Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Nutley Hall

Nutley, Uckfield, TN22 3NJ

Tel: 01825712696

Date of Inspection: 10 February 2014

Date of Publication: March 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✗ Action needed
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Nutley Hall
Registered Manager	Mr. Paul Bradford
Overview of the service	Nutley Hall is a care home which provides personal care and accommodation for 33 adults who have a learning disability. The home is made up of a number of small group homes in a community setting.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 10 February 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

We looked at the care records relating to people's care and support and saw that people's wishes had been taken into account in planning their care, with support from health professionals and relatives if necessary. Risks to people's health had been assessed and documented. However at the time of our visit there was no effective system in place to demonstrate that people were cared for and supported by staff effectively at all times.

We looked at the procedures for administering medicines to people and found that whilst these were administered safely, they were not always stored and maintained correctly.

Due to people's complex needs they were not able to tell us fully about their experiences of living at Nutley Hall. One person told us they were "happy here" and another told us the staff "were nice". We spoke with one relative who told us they were "very happy with the care here". They said they had never needed to make a complaint and added that the staff were "always very friendly". We spoke with four members of staff, one of whom told us people "have lots of opportunities".

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 18 March 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. When we arrived at the setting most people were engaged in their individual programme of planned activities. We were shown around the building and we noted that people's rooms were furnished with personal items such as photographs. The rooms and public areas we saw were warm, light and had no unpleasant odours.

Call bells were not in place as standard, although we were told that where people were at risk of falls measures were in place to alert staff, such as a trigger mat in one room in case the person got out of bed in the night. The manager explained that people's needs were assessed on an individual basis and if it was considered necessary, call bells were installed. Bathrooms, toilets and shower rooms did not have call bells in place but we were told that members of staff were always present to supervise personal care.

We saw that staff treated people with dignity and respect. In addition to workshops and other activities people were encouraged to help with most aspects of daily living tasks such as helping with laundry, laying the tables for meal times and washing up or loading the dish washer. We saw people engaged in these activities, with support from staff, during our visit. One person was reluctant to help and we saw a member of staff calmly but assertively remind them that it was their turn to help with washing up.

We were told that cooked meals were prepared in a central kitchen and taken to the individual houses/flats within the community setting. It was one person's birthday on the day of our visit and we were told that people could choose what to have for lunch when this was the case. Home cooked pizza and salad were being prepared to be distributed to the individual houses and we saw staff and people line up to collect and deliver them. The provider might wish to note that some houses were a considerable distance, along outdoor paths, from the central kitchen and hot food was delivered in non insulated plastic boxes which could result in people having their food served cold.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We looked at the care plans of four people living at Nutley Hall. These were stored and maintained in the individual houses/flats. The plans included people's personal details, medical history, health records and appointments. Details of people's likes, dislikes, preferred daily routine and weekly timetables of activities and workshops were documented, together with appropriate risk assessments.

Most plans had been reviewed on a regular basis and we were told that this was done by the house co-ordinator responsible for each house/flat. Risk assessments were mostly up to date and there was a statement at the front of some folders to say that plans older than two years should be archived. However this had not been consistently done in the care plans we reviewed, which made it difficult to see when the latest reviews had taken place.

Of the plans we reviewed only one had been signed by the person but we could see that they had been produced in accordance with their wishes, with help from relatives and relevant health care professionals. There were no end of life wishes documented in these plans but the manager explained they were in the process of gathering relative's views on this sensitive subject and we saw the documentation relating to this.

Within the care plans there were daily log sheets which, we were told, were to be completed by the staff who delivered care to people. We found that one person had daily log sheets, not in any chronological order, in three separate locations within the care plans folder. This made it difficult to see continuity in care for that person. In addition the provider might wish to note that two plans we reviewed were not completed on a daily basis, with one having a gap of four days without any care documented.

There were arrangements in place to deal with foreseeable emergencies. We saw that fire exits were kept clear and fire escape routes were clearly marked and displayed. We saw that emergency training for staff was mostly up to date and staff we spoke with gave satisfactory answers when we asked what they would do in the event of a fire. We were told that people took part in fire drills and one person had a personal escape plan in place as they had been assessed as being at higher risk than other people who were fully mobile.

