Cephas Care Limited

Sun Court Nursing Home

Inspection report

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Date of inspection visit:
06 May 2021
09 May 2021
19 May 2021

Date of publication:
12 November 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Sun Court Nursing Home is a nursing home providing personal and nursing care to 26 people aged 65 and over at the time of the inspection in one adapted building. The service can support up to 29 people.

People's experience of using this service and what we found
People were placed at risk of harm. Care planning and records of daily care provided were incomplete and inaccurate. Improvements were required to the premises and ongoing servicing and monitoring had not taken place in line with requirements. Infection prevention and control practice needed to be improved. Staffing levels were insufficient, resulting at times in people not receiving the level of support expected and required. Staffing pressure impacted the ability of the registered manager to complete parts of their role that promoted people's safety. There was not a culture of using lessons learned to reduce the risk of incidents happening again.

Staff training was insufficient. Registered nurses who required training to carry out clinical tasks had not received updates to ensure they were able to do this safely. The quality of food provided was poor at times and choices were limited or not promoted to people. The serving of meals to people did not ensure they were hot and appetising and hygiene standards needed improvement. Staff did not recognise when people needed help to eat or when they needed to provide food at different times if the person was sleeping.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff did not always treat people with dignity and respect. Care provided was task focussed and did not fully involve the service users or encourage independence. People reported they often waited long periods to receive care. Peoples life histories hobbies and areas of interest were not fully explored. Staff did not have the time to sit and converse with people or take an interest in what was important to them. Staff wanted to provide more person-centred care and spend time with people but were unable to do so due to staffing pressures.

People were unable to access activities that enhanced their well-being and quality of life. There was a culture of care that did not encourage staff to be creative in trying to improve people's daily living. Although formal complaints were managed in line with the providers procedures, concerns and feedback was not openly sought from people or their relatives to improve care. Nursing staff who provided clinical care to people at the end of their lives were not fully compliant with the required training to do so.

Improvements had not been made since our last inspection and the services quality of care and management of safety and risk had continued to decline. The provider had not been proactive or effective in addressing longstanding known shortfalls in staffing and the quality of care provided. A negative culture

amongst staff had developed which had adversely affected peoples experience of living at the home because conflict between them was taking place publicly. The registered manager was highly regarded by people and staff who felt that despite their dedicated service, was unable to make the improvements required without further support.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 1 October 2020) where we found breaches of the regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, infection control and management of the home. A decision was made for us to inspect and examine those risks. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sun Court Nursing Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to, safe care and treatment, staffing, nutrition and hydration, dignity and respect, person centred care and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Sun Court Nursing Home

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by three inspectors and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We received feedback from commissioners and the local authority quality monitoring officer prior to our inspection and used on going monitoring of the information sent to us by the provider required in law.

We used all of this information to plan our inspection.

During the inspection
We reviewed the care records of four service users and looked at medicines' administration records of the majority of service users. We reviewed records relating to the management of the premises, training and recruitment of staff as well as policies, procedures and minutes of meetings. We spoke with four members of care staff, an agency staff carer, a cook, a cleaner and the registered manager. In addition to this we spoke with the providers clinical lead, regional manager and the nominated individual. Our expert by experience spoke to five people who lived at Sun Court Nursing Home and three of their relatives by telephone. Inspectors spoke with two people during the inspection at the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with the local authority quality monitoring officers who had also recently inspected the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
At our last inspection the provider had failed to ensure that staffing levels or deployment of staff were sufficient to meet the needs of people. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18

