Mr M E & Mr P R Butterfield

Sotwell Hill House

Inspection report

Brightwell-Cum- Sotwell
Wallingford
OX10 0PS
Tel: 01491 836685
Website: www.sotwellhouse.co.uk

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We carried out our inspection on 4 and 6 November 2015. This was an unannounced inspection.

The service had a registered manager who was responsible for overall management of the home. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

Sotwell Hill House is a care home providing accommodation for people requiring personal care. The service supports older people with a variety of conditions which includes people living with dementia. At the time of our visit there were 32 people living in the service.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS enable restrictions to be used in a person's support, where they are in the best interests of a person who lacks capacity to make the decision themselves. The registered manager had made

Summary of findings

appropriate referrals to the supervisory body. However where people lacked capacity to make decisions the registered manager was not always acting within the principles of the Mental Capacity Act (2005).

People were positive about living in the home and felt safe. People were complimentary about the staff and felt they were treated with dignity and respect. People enjoyed the activities organised in the home, which included trips out.

Throughout the inspection there was a calm, cheerful atmosphere. People laughed and chatted with staff and requests for support were responded to in a timely manner. The registered manager was visible about the home and took time to speak with people and staff.

People felt there was not always enough staff and had to wait to be supported. The registered manager was actively recruiting and employed agency staff when needed.

Medicines were not always managed safely and people were not always receiving topical medicines as prescribed. Risks to people, associated with swallowing difficulties were not always managed safely.

Staff were well supported by the registered manager through regular face to face meetings. Staff had access to training and development opportunities to ensure they had the skills to meet people's needs. Staff felt valued and listened to and were involved in developing the service.

Systems in place to monitor the quality of the service were not always effective. Audits were carried out but had not identified the issues we found during our inspection.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the end of the full version of the report.

Summary of findings

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.

Medicines were not always managed safely.

Risks were not always identified and where risks were identified there was not always clear guidance as to how risks would be managed.

Staff were knowledgeable about their responsibilities to identify and report safeguarding concerns.

Requires improvement

Is the service effective?
The service was not always effective.

Staff were not aware of the principles of the Mental Capacity Act 2005 or associated codes of practice.

Staff were supported by regular face to face meetings with the registered manager and had access to development opportunities.

People had sufficient food and drink to meet their needs

Requires improvement

Is the service caring?
The service was caring.

People were supported by caring staff.

People were treated with dignity and respect.

People were involved in decisions about their care and their choices were respected.

Good

Is the service responsive?
The service was not always responsive.

Care plans did not always contain information that was personalised.

People had access to activities that interested them.

People were aware of the complaints procedure and felt confident to use it if necessary.

Requires improvement

Is the service well-led?
The service was not always well-led.

There were systems in place to seek feedback from people and relatives. Feedback was used to improve the service.

People and staff were positive about the registered manager and felt the service was well-led.

Requires improvement

Summary of findings

Systems to monitor the quality of the service were not always effective.

Sotwell Hill House

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.

This inspection took place on 4 and 6 November 2015 and was unannounced. The inspection team consisted of two inspectors and Expert by Experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law. We had feedback from the commissioners of the service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed care practices throughout the day.

We spoke with 12 people who used the service and three visitors. We looked at eight people's care records, five staff files and other records showing how the home was managed. We spoke with the registered manager, the nominated individual, six members of the care team and the chef.

Following the inspection we gained feedback from two health and social care professionals.

Requires improvement

Is the service safe?

Our findings

Medicines were not always administered and recorded safely. Medication records showed occasions where there was no record of whether a person's medicine had been administered. For example, one person's medicine administration record (MAR) had two gaps where medicines had not been signed for and no code had been recorded to indicate whether the medicine had been given or not. We checked the balance of the medicine. The balance showed the person's medicine had not been administered.

Medicines were not always stored safely. For example, thickening powdered that was prescribed to be used as part of the treatment for people with swallowing problems had been removed from the original container it was dispensed in. It was administered from a plastic container that was kept in the kitchen. There was no detail on the container of who the thickener was prescribed for and no direction as to the quantity or consistency required. The thickening powder was being used for three people. Only one person had the thickener prescribed. This meant two people were receiving a medicine that had not been prescribed for them.

Some people had topical medicines prescribed. Topical medicines are medicines that are applied to body surfaces, for example creams and ointments. Topical medicines were administered by care staff and recording charts were kept in people's rooms. We looked at the topical cream charts and found many gaps where staff had not signed to confirm topical medicines had been administered. We asked one person about their topical medicine, they told us, "They (staff) forget sometimes, my skin is on fire so I have to ring and ask for it".

