

Laudcare Limited

Sunnymead Manor

Inspection Report

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Summary of findings

Overall summary

Sunnymead Manor is a care home that provides nursing and personal care for up to 76 people. At the time of the inspection there were 56 people using the service. The people who received care at the home were older people. This included people who required support due to their dementia care needs.

The home was not clean and people were at risk of acquiring infections. The management of the home did not have effective systems in place to ensure that the home was clean.

We found people were not consistently involved in their assessments of need and there was limited ongoing involvement. This was particularly noted for people who were unable to express themselves verbally. No alternative methods of communication such as pictures or objects were considered by the staff to aid people.

Although there was some information about people's likes and interests there was limited social activities for people to be involved in. There was no activity programme in place based on consultation with people.

There was a management structure in the home but it did not provide people with clear lines of responsibility and accountability. There had been no registered manager in place at the home since September 2013. The acting manager in the home had carried out quality monitoring

to assess the quality of care provided and plan ongoing improvements but these were not effective. However the area manager was aware of the issues and a remedial action plan was in place to address some of the concerns highlighted in their quarterly monitoring reports but this plan was not improving standards at the service.

Each person had a care plan that outlined their needs and the support required to meet those needs. People received care that met their physical needs although we found there was limited support in place to meet people's emotional and social needs. Risk assessments had been written and measures had been put in place to minimise the risks identified by the assessments but these were not kept under review.

People we spoke with said that staff were kind and polite. We observed that staff assisted most people with their care needs in an unhurried manner. However we also saw that people's privacy and dignity was not always respected.

There was always a registered nurse on duty which helped ensure people's healthcare needs were met but we found that they did not always take the lead on providing guidance and support to other staff. People received care and treatment from healthcare professionals according to their individual needs.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

People were not safe because the environment was not clean and infection control policies and procedures of the home were not being followed. This meant that people were at risk of harm through health acquired infections. There were no effective systems in place to ensure that the home was clean. We found the home needed to make improvements in this area. The action we have asked the provider to take can be found at the back of this report.

We looked at seven care plans and saw risk assessments were in place to protect people from harm. These were not kept under review and significant incidents were not used to review the risks that people faced.

The majority of staff told us they had received training in the protection of vulnerable adults and were able to tell us about the actions they would take if they had concerns. We were not able to verify that this training had taken place due to the lack of training records.

The acting manager had worked with the local authority following a report of a safeguarding issue. However the response to requests for information by the local authority to aid there investigation was prevented by the loss of care records relating to the person concerned. We found the service needed to make improvements in this area. The action we have asked the provider to take can be found at the back of this report.

Staff were aware of the Mental Capacity Act 2005 but their knowledge was limited. However they did receive the support from the area manager who had an in-depth knowledge of this issue and were aware of recent changes in legislation and the impact this would have.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards.

We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

While no applications had been submitted, proper policies and procedures were in place but none had been necessary.

Are services effective?

The service was not effectively meeting the needs of the people who used the service.

Summary of findings

People who were at risk of malnutrition or dehydration were monitored through the use of food and fluid monitoring records. Whilst staff recorded what they had given to people to support their needs there was no system in place to review these recordings to ensure that the support given was effective. Staff did not have guidance on the expected amounts of food and fluid to meet people's individual needs. One staff member told us "a lot of people are on food and fluid charts, I don't know why". We found the home needed to make improvements in this area. We have told the provider to take action about these concerns.

People who lived at the home told us they were not fully involved in decisions about when they received support from staff. The people we spoke with were not fully aware of the choices they had. One person told us "no one has ever asked me" in response to our enquiries. The process in place to gain the views of people nearing the end of their life was ineffective. It failed to consider that people may not be able to communicate their wishes at the time the home sought to gain their views. We found the home needed to make improvements in this area. We have told the provider to take action about these concerns.

Part of the home cared for people living with dementia. In this area we saw that bedrooms had been personalised and corridors had objects for people to interact with. The communal lounges and dining rooms did not have any form of stimulation with the exception of the television. In the communal areas we did not see resources such as reminisce objects that are often used to help people to remember their past. We found the home needed to make improvements in this area. We have told the provider to take action about these concerns.

Are services caring?

The staff were caring but improvements were needed to make sure people received a personalised service.

People's privacy and dignity was not always respected. We observed people's care records detailing their personal care and support interventions were in the hallways outside people's bedrooms. This was for the benefit of the staff and did not respect people's rights to privacy, dignity and confidentiality. We found the home needed to make improvements in this area. We have told the provider to take action about these concerns.