● On the two days of our inspection visits, we saw there were enough staff deployed to meet people's needs to keep people safe. However, we saw that at times peoples were told they would have to wait for care and we observed people needing support not receiving this in a timely way. Staff and people living at the service told us the service had experienced significant shortfalls in staffing levels for several months. One person told us, "I have to be honest, I do have to wait a long time sometimes, maybe 20 minutes, They [staff] seem so very busy, I am sure they are short of staff." Another person told us that they had waited up to 45 minutes on occasions.
● Staff told us they were stressed and felt guilty because they did not have time to spend with people and had to rush the care they provided. One staff member said, "We are rushing around trying to get everything done, there is not always the time to talk to people, it's boring for them, they have to sit and watch telly, there's not time for activities."
● At our last inspection in September 2020, the provider had told us that they were in the process of addressing staff shortages. However, we found that progress had been insufficient. Some staff had been working excessive hours in order to ensure that service remained safe. For example, in the week before our inspection, the registered manager who was a Nurse, reported they had worked 37 hours covering Nursing shifts, and 37 hours in their management role.
● We identified one person, who had been funded to receive 1:1 care for additional support needs, did not always have this support provided. We asked the registered manager about this, they told us due to staff shortages it had not always been possible to provide this. Records we reviewed did not identify consistently when this shortfall occurred, and the registered manager did not know whether funders had been charged for this or not.
● The shortages of staffing and failure to recruit enough competent staff had impacted the registered managers ability to address shortfalls identified at the service. The registered manager told us several long-standing staff had left during the past 18 months. They told us this had negatively impacted morale amongst the staff team because replacing them with the right calibre staff had been unsuccessful. Until recently, the registered manager had not been involved in recruiting staff, with the provider management team choosing to do this themselves.
● We found the providers calculations of the number of staff required did not accurately reflect the numbers

required to meet people's needs in a person-centred way. Dependency tools used to calculate the number of staff were not accurate, and included times where staff were on a break. Staff told us they were expected to attend to call bells whilst on their break, and we observed staff having to stop eating their lunch and attend to people who needed help in the lounge area, as there were no other staff available. Despite assurances at our last inspection that call bell response times would be looked into, this was yet to take place.

We found no evidence that people had been harmed however, despite the provider giving us assurances they would improve staffing levels, this was a repeated breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

● Staff recruitment was completed safely, and all required checks including a criminal records check were completed to reduce the risk of unsuitable staff being recruited to support vulnerable people.

Assessing risk, safety monitoring and management

● At our last inspection, we found that improvements needed to be made to ensure care records were up to date, accurate and used to monitor people's wellbeing and reduce the risk of them coming to harm. At this inspection we found progress had been insufficient, and shortfalls remain which posed a risk to people's safety. Progress had been impacted by the staffing shortages experienced.

● Care records and plans for the management of areas of risk, such as pressure areas or the use of bed rails had not been routinely updated or amended after a person's needs had changed. One person who had acquired a significant pressure ulcer did not have a care plan in place for staff to follow to manage this. Senior nursing staff we spoke with did not know how often the dressing should be changed on this injury. The registered manager told us care plans and records were in need of updating and in some cases rewriting, but this had not been completed due to their time being spent covering nursing staff vacancies. The providers clinical lead had been deployed to support with this since November 2020 but progress had still been limited.

● We found significant shortfalls in records in the management of risks to people and staff from the premises. The servicing of fire safety equipment had not taken place as scheduled and the homes annual external completion of the fire safety risk assessment was very overdue. Fire safety signage was missing and had not been identified as such. Flammable items, such as wheelchair cushions, had been stored under staircases which increased the risk of the spread of a fire. Fire drills had not been completed as the provider stated they would be. Following the first day of our inspection, the provider responded to our concerns and carried out fire alarm drills.

● We found unsecured toiletries, cleaning chemicals and prescribed pain-relieving gels in people's rooms which put them at risk of accidental ingestion or use. We saw that hot water pipes had been left uncovered in people's bedrooms which exposed them to the risk of burns should they come into contact with them.

● We found that records relating to the monitoring of water temperatures and Legionella "dead leg" testing had gaps or had been incorrectly completed. This had not been identified by the providers health and safety management processes.

Preventing and controlling infection

● We were not assured that the provider was meeting shielding and social distancing rules. The registered manager told us that risk assessments had not completed to review the impact on people from being isolated and unable to receive visitors as usual throughout the COVID-19 pandemic.

