Inspection Report

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

Sutton Lodge Nursing and Residential Home

Station Road, Sutton-on-Sea, Mablethorpe, LN12 2HR

Tel: 01507441905

Date of Inspection: 10 December 2013

Date of Publication: January 2014

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safety and suitability of premises	✗ Action needed
Safety, availability and suitability of equipment	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Notification of death of a person who uses services	✓ Met this standard

Details about this location

Registered Provider	Habilis Operations Limited
Registered Manager	Mrs. Wendy May Draper
Overview of the service	The home is registered to provide accommodation for nursing and personal care, treatment of disease, disorder or injury and diagnostics and screening. The maximum number of people that can be accommodated is 34. It catersfor men and women whose main need is related to old age.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

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'.

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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 December 2013, observed how people were being cared for and talked with people who use the service. We talked with staff, reviewed information given to us by the provider and talked with commissioners of services.

What people told us and what we found

On the day of our visit we observed people were participating in a reminiscence session. People looked well groomed and appeared to be relaxed in their surroundings. Some people had chosen to remain in their bedrooms and others were seated in communal areas. People told us they were able to make their own decisions about what they were involved in and that their wishes were respected. People told us that the standard of care was good and that they were happy living at Sutton lodge. We observed several people had visitors and they were welcomed by the staff.

We observed staff assisting people with various tasks and noted that the staff were respectful in how they approached and spoke to people. Care plans and risk assessments were in place and we noted these were reviewed on a regular basis.

We reviewed the arrangements at Sutton lodge for obtaining consent and noted the provider had appropriate arrangements in place, although two consent forms were not signed or dated and the manager told us that they were waiting for relatives to visit to get them completed.

The home consisted of three living areas, the main building, the stables which were three self- contained units and the "Vicarage". We noted that the "Vicarage" building was in a poor state of repair and had not been maintained to an appropriate standard which promoted people's wellbeing.

The equipment that was in use at the home had been regularly maintained to ensure it remained safe to use.

We reviewed the arrangements for monitoring the quality of care at Sutton Lodge and found these to be appropriate. Audits had been completed for various aspects of the home. However, there were no maintenance audits for the Vicarage building and the risks to people were not being managed effectively.
We reviewed notifications that the provider was required to send to the care quality

commission to notify them about an event or the death of a person who used the service and found that these were appropriately completed and sent in a timely way.

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 23 January 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

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes and where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

We spoke to staff and asked them how they ensured they had obtained consent from people who used the service before providing any care, treatment or support. People we spoke with told us they had been asked for consent. We observed staff asking people for consent and explaining what they were going to do before commencing the delivery of care. This process ensured that people were given the choice to accept the care or decline it if they wished.

People we spoke with also told us that the staff listened to them and acted in accordance with their wishes. One person told us, "I have my own routine and ways of doing things and the staff have always respected my wishes".

We looked at the care records for four people who used the service. We saw that all four had a document about consent. However, the provider may wish to note two of the forms had not been fully completed for example they were not signed and dated. The manager told us the two people concerned had limited capacity and that they were waiting for relatives to assist with the consent process. Nevertheless, in the meantime we could not establish if consent had been obtained. Although we were told verbal consent was given, this could be unreliable and could not be evidenced. We did not see where consent had been reviewed or recorded, but the manager told us that consent was reviewed and would be recorded in future.

We saw that the provider had written guidance available for staff to refer to on the Mental Capacity Act 2005 in relation to obtaining consent. Staff had been trained in (MCA) and this meant that staff were aware of how to obtain consent from people who may not have had the capacity to give consent reliably.

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.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in lin with peoples individual needs.

We observed care being delivered in a way that was appropriate and relevant to the needs of people who used the service. For example, we saw one person receiving some one-to-one care and this was provided in accordance with the persons care plan. We noted that the staff engaged well with the person they were assisting. In another example we saw a person being assisted with a cup of tea, and they chatted away in a relaxed manner.

We looked at four care plans and found that they contained detailed information that was specific to the person they related to. Each care plan showed that people's needs were assessed when they arrived and that they were regularly reviewed to ensure they reflected people's current needs. There was information about, communication, medication, pain management, personal hygiene and many other areas of the person's life. We noted that risk assessments had been completed and each care file contained a review sheet which detailed when the care plan and or risk assessment had been reviewed and if there were any changes.

People received care, treatment and support that was appropriate and met their assessed needs.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who used the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

We have judged that this has a moderate 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

The registered person must ensure that the service users and others are protected against the risks associated with unsafe or unsuitable premises. We observed that parts of the "Vicarage building" had not been maintained to a safe and appropriate standard that promoted the health and well- being of people who used the service.

