping was sometimes poor. For example, staff told us the system of recording incidents and accidents was confusing, resulting in incidents being recorded as accidents and wording such as 'unsettled' and 'redirected' being used that did not clearly describe what had occurred or the staff response. This meant information about the reason for a person's distress or what approaches staff used was not always available to identify trends and reduce re occurrence.
- The provider could not be assured incidents were always identified, reported by managed in line with current good practice guidance. For example, incidents of conflict between people had not been reported to the local authority or CQC by managers. When this was raised with the registered manager at the inspection, they took prompt action and reported the incidents as required.
- Governance processes were not effective and did not always keep people safe, protect their human rights and provide good quality care and support. For example, the provider's updated safeguarding policy had not been shared with staff. Full information about people's care and support needs, including risk assessments, had not all been transferred to the electronic planning system. This meant that staff did not always have all the information they needed to keep people safe. This was raised with the registered manager who told us they would take immediate action.
- One person's bedroom door was wedged open with a rubber door wedge; this prevented the door automatically closing in the event of a fire. Another door to a sitting room had a door wedge holding it open because the automatic door closure was not working. When inspectors raised this with the registered manager it was immediately addressed, however, it demonstrated safety monitoring had not been effective.

● General and environmental risks had not always been recorded and were not always available to staff. For example, the risk assessments for the use of some items of mobility equipment were not in place.
● The provider could not be assured of the effectiveness and practicability of night-time fire evacuation procedures as they had not been tested by conducting night-time fire drills. This has been addressed but was not picked up by the providers quality assurance systems.
● The provider had failed to ensure people's communication and sensory processing needs were fully assessed. This meant that people may not have the communication tools and sensory support to enable them to engage with others in the most effective person-centred way.

The provider had failed to establish adequate systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This placed people at risk of harm. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff completed regular meetings with people where activities and ideas were discussed. One person told us, "I like talking to (registered manager) and (home manager)."
● Staff told us they felt respected, supported and valued by managers and the provider. One staff said, "I can go to the managers anytime and when I have wanted to talk to the provider they came back to me within 24 hrs."
● Relatives told us they were consulted about their loved one's care and felt they could express their views.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had not always acted in line with the requirements of duty of candour as they had not reported all incidents of conflict to the local authority and CQC. This was as a result of a lack of understanding of the reporting requirements and has since been addressed.
● Relatives were confident the home manager and staff would ensure they would be made aware if something went wrong and gave examples of this happening.

Continuous learning and improving care
● Lessons learned from inspections of the provider's other services were beginning to be cascaded to this service and there was a mixed picture of how effective this had been so far. Improvements need to be sustained and embedded over time to be effective.
● Positive Behaviour Support training for managers was underway with the registered and home manager at Homewood and they had started to cascade this learning to staff.
● Staff told us that the home manager encouraged them to discuss issues and was focused on solutions. One staff told us, "(name) is always keen for us all to learn to do things better."

Working in partnership with others
● The service worked with health professionals. This included the GP, Speech and language therapist physiotherapist

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure people were safe from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish adequate systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff received appropriate training and support to enable them to meet people's needs.