● We were not assured that the provider was using PPE effectively and safely. We saw that used PPE was disposed of in wastepaper type bins without a lid in one area of the home. Following the first day of our

inspection, the provider responded to our concern and put in place a suitable bin for the disposal of used PPE. We observed staff to fail to remove PPE after providing personal care in a bathroom and moved around to other areas of the home whilst still wearing these items.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Staff did not have adequate room to don or doff uniforms and PPE on arrival for their shift or at the end or their shift before returning home. One staff member told us they travelled to work in their uniform using public transport, which increased the risk of bringing in contaminated clothing to the service. People who were at additional risk from the effects of COVID-19 due to a health condition or factors associated with their ethnicity, had not had this assessed or reviewed. At our last inspection we saw that clean linen bundles were being stored on bathroom floors, at this inspection we found that this poor practice remained.

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. We saw that cleaning records did not evidence repeat cleaning of communal areas or high-risk touch points. We observed staff completed lateral flow device tests in the entry way of the home next to a trolley of uncovered plated meals, which increased the risk of infection transmission. We identified gaps in cleaning schedules in the kitchen and saw in some area's dirty floors with spilt died food, and freezers that required cleaning and defrosting. We observed staff did not wash or sanitize their hands between serving meals to people in different bedrooms.

We found no evidence that people had been harmed however, systems appropriate checks, risk assessments and associated actions were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed all the actions from the fire risk assessment were now completed and suitable checks of the environment and equipment were in place. Action had been taken where required.

● We were assured that the provider was admitting people safely to the service. People were required to isolate on arrival at the service and complete regular COVID-19 testing during this period

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

● We were assured that the provider was preventing visitors from catching and spreading infections. Visitors were required to complete a lateral flow device test and have their temperature taken upon arrival. Visitors wear issued with PPE and shown how to use this.

Systems and processes to safeguard people from the risk of abuse

● Staff we spoke with told us they knew how to raise concerns to senior staff or external agencies such as the local authority or CQC if they were concerned that people were at risk of being abused.

● However, we saw that the providers policies for raising concerns contained missing and incorrect contact details for the agencies. The whistle blowing policy entitled 'Alerter Policy' directed staff to only raise concerns externally if they, "Have evidence to back up your concern". Staff are not required to have evidence to 'back up' concerns should they which to raise a concern with the CQC or local authority.

Using medicines safely

● Records we reviewed showed peoples medicines were safely managed, however we found records

relating to prescribed topical creams needed improvements to ensure records were accurate.
● For example, we found for one person who was prescribed three different creams to manage skin conditions, records had 10 missing entries to show these had been given in the past for the 28 day cycle. The registered manager told us they were aware staff performance in this area was unsatisfactory and improvements were required. Some staff had recorded "Not used" but had given no reason as to why.

Learning lessons when things go wrong
● The provider did not always ensure that improvements were made to reduce the risk of incidents happening again.
● We identified one issue whereby a person had fallen, but their pressure mat to alert staff had failed in November 2020. Follow this the service had said they would keep spares; however this had not been implemented.
● At our last inspection, where breaches of the regulations had been identified, the provider had not implemented an action plan that was sufficient to identify and monitor where improvements were required and demonstrate where progress was made.

Requires Improvement

Is the service effective?

Our findings

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

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

Supporting people to eat and drink enough to maintain a balanced diet

● People's views of the food provided was poor, we were told quality was very variable and had declined. The service had experienced staffing issues with catering staff, resulting in the registered manager cooking meals on occasions.

● We observed that people were offered limited choice and were not able to choose from a plated meal or photograph of the options available. On both days of the inspection, choices of main meals were limited to two versions of the same main ingredient of lamb or fish. The daily menu written on the whiteboard was out of date, and the menu was not provided in any other format.

● For people who wished to eat in their room, meals were served from an unheated trolley, where plated food was left uncovered. We observed meals being placed in front of people who were asleep, then taken away uneaten. Hot desserts were served at the same time as the main course which would go cold by the time the person was ready to eat it.

● We observed that some people did not receive the support from staff to eat and drink that they required. For example, one person's care plan stated staff should sit with the person and encourage them to eat because they quickly lost concentration. During our observations we saw this person did not receive support from staff, and staff did not ask the person what they wanted or tell them what the food they had brought was. We also observed another person calling out for help to eat their meal, staff on arrival spoke from the doorway and told the person that they could manage okay on their own.

● Staff we spoke with told us the quality of ingredients provided when the current provider had declined, resulting in poor quality food being served. They told us they raised this with the provider who agreed to increase catering budgets and the quality of ingredients had improved.