Workshop procedures were in place for all of the workshops on the premises and we were told that there was always a qualified first aider in each workshop building. Workshops which were considered to be high risk, such as the woodland workshop, were cancelled in the event of bad weather and/or if the member of staff responsible for first aid was on holiday or off sick. However at the time of our visit we noted that there were three more people in the knitting and weaving workshop than was recommended.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We looked at the home's safeguarding policy and saw that it had been updated in January 2014. This included details of the whistleblowing policy and we saw that the policy was reproduced in a format that could be understood by the people living in the home and displayed prominently on notice boards.

We spoke with three members of staff, all of whom were able to tell us about safeguarding procedures. All three knew the role of the safeguarding team and were able to outline the home's safeguarding policy. They were able to explain whistleblowing procedures. We saw that staff had received training on safeguarding in the week prior to our visit.

We asked about accident reporting procedures and one member of staff told us that accidents and incidents were recorded in a book held within each unit and reported to the manager. They were also recorded in the care plans. However they told us that some minor accidents did not get recorded in the book which meant that it was not always easy for the manager to see records of all accidents.

At the last inspection it was noted that one person had some unexplained bruising that was not reported to the local safeguarding team. We asked the manager about this and they told us that a meeting had taken place with the safeguarding team to review the guidelines and establish what was appropriate to refer to them. We were told that in this case the person had been monitored and the team were satisfied that the matter had been dealt with in a satisfactory way.

During our inspection we noticed that one person had a bruise under their finger. They told us it had been jammed in a door. We reviewed the records relating to this and saw that appropriate action had been taken. Another person, who had been risk assessed for accessing the gardens and paths to Nutley Hall alone, had injured their ankle. A member of staff told us that it was difficult to establish when and what exactly had happened. We saw that appropriate action, which included hospital investigations, had been taken and

documented.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Medicines were prescribed and given to people appropriately. We saw that the home used the dosette system for giving medication to people. These were supplied by a local pharmacy and delivered to the central building in the home from where people's prescribed medicines were taken to the relevant units by the responsible member of staff from each house. We were told that it was each house supervisor's responsibility to check that the correct medicine had been delivered. Unused medication was recorded and returned to the pharmacy.

Medicines were handled appropriately and safely administered. We observed the lunch time medicines being given in one house. The member of staff dispensed the medicines into clean pots, using a no touch technique. Medicines were clearly labelled and the member of staff checked that it was the correct medication for each person before asking them to take it. We asked two people, who were able to communicate verbally, if they knew what their medication was for and they did.

Appropriate arrangements were in place in relation to the recording of medicine. We looked at the Medication Administration Record (MAR) sheets and saw that these were up to date, signed and the correct codes had been used when medicines had not been given. Leaflets containing information on medicines were stored with the MAR sheets. At the time of our visit no-one had been prescribed controlled medicines. Photos of people and other information such as allergies and date of birth were not contained within the MAR folders but we saw that staff responsible for giving medicines knew the people well.

Non refrigerated medicines were stored safely in a locked cupboard attached to the wall. The person in charge of administering medicines held the key to the locked cupboard. Some medicines needed to be stored in the kitchen fridge which was unlocked and some medicines were kept in an unlocked plastic box. In addition there were no records to indicate that the fridge was maintained at the correct temperature. This meant that not all medicines were kept safely, nor at the correct temperature.

We looked at the medication policy which staff were using in one house, which was dated October 2011, although the manager later gave us one dated October 2012. There was also a medication procedure in one house which was dated November 2011. In addition there had been a doctor's "annual health check" in October 2013. The latter gave recommendations on medication procedures and we saw that some had been implemented such as guidance on the giving and recording of as required medicines (PRN). However some guidelines, such as printing rather than handwriting MARs labels for homely medicines, had not been implemented.

We checked the dates on some medicines and noted that one was due to expire at the end of the month. We saw that the policy stated medicines should be checked for expiry dates but were told that this was not formally done on a regular basis but that it would be soon. This meant that people were at risk from receiving medication that was out of date.

