Woodean Limited

Sunhill Court Nursing Home

Inspection report

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Tel: 01903261563

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 18 April 2017 and was unannounced.

Sunhill Court Nursing Home provides nursing care for up to 40 older people with dementia care needs and/or mental health needs. At the time of our inspection, there were 32 people living at the home. Sunhill Court Nursing Home is a large Edwardian building on the outskirts of Worthing and overlooks the South Downs. There are several communal areas – a large lounge, dining area and conservatory on the ground floor and a smaller lounge on the first floor. A passenger lift provides access between the floors. On the ground floor is a private room which is used when the hairdresser visits on a weekly basis. We also observed other seating areas along the hallways where people could rest and where dementia friendly activities were placed for people to engage in. People have their own rooms and have access to a large garden at the rear of the property.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not available on the day of the inspection. The operations director made themselves available to assist with the inspection.

The last inspection took place on 24 and 26 February 2016. As a result of this inspection, we found systems and processes had not been established to prevent abuse of service users. This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had rated the service as Requires Improvement overall, because although significant improvements had been made to address previous shortfalls raised at the inspection in June 2015, where the service was rated as Inadequate, these improvements were yet to be embedded and sustained. Following the last inspection, the provider wrote to us to confirm that they had addressed these issues. At this visit, we found that the actions had been completed and the provider had met all the legal requirements.

People were cared of by staff who understood the importance of making sure they were safe and protected from harm. People were protected against the risk of abuse; staff had a good understanding of how to recognise abuse and what action they should take if they suspected it had taken place. Staff demonstrated they were clear about how to report any concerns. The service had systems in place to notify the relevant authorities when concerns were identified. Staff were confident that any allegations made would be fully investigated to ensure people were protected. People and their relatives said they would speak with staff if they had any concerns and seemed happy to go over to staff and indicate if they needed any assistance. We observed staff to be vigilant about protecting each person from possible negative interactions with other people living at the home, recognising frustrations and misunderstandings between people due to them living with dementia.

Systems were in place to identify risks and protect people from harm. Care records contained guidance and

information to staff on how to support people safely and mitigate risks. Risk assessments were in place and reviewed monthly. Where someone was identified as being at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required. Accidents and incidents were accurately recorded and were assessed to identify patterns and trends. Records were detailed and referred to actions taken following accidents and incidents.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely.

There were sufficient staff in place to meet people's needs, the registered manager used a dependency tool employed by the provider to assess staffing levels were based on people's needs, were up to date and reviewed monthly. Robust recruitment practices ensured that new staff were vetted appropriately and checks were undertaken to confirm they were safe to work in a caring profession.

Staff received an induction into the service and senior staff checked competencies in a range of areas. Staff had received a range of training and many had achieved or were working towards a National Vocational Qualification (NVQ) or more recently Health and Social Care Diplomas (HSCD). Staff received formal supervision and annual appraisals from their managers. At the last inspection, we found some staff, who did not have English as a first language, were unable to communicate effectively and people living with dementia may have found it difficult to understand them. At this inspection, we found this had improved and we observed all staff being able to effectively communicate with people.

People looked comfortable and happy moving around the home, some people stopping for rests or a nap, other people enjoyed having a late breakfast, doing a crossword or reading the newspaper. Staff were always visible to interact or sit with people. Staff said it was important they were also involved in ensuring people had something to do or someone to talk with. The operations director showed great enthusiasm in wanting to provide the best level of care possible and valued their staff team. For example, providing opportunities for staff team building and on-going training in a variety of courses to make the training more interesting. Staff had clearly adopted the same ethos and enthusiasm and this showed in the way they cared for people in individualised ways. Staff were very positive about working at the home. All staff had a good understanding of the implications and requirements of the Mental Capacity Act 2005 and associated legislation under the Deprivation of Liberty Safeguards

People had sufficient to eat and drink and were supported by staff to maintain a healthy diet. Observations of meal times showed these to be a positive experience, with people being supported to eat a meal of their choice and where they chose to eat it. Staff engaged in conversation with people and encouraged them throughout the meal, noting who liked to sit with whom. Nutritional assessments were in place and special dietary needs were catered for. Where needed, advice and guidance was sought from healthcare professionals.