● Records of peoples weights we reviewed showed us actions were taken in a timely way by nursing staff should a person need support to remain healthy. However, we saw that where people required the use of calorie supplements, staff did not always record when they had been given so that nursing staff could monitor their effectiveness.

We found no evidence that people had been harmed however improvements are needed to ensure people are supported to remain healthy through the provision of adequate nutrition and hydration at a standard they enjoy and at a suitable time. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Records of staff training to promote oversight of compliance by the provider were inaccurate. Multiple

versions were in use and we saw some staff were overdue some aspects of their training. This included oral hygiene and treating people with dignity and respect.
● Prior to our inspection we received concerns from the local authority quality monitoring team, and healthcare commissioners that registered nurses working at the service had not completed training updates to essential nursing tasks such as the use of syringe drivers for people receiving end of life care. The provider and registered manager had taken action to address this.
● Although there were shortfalls in staff training, the provider did not have a comprehensive plan to catch up and deliver this. The providers training manager was on site on the second day of our inspection. However, when we asked the registered manager if they were expecting them and how would staff be covered whilst they were training, we were told this had not been arranged.
● We received mixed feedback from staff as to the quality of training from the provider. Newly recruited staff told us they felt well supported however some staff told us training was poorly presented.
● Regular supervision and competency checks of staff performance, including registered nurses had not been taking place as scheduled. This was in part due to staff pressures and the registered manager needing to cover nursing shifts themselves. Team meetings had not taken place as scheduled. The clinical lead had started to facilitate a professional development discussion group for nursing staff to address this.

This was a further breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● We found the premises to be in need of repair and improvement, and suitably adapted to meet the needs of people living with dementia. A regular schedule of maintenance had not maintained the decorations and furnishings to a suitable standard. For example, paintwork had become worn and damaged, damaged light fitting's had not been replaced and bar wires were left hanging from the ceiling.
● The needs of people living with dementia were not prompted by the design and decoration. Signage and colour schemes had not been considered that could aid people's navigation around the home and reduce confusion.
● The service did not have suitable areas for the storage of equipment. We saw flammable items stored under stair wells because of a lack of alternative space. A lounge area, through which one person accessed their room, was cluttered with deliveries of incontinence pads, care equipment and a catering freezer. Bundles of clean linen were stored on bathroom floors. This meant that as well as compromising people's safety, their wellbeing was not promoted by the service not having a homely feel.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Care plans and assessments did not contain enough information on how to support people with all aspects of their wellbeing. The recording of people's needs was task focussed and did not direct staff how to support people in a person-centred way.
● The registered manager and provider were aware that substantial work was required to improve the quality of information in care plans, and the clinical lead had been supporting with this. However, progress to achieve this work had been impacted due to staff shortages.
● Daily records of care provided need improvement. We found staff did not always record when people had been supported. For example, when people who required regular turns to prevent pressure ulcers, staff had not recorded when this took place. This placed people at risk of receiving unsafe care.
● People told us they were able to see a doctor or other health professional if they required. Records showed us that nursing staff worked collaboratively with community healthcare agencies to provide holistic

care. The registered manager had developed positive and long-standing relationships with these bodies.
● The registered manager took a close overview of peoples existing and ongoing medical health needs. They regularly took people to hospital appointments themselves so they could discuss and manage first-hand the nursing needs of people with consultants and specialists.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff did not always seek peoples consent before providing them with care. We observed a staff member walk into a person's room without knocking and start to support them without asking. The person asked the staff member to leave the room and leave them alone as they were talking to the inspector and did not want to be disturbed.
● Where applications had been made to deprive a person of their liberty, this information was recorded. However, the recent local authority review identified that in one case, an application had expired and no follow up to renew this had been made.
● People's care records contained information on people's ability to make decisions. Recent improvements had been made to these records following feedback from a local authority review of the service. Where people had fluctuating capacity to make decisions affected by their mood, the registered manager could demonstrate to us how staff were supported lawfully on those days.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