We spoke with the member of staff responsible for overseeing medication in the home and they told us that staff received updates on medication via meetings and training sessions. It was not clear from the training matrix, which was written in pencil, who had received recent training. The last recorded date on the matrix was 2009. However we were shown a sheet that detailed all the staff who had attended a meeting on medication records in October 2013.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

At the time of our visit 33 people were living in a community setting at Nutley Hall. The community comprised several houses/ flats on the premises. The manager was unable to tell us how many staff were on duty at the time but said there were "loads". They told us most staff live on the premises and were therefore around most of the time. We asked for staff rotas and were told that the home "doesn't really have a rota".

We were shown around the home and noted that some staff were in the houses while people were engaged in workshop activities. Other staff were supporting people with planned activities in different workshops. Throughout our visit people had freedom to go in and out of several buildings on the premises, in accordance with their plan of care. We were told that workshops were risk assessed and ratios of staff to people were allocated.

Because of poor weather the woodland workshop had to be cancelled. The provider might wish to note this meant that on the day of or visit several people were engaged in other workshop activities, over and above the average group size.

The knitting and weaving workshop procedure recommended that seven people take part in activities. At one stage during our visit there were 10 people supervised by two members of staff in the workshop. This, we were told, was very unusual because one person had an injury which prevented them from doing their scheduled activity and also because the weather was inclement and the woodland workshop had to be cancelled. There were several items that could cause injury to people such as knitting needles, and sewing needles in the workshop. The provider might wish to note this meant that staffing levels were insufficient to ensure the safety of people at that time.

We spoke to three members of staff who told us that staffing levels were adequate. One member of staff outlined the approximate numbers of staff on duty at any given time in each unit. They said that this depended on the level of care each person needed. For example one person, we were told, was allocated one-to-one care.

We asked the manager again for some kind of staff rota and they told us the individual houses sorted their staffing out amongst themselves. They told us there was no centralised rota. We asked what arrangements were in place for holidays and sickness

and were told that it was covered by existing staff and agency staff were not used at all.

At the last inspection it was noted that there was no training matrix in place. We asked to see this and were told that the home was in the process of going over to a system that could monitor staff training more effectively. The provider might wish to note that at the time of our visit, however, the system was not in place and staff training was recorded in pencil.

Some of the information entered was not up to date, for example the records relating to medication training. We saw that moving and handling training for two members of staff had not been done since 2010 and were told that the records would be updated once the new system was in place.

Towards the end of our visit a member of staff gave us some of the units' staffing details. We requested the other rotas which were provided for us after our visit. Some were hand written and some were produced on a computer. The manager reiterated that they had not collated the staffing levels onto a centralised system.

One rota did not indicate that there were staff in the unit at night but we were told that this was always the case as staff lived in the home. In addition one rota indicated that all staff were off duty at a time when medication was due to be given. We were told that this didn't matter as a member of staff from a different unit was around to give it if necessary and that they would also check a person's blood sugars. This meant that there was insufficient information on staffing levels to be able to ascertain whether people received the correct care at the correct time.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available.

Reasons for our judgement

People were made aware of the complaints system. This was provided in a format that met their needs. We saw that the complaints procedure was clearly displayed on the noticeboard. This was in bold type and had clear instructions of who to contact if people had a complaint, including CQC.

We were told that daily resident meetings took place in the community hall within the premises. This, we were told, was an opportunity for people to discuss what they had been doing with regards to activities, involvement with the local community and achievements. On the day of our visit it was someone's birthday and we saw that some people were involved in planning their party.

In addition to daily meetings there was a resident's forum, held by the manager, and we saw details of the last one which was held in November 2013. We saw that a wide range of topics was discussed at the meetings and forums, for example how people could vote and staff changes.

We looked at comments taken from a resident's survey. We did not see an action plan but the manager told us people's comments were raised in staff meetings and the gathered data was incorporated into the home's development plan.

People's complaints were fully investigated and resolved, where possible, to their satisfaction. We were told that there were rarely any complaints. We saw details of the last complaint that had been raised in February 2012 and noted that this had been dealt with in a satisfactory manner within the agreed 28 day timescale.

The staff we spoke with told us they knew who to go to if they had a complaint. They told us problems were usually sorted out within each house.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not protected against the risks associated with the unsafe use and management of medicines because some medicines were not kept safely and there was no systematic process for monitoring and recording the storage temperature for certain medicines. Regulation 13

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 18 March 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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