The home had been decorated and arranged in a way that supported people living with dementia.

People were well cared for and treated in a respectful way. People were involved in planning and reviewing their care as much as they could, for example in deciding smaller choices such as what drink they would like or what clothes to wear. Where people had short term memory loss staff were patient in repeating choices each time and explaining what was going on and listening to people's stories.

Staff had good knowledge of people, including their needs and preferences. Care plans were individualised and comprehensive ensuring staff had up to date information in order to meet people's individual needs

effectively.

People's privacy was respected. Staff ensured people kept in touch with family and friends. Two relatives told us they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in private.

At the last inspection, an activities co-ordinator was employed for three mornings a week and a programme of activities had been organised for people. Since the last inspection, this had increased to being a full time role, Monday to Friday 8am to 4pm. People were engaged in these activities in a meaningful way and appeared to enjoy what was on offer.

Complaints were listened to and managed in line with the provider's policy. Relatives told us that they felt welcomed at the service and people and relatives said that they would be confident to make a complaint or raise any concerns if they needed to.

People and their relatives were involved in developing the service through meetings. People, relatives, healthcare professionals connected to the service and staff were asked for their feedback in annual surveys. All responses were positive from the recent quality assurance questionnaire. People's views were acted upon where possible and practical. Their views were valued and they were able to have meaningful input into the running of the home, such as activities they would like to do, which mattered to them. Staff felt the registered manager was very supportive and said there was an open door policy. Relatives spoke positively about the care their family members received.

There were effective quality assurance processes in place to monitor care and plan on-going improvements overseen by regular provider audits. An area manager and operations director who visited the home on a weekly basis supported the registered manager. We met with the operations director during the inspection and people knew who they were and enjoyed spending time with them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People had detailed care plans, which included an assessment of risk. These contained sufficient detail to inform staff of risk factors and appropriate responses.

Staff had received safeguarding training and knew how to recognise and report abuse.

There were sufficient numbers of staff to make sure that people were safe and their needs were met.

People were supported by staff that had been safely recruited with appropriate pre-employment checks.

People received their medicines safely and as prescribed.

Is the service effective?

Good

The service was effective.

Staff were trained in a range of topics, which were relevant to the specific needs of people living at the home.

People who were able to consent to their care had done so and staff provided care in people's best interests if they were not able to consent.

People were provided with a balanced diet and had ready access to food and drinks.

People were supported to maintain good health and had regular contact with health care professionals.

The environment was conducive to meeting the needs of people living with dementia.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with dignity and respect, promoting independence and maintaining people's privacy.

People and/or their representatives were consulted, listened to and their views were acted upon.

People and/or their representatives were confident their wishes related to end of life care would be followed.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support which were responsive to their changing needs. People's social, and leisure needs were met in an individualised way.

People made choices about aspects of their day to day lives.

People and/or their representatives were involved in planning and reviewing their care.

People and relatives knew how to raise any concerns and told us that they would feel confident to do so.

Is the service well-led?

Good

The service was well led.

There was an honest and open culture within the very stable staff team who felt well supported.

People benefited from a well organised home with clear lines of accountability and responsibility within the management team.

Staff told us that the registered manager was approachable and that they were encouraged to discuss any issues or concerns.

There were effective quality assurance systems in place to make sure areas for improvement were identified and addressed in a timely way.

Sunhill Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 18 April 2017 and was unannounced. Two inspectors and an expert by experience undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience at this inspection had expertise in dementia care.

Prior to the inspection, the provider completed 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 any improvements they plan to make. We reviewed the PIR and other information we held about the service including previous inspection reports. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events, which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people, relatives and staff. We spent time looking at records including six care records, five staff files, medication administration records (MAR), staff rotas, the staff training plan, complaints and other records relating to the management of the service. We used the 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.