● All the staff we spoke with told us that they did not have the time to sit, talk and spend time with people. Care interactions we observed were task focused. Staff did not always talk to people when providing them with care or seek their consent before supporting them. For example, we saw two staff talking to each other about what they had seen on television but did not involve the person they were supporting in the conversation. One relative we spoke with told us their family member had expressed concerns that, "They were treated like an object" by some staff.
● We received mixed views about the quality of care provided. Some people felt that the quality of care had declined since the provider took over the service. This was in part they felt due to staffing pressures and a high turnover of staff. One person told us, "The carers are kind, but we only have three left from the last three years. They never have time to stop and chat like they used to. I'd get my nails done if I asked, but not now."
● People were not always treated with dignity and respect. For example, one person who repeatedly asked for care was not responded to for 20 minutes. A visiting social worker intervened and asked staff to support the person, however they were told the person would have to wait for another hour, because, "that's when personal care was done".
● People who needed support to maximise their independence when eating did not receive this from staff. Food was placed in front of people, without asking the person if they needed food cutting, or cutlery placed in their hands.
● Staff were not always discreet when referring to peoples support needs. We heard staff speaking in communal areas and could be overheard referring to which people they were going to support to use the toilet. The staff handover between shifts took place in the lounger diner area where people were sitting and could hear confidential information being discussed.
● Care plans did not detail people's life histories and experiences or what people enjoyed doing. Family members and friends who were important to people were not included, so that staff could engage in conversation in a meaningful way.
● People were not fully involved or supported to express their views about their care. Residents meetings had not taken place and people were not routinely asked for their view.
● A recent survey by the provider had only three very limited responses, whereby people were asked about the view of the care by the staff providing this care. This did not promote an open and transparent culture.
● People had not routinely been asked if they wished to be involved in the creation of their care plan or

been provided with a copy of this.

This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; Meeting people's communication needs

- Peoples care plans were of poor quality. Many were incomplete or did not accurately reflect people's needs or direct staff how best to support a person. They had been written without promoting people's lifestyle choices, hobbies or how they wished to be cared for. Although this had been identified at previous reviews of the service, limited progress had been made.
- People did not have adequate access to activities and were not supported to enjoy hobbies. One person told us, "There aren't opportunities for painting, which I like, and they have never asked me about it."
- The service did not have a staff member allocated to provide activities, and care staff did not have the time to do this. Staff were not encouraged to spend time with people. We heard one carer ask the senior carer on duty if they could sit and read to a person. The senior carer said there was no point as, "They wouldn't be able to remember". The carer walked away and said, "I won't bother then."
- Records did not show that that people or their relatives had been consulted and involved in planning or reviewing their care. People and relatives, we spoke with told us they had not been provided with this opportunity.

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Staff did not ensure that people with a sensory impairment had the equipment needed to reduce the impact of this. We found one person's hearing aids in their room. We asked the staff member if the person should be wearing them and they said they should be. We met the person in the living room later that day, and they were still not wearing them. When we asked about this the person told us they did want to wear them and was quite cross.
- Essential information, such as menus, were not provided in a format that people could use. Daily options were written in coloured pen on a whiteboard, that was placed high on a wall and at the opposite end of the room from where many people were seated.
- Signage that would help people living with dementia was not used around the home to help them identify specific areas, such as a bathroom or a communal area.
- A shelter had been created for window visits that were socially distant. However, these were in a communal area of the service, which was connected to a person's room, which compromised privacy. We found people did not have individual care plans or assessments around this type of contact.

This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns

● People we spoke with consistently told us they felt standards at the service had declined since the current provider started running the service. There were concerns related to staffing, activities and food. However, the provider had no plan in place to address these concerns and did not engage with people to further explore their concerns and improve the quality of care.

● People and their relatives were not issued with guidance from the provider about how they could raise their complaints, internally or to an external body if they wished.

End of life care and support

● The service was commissioned to provide end of life nursing care and support by local healthcare commissioners. However, the provider had not identified that staff qualified to provide this care, including the registered manager were not current in their training to provide this.

● How people wished to be cared for at the end of their lives had not been discussed and recorded with all people.

Inadequate

Is the service well-led?