Topical medicines did not always have a record of the date of opening. For example, one person had four pots of the same topical medicine in their bathroom. Two pots had been opened but there was no date recorded on either of the opened pots. Another person had a topical medicine that had been prescribed several months before. There was no date of opening. The recording chart showed it had been administered several times during the previous month. There was no detail as to when and where the medicine should be administered. We spoke to a member of staff who told us it was 'applied anywhere needed'. This medicine was not on the person's MAR, we spoke to the registered manager who told us it was no longer prescribed.

Care plans contained risk assessments. However where risks were identified care records did not contain detail of how risks would be managed. For example, one person had been identified at 'high risk' of developing pressure ulcers. There was no care plan detailing how staff should support the person to manage the risk. There was no record of any specialist pressure relieving equipment the person used or needed. We saw this person did have a pressure relieving cushion in their room. However staff did not always support the person to use it. We saw the person sitting for three hours without the cushion. We spoke to the person about their cushion. The person told us, "It's more comfortable to sit on it. They (staff) don't bring it and I don't like to ask or buzz because they are so busy".

This was a breache of Regulation12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were not always enough staff to support them at a time of their choice. Comments included: "There are not enough staff and we often wait, it is worse when staff are on holiday or off sick, we then have agency staff"; "We do wait, there are not quite enough staff. We don't really have much choice with getting up and going to bed, we have to fall in with the staff"; "I hate getting up so late, my morning is spent just trying to get up and get dressed it takes all morning, I would like to get on quicker but I just have to wait"; "I do have to wait but I am independent and they get to me when they can. I have no concerns about the staff they are just too busy" and "There is not enough staff here, we depend on agency staff. The agency staff don't know us and they don't know what to do".

Staff we spoke with told us there were occasions when there were not enough staff. One staff member said, "Staffing levels have been a little low with only four care workers. Manager does try to get agency where possible".

The registered manager regularly assessed people's needs and used the dependency assessment to inform staffing levels. The current level of staffing was five care workers throughout the day. We looked at the rotas for a four week

Requires improvement

Is the service safe?

period and saw that staffing levels were below the required number for five mornings and four afternoons. The registered manager had contacted the agency to try and cover the shortfalls.

We spoke with the registered manager who was aware of the difficulties and told us they were actively recruiting care staff. The registered manager told us that where possible they used agency staff to cover shortages and worked with the agency to provide consistency of staff. The registered manager also assisted staff when there were shortages by administering medicines to enable the care staff to concentrate on supporting people's personal care needs. We saw the registered manager administering medicines on the day of our visit. The registered manager told us there were five housekeepers who were responsible for supporting the care staff team by ensuring people had access to regular drinks and snacks throughout the day.

During the inspection we saw that people's call bells were answered promptly and that people requesting support were responded to in a timely manner. During the morning staff were busy supporting people with personal care in their rooms, however people were not rushed and people were supported to the communal areas of the home in time for them to take part in activities.

People told us they felt safe. Comments included: "Oh yes, we all feel safe here. I never feel frightened here and have never seen anything untoward"; "I feel very safe here, there is always someone around" and "I feel safe living here". Visitors also told us they felt people were safe. One visitor said, "Oh goodness, yes, she is very safe".

Staff had completed training relating to safeguarding people and staff were knowledgeable about their responsibilities to identify and report safeguarding concerns. Staff were confident all concerns would be taken seriously and acted upon. Staff were aware of the outside agencies they could contact to report concerns if action was not taken through internal procedures. One member of staff said, "I would report to my management and then to the Care Quality Commission (CQC). I wouldn't hesitate".

The provider had a safeguarding policy and procedure in place. Records showed that safeguarding concerns had been managed in line with the policy and procedures and outside agencies had been notified appropriately.

Requires improvement

Is the service effective?

Our findings

People were not always being supported in line with the principles of Mental Capacity Act 2005 (MCA). People's care plans did not always contain clear information relating to their capacity to consent to their care. For example, one person's consent care plan stated, '[Person] has provided consent to receive on-going care. In addition [Person] has specifically consented to have photographs taken as necessary". The document also stated, 'Please note that as [person] is unable to make decisions that affect her life and well-being for herself the mental capacity assessment and associated care plans need to be used to assess [person's] needs'. The outcomes section of the consent care plan stated, '[Person] wishes to receive only the care and any necessary treatment required that [person] has expressly consented to, whether written, verbally agreed to or implied'. It was not clear from this document whether the person had capacity to consent to their care. We spoke to the registered manager who told us the person lacked capacity to consent to their care; however there were no capacity assessments on the person's file.

Some staff told us they had not received training relating to MCA. We looked at training records and there was no record of MCA training. We spoke to the registered manager who told us MCA was discussed in safeguarding training. Staff were not always aware of the principles of the MCA and associated codes of practice and how this would impact on their support for people who were assessed as lacking capacity.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The registered manager understood their responsibilities and had made applications for Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be restricted of their liberty for their own safety.