On the day of our inspection, we met and spoke with four people living at the service and two relatives. Due to the nature of people's complex needs, we did not always ask direct questions. We did however, chat with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the operations director, administrator, activity co-coordinator, two team leaders, a registered nurse, two care staff, the chef and kitchen assistant.

Good

Is the service safe?

Our findings

At the last inspection in February 2016, we found the provider was in breach of a Regulation associated with not ensuring people were protected from abuse and harm consistently. People were not supported by staff who always knew what action to take if they suspected abuse was taking place. Insufficient action had been taken to ensure all staff had a thorough understanding of safeguarding and how to support people safely. At this inspection, we found that sufficient steps had been taken and the provider was meeting the required standards.

The provider had systems in place to make sure people were protected from abuse and avoidable harm. Staff had been trained to recognise the signs of potential abuse. We asked staff about their understanding of safeguarding and what action they would take if they suspected abuse was taking place. Without exception, all the staff we spoke with told us they would report any concerns they had to the registered manager. Staff were confident that any allegations made would be fully investigated to ensure people were protected. The provider's policy relating to safeguarding procedures was kept in the office and staff told us they would also check with this policy to ensure that appropriate action was taken. One staff member told us, "I would let {registered manager] know but I know I can contact you [Care Quality Commission] if I need to". Another staff member said, "I would raise a safeguarding if poor care or abuse was going on".

Two visiting relatives we spoke with were happy their family member was safe. They told us, "I visit every day, I watch the staff and how people are responded to. I have only ever seen safe care being given. I have no concerns about the safety of [named person]." Another relative told us, "I visit almost every day. I have never seen unsafe practice. People are well cared for. Things have really improved over the last year."

Staff encouraged and supported people to maintain their independence. Care staff ensured they prompted people to dress themselves and assisted with ensuring people dressed in the correct order. People were wearing appropriate clothes for the weather. Staff were visible around the home and quickly noticed if anyone was trying to mobilise on their own without waiting for help if they needed assistance. People's risks were identified, assessed and managed safely. Risk assessments relating to people's mental health, physical health, personal health, moving and handling, behaviour, skin integrity, nutrition and falls had been completed and were stored within people's care plans. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. We looked at risk assessments for six people and these contained advice and guidance for staff on how to manage and mitigate potential risks to people. For example, where people required pressure relieving equipment to maintain their skin integrity, staff ensured cushions, were transferred with the person when they moved. One staff member told us, "We don't stop someone doing something for themselves if they can. In fact, we encourage it". Another staff member said, "If someone has [mental] capacity, it's up to them what they do. We try to keep people safe but it's their right to do what they want". Our observations on the day confirmed staff were mindful of people's rights to take risks.

We mostly observed staff support people to move safely throughout our inspection. Staff told us and

records confirmed the training they had received in moving and handling safe techniques including the use of hoists and standing aids. Staff used equipment cautiously and offered reassurance to people who may have felt vulnerable whilst transferring from an armchair to a wheelchair using a hoist. However, we observed one incident of unsafe moving and handling. We observed two members of care staff supporting a person to move into their wheelchair from an armchair. They used a handling belt, which was not fitted properly. The two care staff used the belt to take the person's full weight. This was immediately addressed by the inspector, as this transfer was not in accordance with best practice approaches and current legislative guidance. We fed back our observations to the operations director. A qualified moving and handling instructor was on shift at the time of the inspection. He took immediate action and spoke with both staff members and booked them to attend further training to ensure agreed best safe practices were used at all times when supporting people to move. For the remainder of the day, we were told the moving and handling instructor would observe all transfers to ensure moving and handling was being done safely. We observed safe moving and handling for the remainder of the inspection.

Accidents and incidents were also logged and risk assessments reviewed and updated if needed. Senior staff reviewed people's risk assessments on a monthly basis to ensure they were in line with their current needs.