Our findings

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

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The service was not promoting a person-centred culture. Principles of person-centred care planning and support were not embedded within the service.
- Care plans did not always reflect people's needs as information was incomplete and not always accurate. This had a negative effect on the delivery of person-centred care.
- Processes to ensure people and relatives could provide feedback on their care were not in place. People and their relatives told us they were not asked for their views on the service provided, and felt that communication from the service and provider through the COVID-19 pandemic was disappointing .The provider had failed to consider how feedback could be gathered from these people to improve the quality of the care provided.
- Service users and staff had not been offered opportunities to participate in risk assessments in relation to equality characteristics and any additional risks from Covid-19 relating to this.
- People, their relatives and staff told us that the quality of care provided at Sun Court and declined significantly since the provider took over. One relative told us, "They [Provider] have replaced a family care home with one that does not bear comparison."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others

- Whilst quality monitoring systems were in place, they had failed to ensure standards of care and regulatory requirements were met. We identified numerous failings across the service that placed people at risk of harm. Where audits had identified issues, we found timely and effective action had not been taken.
- The registered manager had been working under considerable pressure, which had impeded their ability to undertake all aspects of their role. They were aware of the shortfalls we identified but told us they simply did not have the time to make the required improvements to staff practice, records and the premises because of continuing staff shortages.
- Staff views were not sought or used to drive up quality, or for the provider to understand the challenges staff faced through the pandemic. Staff reported a poor team spirit due to pressures upon them which resulted in a culture of conflict at times, with staff arguing in front of service users. The provider had identified this earlier this year but had not addressed it. At the time of our inspection, attending paramedics had raised a safeguarding concern after witnessing conflict between staff.
- The providers management team had been ineffective in supporting the home to improve. They had been

aware of shortfalls at the home and the pressures it faced for some time. The action plan submitted to the Care Quality Commission following our last inspection in August and September where we identified breaches of regulation, had not been effective. The last update to this plan was on 29 March 2021 and identified many areas of high risk that had not yet been addressed.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider did not encourage a culture that was open and in which staff could raise concerns externally. The providers whistle blowing procedure contained no details for the Care Quality Commission, who are a statutory body that can receive concerns relating to care providers.

● This policy stated staff should only raise a concern externally if they had evidence to back up their concern. There is no requirement that staff need evidence to validate raising a concern to external bodies.

Quality monitoring systems were ineffective in monitoring and improving the quality of the service. The systems in place had failed to identify, monitor and mitigate concerns within the service which placed people at risk of harm. This meant the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People living at Sun Court Nursing Home, their relatives and staff all spoke very highly of the registered manager, who had worked at the home since the 1980's. They told us that she was supportive and kind and tried to look after people well. People and staff told us they felt sorry for her and that she was, "Swimming against the tide."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Care provided was often task focussed, staff did not always involve people in their care or engage with the prior to and during being supported.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs people did not receive sufficient choice of meals or have these served to a sufficient standard in a hygienic way. People who needed support to eat were not always provided with this. People who were asleep at mealtimes were not provided with a meal at an alternative time.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The care provided did not meet people's needs. Collaborative assessments with people and relevant persons had not been carried out. Relevant persons had not been supported to make or participate in making decisions about the care and treatment provided or in the manner the regulated care is carried out. Care plans did not consider how people's support would be carried out in order to meet their needs.

The enforcement action we took:

NOP impose condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were placed at risk of harm because risks were not assessed and actions to mitigate risks were not taken. Actions had not been taken to ensure the premises were safe for their intended purpose. The provider had not ensured staff had the skills and competence to provide care safely. Staff had failed to ensure the risks of infection were assessed, prevented, and controlled. Regulation 12 (1) (2)(a)(b)(c)(d)(h)

The enforcement action we took:

NOP impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Quality monitoring systems were ineffective in monitoring and improving the quality of the service. The service had failed to identify, monitor and mitigate concerns within the service which

placed people at risk of harm. Records were not accurate or complete Feedback had not been sought to enable the provider to evaluate the service provided. The provider had failed to evaluate and act on concerns.

The enforcement action we took:

NOP impose condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensure that enough suitably training and qualified staff were deployed to keep people safe. Reg 18 (1)

The enforcement action we took:

NOP impose a condition