People were complimentary about the staff supporting them. Comments included: "The staff understand me and keep me independent" and "The staff know us and know what we like".

Staff completed an induction programme which included training in: safeguarding; food safety; principles of care; infection control and moving and handling. Staff competency was assessed through the induction programme. Staff told us they completed regular updates of training and could request additional training. For example, one care worker had requested medication training to help their career development. The care worker told us they had completed the training.

Staff were supported through an effective supervision and appraisal system and received supervision in line with the organisations policy. Staff told us supervisions were useful and gave an opportunity to discuss career development. One care worker told us they had requested the opportunity to study for a level three diploma in health and social care and showed great enthusiasm when telling us they had just enrolled for the qualification.

Records showed that supervisions were an opportunity to reflect on training staff had completed. Issues relating to staff conduct and competency were also managed through supervision. Where staff had exceeded the expectations of their job role this was discussed and documented in supervision records. For example, one care worker had been praised for their support of a person at the end of their life. As a result the member of staff had been made a dignity champion in the home.

People told us they enjoyed the food and drink provided in the home. Comments included: "The food is good here. I get plenty to eat and drink"; "We both get plenty to eat and drink, it is too much really"; "The food here is good and I am a fussy eater"; "I have no complaints about the food, if there is something you don't like they bend over backwards to find you something you do like" and "We are given more than enough food".

Visitors told us they were invited to eat in the home and the food always looked appetising. One visitor told us, "The food is lovely I eat here sometimes, the chocolate cake is to die for".

Where people were at risk of weight loss, weight was monitored and a fortified diet was provided. The chef was aware of people who required a fortified diet and we saw this was provided.

Where people required a specialised diet, staff were not always clear about the consistency of food to meet people's needs which put them at risk of receiving food that did not meet their dietary requirements as detailed in their care plan. For example, one person had been assessed by the Speech and Language Therapist (SALT)

Requires improvement

Is the service effective?

who had recommended the person should have a soft diet. One member of staff we spoke with told us the person had a 'blended diet', another member of staff said the person had their food liquidised.

People were referred to appropriate health professionals when required. One person told us, "I see the podiatrist every eight weeks and the Doctor when I need one". Another person said, "The staff arrange when I have to go to hospital visits and if my daughter can't take me [registered manager] does". Health professionals told us people were referred to them appropriately and that any guidance or recommendations were followed.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. Comments included: “The staff are very kind and caring to me”; “Yes on the whole they are very caring. I would say we are very much treated with dignity and respect”; The staff here are all lovely”; “The staff are all caring and good. They treat us very well here” and “The staff are caring, patient and kind and they are very pleasant”.

Visitors were complimentary about the caring nature of the staff. One visitor said, “The staff are amazing. [Person] had a fall and the young carer was really upset and it came from the heart”.

One health professional told us there was a caring culture in the home and that staff always put the needs of the people in the home at the forefront of everything they do.

We saw many kind and caring interactions. For example, one person did not want to sit and eat their meal and had spent much of the morning walking around the home. A care worker went with the person into another area of the home and asked if the person would like a dessert. The person indicated they did not want a dessert. The care worker used her knowledge of the person and showed them a cake. The person immediately smiled and took the cake. The care worker supported the person to sit down, encouraging the person to sit and rest for a while.

We saw members of the whole staff team talking with people in a relaxed and supportive manner. This included members of the housekeeping team, office staff and maintenance person. People clearly enjoyed these interactions as they smiled and laughed with staff.

People were treated with dignity and respect. Staff knocked on people’s doors and waited to be invited in before entering. People were supported with personal care discretely and in ways which upheld and promoted their privacy and dignity. People were addressed using their preferred names. We saw that people were clean, well-cared for and dressed appropriately for the weather.

People’s decisions were respected. One person was walking around the home in their night clothes. Staff approached the person on several occasions and asked if they would like to be supported to wash and dress. The person declined, staff respected this and ensured the person’s dignity was respected by fetching a dressing gown for them. Staff continued to offer support and in time the person was supported to wash and dress.

People told us they felt listened to and were involved in their care. Comments included; “I get involved in my care it is sensible to” and “We are involved in our care and we are listened to”. One person told us they were not involved in their care, the person told us, “I don’t really get involved in my care, I don’t want to. I do feel listened to”.

Staff obtained people’s permission before providing support and explained what was going to happen both before and during support. Staff made sure people were happy with the support being offered and understood what was happening.

Requires improvement

Is the service responsive?

Our findings

People and relatives were involved in the development of their care plans. One relative said, "I get involved in every element of their care". Care plans were regularly reviewed and amended when people's needs changed. However, people's care plans did not always contain clear information to enable staff to meet people's needs. Care plans were not always personalised. For example, we saw two care plans related to the support needs of people living with dementia. The dementia care plan for both people stated, 'Ensure [person] has any memory aids she relies on with her at all times'. The care plan did not detail the memory aid each person needed. We spoke to the registered manager who was aware of the memory aids; however there was no system in place to ensure agency staff had access to this information.