The service maintained a safe environment for people because regular checks of the building and fire evacuation procedures were in place. Risks arising from the premises or equipment were monitored and checks were carried out to promote safety. These checks included the gas heating, electrical wiring, fire safety equipment and alarms, Legionella and electrical appliances to ensure they were operating effectively and safely. The service had a fire risk assessment, which included guidance for staff in how to support people to evacuate the premises in an emergency.

Records and our observations confirmed there were sufficient deployed skilled and experienced staff to ensure the safety of people who lived at the home. On the day of the inspection, there were the operations director, administrator, two team leaders, a registered nurse, five care workers, a chef, a kitchen assistant, a person in charge of maintenance and a housekeeper alongside the activity co-ordinator. Shifts had been arranged to ensure that known absences were covered. Rotas also confirmed the use of agency staff was minimal and people were being supported by a stable team. The service had a 24 hour on call system in case of unforeseen events and if additional staff were needed.

Staffing numbers were determined by using a dependency tool, which looked at people's level of need in areas such as mobility, nutrition and maintaining continence, although staffing levels remained flexible. Staffing could be changed if required, for example if people became particularly unwell or if a person was nearing the end of their life. We saw that people received care and support in a timely manner. Care plans detailed whether people could use their call bells effectively and monitored people accordingly. Staff were attentive to people's needs, knowing them well and interpreting body language. For example, one person became agitated in the lounge and staff discreetly assisted them, ensuring they were comfortable in a quieter environment and enjoying the garden views, as staff knew they liked gardening. Staff told us there were always enough staff to respond immediately when people required support, which we observed in practice. One staff member told us, "It's much better than it was. We don't really use agency staff now". Another staff member told us, "We save a lot of time by not having to explain things to agency staff. We've got a good team now and have the time to spend with the residents".

Staff files showed that safe recruitment processes were in place. Checks had been made with the Disclosure and Barring Service to ensure that new staff were safe to work in the care profession. In addition, two references were obtained from previous employers before staff commenced employment. Checks were also undertaken to ensure that overseas staff had the required documentation in place and the right to

undertake paid employment in the UK.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. We observed the registered nurse administering medicines to people at lunchtime. Medication Administration Records (MAR) were clearly printed and each had photo identification of the person and any known allergies; there were also photos of each medicine. The registered nurse cross-referenced the medicine, dose and time with the information on the monitored dosage system blister packs. The medicines trolley was locked at all times when unattended. The registered nurse washed their hands between each administration of medicines and ensured that people had taken their medicines before signing the MAR. Medicines were stored in a locked drugs cabinet within a locked storage room. The registered nurse for each shift held the keys to the medicines storage room. A refrigerator dedicated to medicines storage was also in the room. The fridge temperature and room temperature were within recommended ranges to ensure the efficacy of the medicines; daily checks were made and temperatures recorded. We checked a sample of the medicines and stock levels and found these matched the records kept.

Registered nurses administered medicines and their competency was checked by the registered manager. A medicines policy provided guidance to staff on the safe administration, handling, keeping, dispensing, recording and disposal of medicines. Specimen signatures were on file for staff who were permitted to administer medicines as a means of identifying their signatures. Clinical observations were undertaken by the registered nurse to monitor people's blood sugar, blood pressure and pulse rates which indicated whether a person should be given a particular medicine or not. The registered nurse had a good understanding of what each medicine was for and how often people had reviews of their medicines undertaken.

Good

Is the service effective?

Our findings

Our observations showed staff were confident and knew how to support people in the right way. Throughout our inspection, we saw that people, where they were able, expressed their views and were involved in decisions about their care and support. We observed staff seeking consent to help people with their needs.

At the last inspection, we found some staff, who did not have English as a first language, were unable to communicate effectively and people living with dementia may have found it difficult to understand them. At this inspection, we found this had improved and we observed all staff being able to effectively communicate with people.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Records confirmed that staff had completed training in the MCA and had a good understanding of this topic. For example, staff confirmed that people were enabled to give consent to most decisions concerning their day-to-day support by using communication techniques individual to the person. One staff member told us, "We assume everyone has (mental) capacity unless we can prove otherwise". Another staff said, "We can't just restrict people. There's a process to go through".