We were concerned with the suitability of the premises and the safety of people who may enter or use the premises, including vulnerable people who may visit the service. There was very little paint on any of the window frames in the Vicarage as this had peeled off to reveal the poor state of the wood. For example we found that the window frames were so badly decayed that they had large holes in them. In some cases they had been repeatedly filled with a substance, which had fallen out to reveal large gaps in the wood. The structure of the wood was weakened and there was risk of the whole frame collapsing in poor weather. (This was a particular concern given the close proximity of the sea which was very close by). In another room the window did not open and had a large sheet of plastic covering the window to assist with keeping the draft out. This meant that people were not being cared for in a safe environment and were not protected from the risks associated with poor maintenance of the premises.

We found evidence that the provider had not carried out repairs to other areas of the vicarage. The wallpaper in the lounge was peeling off to reveal the plaster. In a disused bedroom on the first floor the wall was very damp. There were multiple areas of damp in the vicarage and these areas felt cold to the touch, and smelt strongly of damp. This lack of maintenance put people's health at risk because the building was so cold in the parts where the walls were damp. We found carpets with a frayed edge on the step as you came in the side door to the Vicarage and this was a trip hazard. In the lounge a "bath" was propped up against the wall along with the side panels. The manager told us this had been purchased to put into one of the bathrooms, but had not been installed yet. This presented a health and safety hazard for people who lived at the service as well as staff and visitors.

We observed that in the bathroom upstairs the bath panel was broken in three parts and had been stuck with tape. This had put people at risk of sustaining an injury. The letter box on the front door of the Vicarage was broken and did not close properly. An armchair in the Vicarage presented a health and safety risk, because the material was so badly ripped the inside of the furniture was exposed. This meant that the provider had not maintained a "comfortable" environment and the safety of people who used or entered the building were compromised.

We noted that the home was in need of redecoration as the paint was chipped, wallpaper was soiled in parts and was marked, and carpet was soiled and very worn in some of the bedrooms in the main building. The premises did not provide an environment which protected people's rights to privacy, dignity, choice, autonomy or safety.

Safety, availability and suitability of equipment ✓ Met this standard

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

Reasons for our judgement

The provider must ensure that equipment which is used in the home is properly maintained and used correctly and safely.

We found that equipment had been regularly maintained. For example we noted that all portable equipment had been recently tested in October 2013 and had been signed and dated and the date of the next inspection was recorded. The date was recorded on file to ensure the next check was booked when it became due. The hoists and all lifting equipment had all been tested and were displaying recent test labels. Other audits and quality monitoring checks were in place such as fire safety checks, food audits and medication audits. This meant that people were protected from the risks associated with equipment that is not properly maintained or unsafe.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

There were systems in place for monitoring the quality of care people received. If people had any concerns they were able to do this by speaking to the manager or a member of staff, or if required in writing.

The home had conducted surveys with people who used the service and relatives had been involved in the process. Two visiting relatives spoke positively about the "standard of care people received". If any negative comments were received they were used as a learning process and were addressed in an action plan. This process ensured that the provider listened to and acted on people's feedback.

The home also held regular meetings for residents and relatives where they were able to provide feedback to the staff team and raise any matters of concern. This enabled people or their relatives to make their needs known and to be involved in making decisions that affected their care.

Various quality checks and audits were in place to ensure that people were kept safe and appropriate care was being provided. However, quality monitoring and risk assessments relating to the Vicarage building were not always completed, and this meant that people may have been put at risk.

The home completed monthly monitoring checks on a range of topics and systems such as the health and safety, maintenance of equipment, care planning, risk assessments, and fire checks.

Notification of death of a person who uses services ✓ Met this standard

Adult social care and independent healthcare services must tell us when somebody dies in their care. NHS services must tell us when somebody dies because they have not been given the right care

Our judgement

The provider was meeting this standard.

The provider notified the Care Quality Commission about the death of a person who used the service.

Reasons for our judgement

The provider is required to notify without delay the death of a person who used the service. We reviewed the process that was in place to notify the Care Quality Commission of the death of a person who used the service and found there was an appropriate process in place. We reviewed the records and found that there had been seven deaths at the service in the last year and these had been reported to the Care Quality Commission without delay.

People who used the service could be confident that deaths of people who used the service were reported, so that where needed the Care Quality Commission could take necessary action.

We asked the manager if there had been any accidents or incidents that were required to be reported to the Care Quality Commission as there were none recorded but we were told that there had been none.

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 activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The buildings where people lived were in a poor state of repair.

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 23 January 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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