Care plans reflected people's choice in relation to their equality, diversity and human rights. For example, one person had specific needs relating to their religion. The person's care plan detailed the support they required to meet their religious needs. Staff we spoke with were aware of the person's needs and we saw that staff supported the person in line with their care plan.

Some people's care plans contained reminiscence workbooks. Workbooks included information about the person's history, their likes, dislikes and what was important to them to enable staff to understand more about the person. The activity co-ordinator was working with people and their families to complete reminiscence workbooks for everyone living in the home.

Whilst we saw many interactions that were person-centred, staff did not always use language that promoted a culture of person-centred care. For example staff referred to 'toileting being late' and 'the next pad change round'.

People told us they enjoyed living at the home. One person said, "I love every minute of it living in this home". People were able to spend time as they chose. One person told us they liked to go out in the garden and were supported to do so by staff.

One relative said, "They [staff] really encourage [person] to join in activities. There's a lot of community involvement and visits out. [Person] really enjoys them, when they were at home they wouldn't leave the house".

The home employed an activity coordinator who arranged a range of activities in the home and trips out. During our visit people enjoyed a musical quiz. On the evening of our inspection there was a firework display. People told us they enjoyed the activities and were able to spend time doing activities that interested them. One person said, "Crumbs, there is so much going on here, we are kept busy. I love music and we had a concert yesterday".

People told so they knew how to complain and were confident to do so. Comments included: "We have no complains and if we did we would tell [registered manager] or [nominated individual]" and "I have never had to complain but if I did need to I would tell [registered manager]". Visitors were also aware of the complaints procedure and felt confident any issues would be taken seriously and resolved in a timely way. One relative said, "We would complain to [registered manager], there is no need to complain this place is fabulous".

There had not been any complaints since our last inspection. The registered manager kept a file of all comments and compliments. We saw many thank you cards and letters complimenting the care and support provided at the home.

Requires improvement

Is the service well-led?

Our findings

People told us the service was well-led. Comments included: “I think this home is well-managed”; "I think this home is very well led, they are very nice helpful people and very pleasant”; “I think the home is very well run, [registered manager] helps serve the food sometimes” and “I think this home is well led, the food is excellent, the home is clean and I have no complaints at all I am very content”.

Visitors were positive about the management of the home. One visitor told us, “We think this home is well-led and we are eternally grateful we found it. The home tailors the care to each individual all the time, [registered manager] is always aware”.

People and visitors were complimentary about the registered manager. One relative told us, “We had no time for a visit because [person] took a fall so [registered manager] said we could move them down here and we would see how it went. [Registered manager] sorted it all out in double quick time even money etc. was sorted retrospectively and we are very grateful and happy with this home”.

Health professionals were positive about the management of the home. They told us the registered manager was approachable and was responsive to advice and guidance given.

Staff were complimentary about the registered manager and felt supported in their roles. One member of staff said, “[Registered manager] is a very lovely manager, firm but fair. She is very supportive”. There were regular staff meetings, where staff were encouraged to share ideas. Staff told us they felt listened to. Staff were aware of the Whistleblowing policy and were confident any concerns would be taken seriously.

There were regular meetings for people and relatives. People told us this was an opportunity to make suggestions for improvements and to be kept up to date with what was happening in the home. Records showed that a suggestion had been made to have place names at mealtimes. One person told us this had been tried but people had not liked it.

Annual surveys were carried out and a ‘share your experience’ electronic system had been installed in the entrance of the home. We saw that feedback had resulted in actions taken to improve the service. For example, comments had been made about the path around the garden. Plans were underway to replace the path to make it more accessible.

There were a range of audits carried out to monitor the quality of the service. These included; infection control, equipment, the dining experience and medicines. Not all audits were effective; for example, although the medicines audit had identified some issues found during our inspection, issues relating to topical medicines and thickening agents had not been identified. We spoke to the registered manager who told us a new medicines system was being introduced to address the issues they had identified through their audits. The registered manager told us they would look at how systems for managing topical medicines and thickening agents could be improved.

Accidents and incidents were recorded; however records did not always show what action had been taken as a result of accidents and incidents. For example, one person had sustained a small injury following an incident with bed rails. There was no record of what had happened to reduce the risk of another incident. We spoke to the registered manager who advised they would review the person’s care plan in relation to the use of bed rails. There was a system in place to look for trends and patterns relating to accidents and incidents. For example falls were monitored for individuals and across the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to mitigate the risks to service users. The provider was not ensuring the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment was not always provided with the consent of the relevant person.