Appropriate DoLS applications had been made and staff acted in accordance with DoLS authorisations. Where Deprivation of Liberty Safeguards decisions had been approved, we found that the necessary consultation had taken place. This had included the involvement of relatives and multi-disciplinary teams. We checked people's files in relation to decision making for those who were unable to give consent. Documentation in people's care records showed that when decisions had been made about a person's care, where they lacked capacity, these had been made in the person's best interests.

Staff received training in a range of areas, which the registered manager had assigned as mandatory and essential to the job role. This included emergency first aid, moving and handling, fire safety, health and safety, infection control, food hygiene and safeguarding. In addition to the mandatory training, the registered manager had ensured specialised training was given to care staff to be able to meet the individual needs of people being supported. This included staff completing courses in equality and diversity, nutrition and hydration, falls awareness, death and dying. We looked at the staff training certificates contained in staff files, which confirmed that staff had received essential training to enable them to support people effectively.

The provider also convened 'training huddles' used to pass on information and educational material amongst staff in an informal setting.

Staff were encouraged to complete various levels of National Vocational Qualifications (NVQ) or more recently Health and Social Care Diplomas (HSCD). These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability and competence to carry out their job to the required standard. All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. This ensured people received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities.

All of the staff we spoke with had received recent, formal supervision or a yearly appraisal. One staff member told us, "I like it. I can say what I want. The manager is very open". Another staff member said, "It's good because we can talk about things we don't day to day". Records showed that at the meetings staff discussed their work, training, residents' needs, any problems, staffing and any suggestions for improvements. Records showed the discussions that had taken place, together with a review of actions agreed from previous supervision meetings. Staff told us that they met together through handovers during the day, staff monthly meetings and residents' monthly meetings. Minutes of these discussions demonstrated staff discussed residents' needs, activities, changing policies and procedures, safeguarding and training needs. Without exception, staff told us this worked for their service and that the registered manager had an open door policy where they could talk to them anytime they needed to.

People were supported to have sufficient to eat and drink and to maintain a balanced diet. We talked with the chef and kitchen assistant who explained how they catered for people's dietary needs. For example, for those who required a soft diet or who lived with diabetes. We observed good communication between kitchen staff and care staff, who advised the chef of changes made to people's diets following input from visiting professionals, such as dieticians and speech and language therapists. People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The registered manager had completed these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for this purpose. Plate guards were used, where needed, to help people to eat their meal independently. We observed people's likes and dislikes were documented and kept in the kitchen, accessible to staff. The chef received written information from care staff about people's preferences and requirements when someone came to live at the home.

We observed the lunchtime meal in the dining room. The atmosphere was calm and relaxed and there was music playing which people told us they enjoyed. Tables were nicely laid with tablecloths and condiments. Staff engaged in conversation with people and encouraged them throughout the meal, noting who liked to sit with whom. Staff assisted people who required support with eating their meal in a discreet and unhurried way. Fruit and biscuits were always available if people wanted a snack. People's food and fluid intake was routinely monitored, whether or not they were at risk of malnourishment. We observed that drinks were freely available at mealtimes and throughout the day in people's rooms and communal areas.

People were supported to maintain good health and had access to a range of healthcare services and professionals. Care records documented the involvement of healthcare professionals such as the GP, chiropodist, district nurse or optician. If needed, staff would support people to attend their hospital appointments. Each person had a transfer to hospital file which provided information that would be required if the person needed to be admitted. This helped to make sure that other professionals would have

information about people's general health, how they communicated and any specific wishes regarding their healthcare.

The colours and décor of the home supported people living with dementia to orient themselves in their surroundings. For example, there were objects placed around the home for people to pick up and engage with. We observed people walking around with various items that were of interest to them, such as knitted items, which some people enjoyed holding and putting on.

Good

Is the service caring?

Our findings

We observed the way staff and people interacted and the care that was provided. Our observations showed us people were positive about the care and support they received. People smiled, laughed, nodded their heads and told us they liked the staff. All interactions we saw were comfortable, friendly, caring and thoughtful. Staff behaved in a professional way. People enjoyed the relaxed, friendly communication with staff. There was a good rapport between people; they chatted happily between themselves and with staff. When staff assisted people, they explained what they were doing first and reassured people. One person had not put on their shoe. Staff noticed and went to get the shoe, then gently encouraged them to put it on.

Relatives spoke highly of the staff especially with regard to how they always showed concern for people's welfare and wellbeing. One relative said, "The staff are wonderful. They look after my husband very well. There is a home nearer to where I live but as soon as I saw this one I knew it was the right place and I have not been disappointed". Another relative told us, "The staff are so caring. They treat [named person] as if they were his own family. That is what I like. I can go home and know [named person] is being looked after."

Staff had good knowledge of each person and spoke about people in a compassionate, caring way. For example, one person found it hard to find the right words, so staff sat patiently and used their experience of the person to communicate. Staff interacted well with people, touching, reassuring and complimenting people as they passed.

The home had no offensive lingering odours and staff ensured people were assisted to the bathrooms discreetly to maintain their continence. Staff supported people who were in pain or anxious in a sensitive and discreet way. This included thinking about whether there may be a physical reason why someone was not behaving in their usual way. People's rooms were homely and comfortable. People were able to decorate their rooms as they wished and display items that were important to them. Laundry was managed by the housekeepers and was well organised with people's clothes well cared for and folded neatly, showing that staff cared about people.

Most people were not able to tell us about their choices directly due to their dementia. Care plans contained people's preferences, which gave staff a basis to work with. Staff said they could update care plans as they learnt more about people. They knew what people liked to do and their preferred routines. Nationally published research has shown that the use of dolls and soft toys could be useful for people living with dementia and these were available as well as pens and paper, magazines and books. One person who appeared confused was comforted by the activity co-ordinator who sat with them talking about their interests and singing. Staff consistently asked people if they were warm enough and gave out blankets if necessary or opened the windows if people were too warm. Tea and biscuits was offered to people and their relatives throughout the day.

Personal histories had been completed for people and provided staff with information about people's earlier lives, their food likes and dislikes, travel, music and activities they liked to do. Any special dates were also recorded, so staff could support people to remember happy times or sad times. This enabled staff to

see what was important to the person and how best to support them.

People were supported to express their views and to be actively involved in making decisions about their care, treatment and support. The majority of people were unable to be fully involved as many lacked understanding in day-to-day decisions about their care and treatment. For these people, the registered manager asked relatives whether they wished to be involved in decisions about their family member's care and how often they would like review meetings to take place. Relatives said they were involved in reviewing care plans. This helped to ensure people's views and wishes were known.

We observed that people were treated with dignity and respect and that people had the privacy they needed. We observed when staff were delivering personal care, doors were shut and curtains drawn. Care plans contained guidance on supporting people with their care in a way that maintained their privacy and dignity and staff described how they put this into practice.

Care records contained detailed information about the way people would like to be cared for at the end of their lives. The registered manager had asked relatives/representatives about people's end of life preferences which were recorded. This was done sensitively and at a time to suit people. There was information which showed the registered manager had discussed with people if they wished to be resuscitated in the event of a cardiac arrest. Appropriate health care professionals and family representatives had been involved in these discussions.

Good

Is the service responsive?

Our findings

We asked staff what they understood by the term 'person centred care'. One staff member told us, "No two people are the same. We have to bear that in mind". Another staff member said, "Some people can't make decisions for themselves so their care can be a bit different. But they can usually make small decisions, like what to eat". A third staff member told us, "It's to ensure that the care we are providing is individual to the person's own preferences, needs and wishes."

We observed people received personalised care that was responsive to their needs. Care plans provided advice and guidance to staff about people's care and how they wished to be supported. They included information on people's personal care, health care, mobility, social care, communication, religious and cultural preferences, dietary needs and medication. Care plans were reviewed monthly to ensure they met people's needs and were in line with their preferences. Each care plan had a one page profile so staff could see at a glance what was important to the person and how best to support them. Information about people's daily routines, likes, dislikes and preferences were contained in their care plans.

Care plans also included information about people's personal histories, which meant that staff were able to have conversations with people about subjects which were meaningful to them. For example, one person's record included how they preferred to be addressed, their hobbies and interests and information about people who were important to them. We saw staff addressing the person in the way described. Care plans were regularly reviewed and we saw what changes had been made to people's care as a result of these reviews. For example, one person had not been sleeping well. This had been highlighted at the review and a referral made to a health professional to explore options to improve this for the person. Where people wished, their loved ones were involved in reviews and relatives told us that they had been involved where appropriate.

People's needs were assessed before they moved into the service. Where a person's care was funded by the local authority, an assessment was obtained from the funding authority so that a joint decision could be made about how people's individual needs could be met. The assessments completed prior to an individual moving into the service formed the basis of each person's care plan.

Visitors and relatives told us that they were welcomed at the service and visited whenever they chose. There were several visitors during the inspection and the front door was always answered promptly by staff who welcomed people and ensured that they signed in the visitors' book before entering the service. One relative explained, "I come whenever I like and I'm always welcomed". Another relative echoed this view and all felt that they were able to visit whenever suited them. We observed that relatives knew staff and interactions were relaxed and familiar.

People were able to access social opportunities in which they had an interest. The activities coordinator worked a 37 hour week. When they were not on duty, care staff engaged people with activities based on a list/planner, thus ensuring people had access to activities on a daily basis. Records demonstrated the activity coordinator had completed a 'person centred activity profile' for each person. This included

individual's social histories, activity preferences and activity ability assessments. It was possible to ascertain from the documents how a person's social, occupational and educational need, for those wishing to engage, were being met.

The activity coordinator managed a mixture of external and internal activities for people including word and puzzle games and regular visits from companies offering entertainment. There was a full timetable available with dates and times of what activities were available and when. On the day of the inspection, we observed people looked comfortable and happy moving around the home, some people stopping for rests or a nap, other people enjoyed having a late breakfast, doing a crossword or reading the newspaper. People who had a particular interest in gardening were being supported to do this at tables and other people participated in a quiz. In the afternoon people living with dementia were engaged with a sensory session, which, made use of people's sense of smell, sight, hearing, taste and touch. A hairdresser visited the home each week and was present on the day of the inspection. We observed people enjoyed engaging with the hairdresser.

Staff also arranged to support a person to meet their spouse on a regular basis for a meal in a local pub and a visit to the garden centre. This would have been part of the person's family life before coming to the home and the registered manager understood that this was important to the person and their spouse. Due to people choosing to spend most of the day in the communal areas, they were able to interact with staff and watch what was going on, so there was a low risk of isolation. The small number of individuals who chose to remain in their bedrooms received 1:1 with the activity coordinator. Activity records demonstrated they chose to relax in their rooms, listening and watching their preferred radio station and television programmes. Activities such as art, exercises and memory games, were also supported in people's bedrooms. This ensured the risk of people being socially isolated was minimised.

The registered manager and her team had made every effort to ensure that the environment was as conducive as possible to supporting people who lived with dementia in having a structured, meaningful day. The ground floor was well thought out. It had stimulating themed corridor walls with lots of interesting objects that could be picked up by people and interacted with. We also observed other seating areas along the hallways where people could rest and where dementia friendly activities were placed for people to engage in.

Staff completed daily records for people, which showed what care they had received, whether they had attended any appointments or received visitors, their mood and any activities they had participated in. The daily records gave clear information about how people were so that staff on each shift would know what was happening. Staff were responsive to changes in need and referred people to appropriate health professionals in a timely way, for example, in relation to chiropody, eye care or GP. Staff used clear body maps to monitor people's skin and to show why and where topical creams were required.

Most people were unable to be directly involved in their care planning, but relatives were able to be involved if they wished. The two relatives we met said they did not need to be involved as they were able to chat to staff or the registered manager at any time. However, the opportunity was there. People had consent forms in their care plans, which asked when people would want their loved ones to be contacted. People who used the service had monthly meetings where they discussed topics that were relevant to them and the service such as social activities and meals.

The service had systems in place to deal with concerns and complaints, which included providing people with information about the complaints process. Staff knew how to respond to complaints and understood the complaints procedure. We looked at records of complaints and concerns received and it was clear from the records people had their comments listened to and acted upon.

Good

Is the service well-led?

Our findings

At this inspection, we found Sunhill Court Nursing Home had the benefit of strong, focused leadership. The registered manager worked five days a week and an administrator supported the registered manager. The registered manager ensured there was a minimum of two team leaders and one registered nurse on each shift, who worked varied hours, leading the shifts to enable staff to feel more supported and offer guidance. They also took the lead regarding how staff were deployed to meet people's personal care needs. Staff and management commented that they were all comfortable about being able to challenge each other's practice as needed and to drive continuous improvement.

There was an open, positive culture within the home. Feedback about the management of the service was positive. Staff said they felt valued and listened to. Staff felt they received support from their colleagues and that there was an open, transparent atmosphere. Staff were aware of the whistleblowing policy and knew how to raise a complaint or concern anonymously. Staff said they felt valued, that the operations director and area manager were approachable and they felt able to raise anything in confidence and it would be acted upon. We were told there was a stable staff group at the service, that staff knew people well and that people received a good and consistent service. One staff member told us, "I think it is really well run. The manager is always around and is very knowledgeable". Another staff member said, "I think it is [well led]. I think now the staffing issues are getting sorted out things are much better".

The operations director told us that what they had achieved to date was down to the whole staff team, demonstrating a respect for others' input into the service. There was a culture of continual reflection by the staff and management team. They were passionate and dedicated in their approach to improvement, and a visible presence in the service, accessible at all times by operating an 'open door' policy. The operations director showed great enthusiasm in wanting to provide the best level of care possible and valued their staff team. For example, providing opportunities for staff team building and on-going training in a variety of courses to make the training more interesting. Staff told us this had resulted in a culture of shared learning and information sharing to support the running of the service. For example, we observed staff visiting the office regularly and asked questions, passing on important information about people and their well-being.

Staff meetings were held every month, which gave opportunities for staff to contribute to the running of the home. Discussion topics included peoples' needs, incident learning outcomes, safeguarding, MCA and DoLS practice, new policy and procedures, staff sickness, staff holiday, and professional conduct. We looked at the meeting minutes of a residents and relatives' meeting, the latest of which was held in March 2017. Meetings were well attended and issues of importance to the effective running of the home were discussed, such as staff attitudes, the quality of care, food and drink and communication. There was an agenda set in these minutes, a review of previous meetings' minutes and formal action planning, with dates for completion and the person responsible for taking any actions identified. Consequently, it was possible to ascertain from this document if, when and by whom issues were resolved. Relatives told us, they found these meetings very beneficial and that they felt management listened.

The service sought annual feedback using a survey, which was sent to people, relatives and professionals

who had involvement with the home. Survey responses were positive overall and where responses showed that improvements could be made, these were actioned. These suggestions were displayed on a board in the dining room. The board was titled, 'they said, we said'. Relatives told us, this provided assurance their views were being listened to and acted on.

We found quality assurance systems in place to regularly review the quality of the service that was provided. The area manager and registered manager carried these audits out monthly. Accidents and incidents were analysed and any patterns or trends were identified and acted upon. The audit tool included an audit of health and safety, medication, safeguarding, falls and infection control. The audit included staff support and supervision, staff training, staffing levels, staff files and team meeting minutes. Complaints were reviewed, menus checked and minutes of meetings reviewed and acted on. Records demonstrated that information from the audits was used to improve the service. Where issues were found, a clear action plan was implemented to make improvements.