Care staff working at the home were aware of the benefits to people of living in a stimulating environment as this helps people to maintain a sense of belonging and to be mentally alert. The staff told us they would like to take people out more, or at least into the

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garden. They told us that occasionally they did take people into the garden but this was an exception rather than a rule. This demonstrated that staff were aware of the benefits to people to have the opportunity to be away from their immediate environment, but had little support in achieving this for the benefit of people living at the home. We found the home needed to make improvements in this area. We have told the provider to take action about these concerns.

People who required the support of staff at mealtimes were not treated with respect or offered choices. We observed that people living with dementia were not encouraged to eat. The staff did not talk to people respectfully during meal times and did not communicate with each other to ensure people's needs were met. We found the home needed to make improvements in this area. We have told the provider to take action about these concerns.

Visiting relatives told us "the physical and nursing care is great" another told us "I think it's a mixed bag. Some staff are gentle; some others are hurried and rushed. There is no mistreatment but the quality of care is not as one would like". A person told us "the staff work very hard but don't have time to chat. I've always liked it here; the girls (staff) are lovely. Life is a struggle but I just get on with it"

Staff met people's basic care needs such as help to go to the toilet or help to stand in a caring manner. We observed that staff in some areas were attentive to people's needs and made them comfortable.

Are services responsive to people's needs?

The service was not responsive to people's needs and improvements were needed.

There was very little for people to do at the home to occupy themselves. One person we spoke with told us when asked; what do you do during the day? "I look after my friend here; there is nothing for us to do except get up, eat and fall asleep". When asked, what you would like to do? they replied "I don't know, no one has asked". We found the home needed to make improvements in this area. We have told the provider to take action about these concerns.

A visiting relative commented that there was nothing for their family member to do except just walk around. We asked staff about what activities were on offer. They told us "that the people have nothing to do" and "people get agitated". The staff told us that there was an activities coordinator but they did not consider the activities provided were enjoyed by the people living at the home. The staff did not see themselves as being responsible for providing

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opportunities for people to become involved in things that interested them. We found the home needed to make improvements in this area. We have told the provider to take action about these concerns.

The staff did not have effective methods to support people with identified health needs. The system in place to ensure that people had their catheter changed was ineffective and put people at risk of infections. Where people needed pressure relieving equipment to prevent skin damage there was no system in place to ensure that the equipment used was set up correctly. This put people at risk of further skin damage. We found the home needed to make improvements in this area. We have told the provider to take action about these concerns.

There was a culture amongst staff of doing things to people rather than for them. Staff could tell us about what tasks people needed to support their physical wellbeing but were less clear about meeting people's social and emotional needs. People's care records lacked the guidance to support staff in relation to this. We found the home needed to make improvements in this area. We have told the provider to take action about these concerns

Are services well-led?

The home was not well led and improvements were needed.

There had been no registered manager working at the home since October 2013. The people who we spoke with were not able to identify who the acting manager was at the home but their relatives were.

There were systems in place to assess and monitor the quality of care provided but these did not stand up to scrutiny. The area manager of the provider was aware of a number of performance issues and a remedial action plan was in place but this was not driving up standards at the home. We found the home needed to make improvements in this area. We have told the provider to take action about these concerns.

There was a staffing structure which should have given clear lines of accountability and responsibility. There was always a trained nurse on duty who took a lead role in ensuring people's clinical needs were met. There was also a senior care worker on duty that was responsible for ensuring other care staff knew what their role was for each shift was. These staff did not provide consistent guidance and support to other staff members. The staff were not receiving formal

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supervision of their work to ensure that their practice was of the required standard. We found the home needed to make improvements in this area. We have told the provider to take action about these concerns.

Summary of findings

What people who use the service and those that matter to them say

During the inspection we spoke with seven people who lived at the home. We also spoke with four visiting relatives.

People who lived at the home told us that staff were kind and polite. One person told us “the staff are very kind and help me when I become anxious”. Another person said “they never rush me and are very patient”

In response to the quality of care people receive relatives told us “I think it’s a mixed bag. Some staff are gentle; some others are hurried and rushed. There is no mistreatment but the quality of care is not as one would like. The staff seem quite stressed and there is low morale”. Another person told us “the staff work very hard. They haven’t got time to chat. I’ve always liked it here, the girls are lovely”.

We spoke with one person about how they spent their time at the home, they told us “I look after my friend here; there is nothing for us to do except get up, eat and fall asleep”. With regards to what they wanted to do they replied “I don’t know, no one has asked”.

Relatives told us that there was little for people living at the home to do, one relative told us “I just walk around with my Mum, do what Mum wants to do there is nothing else”.

Visitors told us of their concerns over the cleanliness of the home. They also told us about their concerns that the acting manager was not available to discuss concerns with them. One relative told us they had wished to be consulted about the care plans for their family member but this had not happened.

Some people recalled discussing the care plans with staff but felt that there was very little ongoing involvement in decisions about care and support. This meant that people who lived at the home had limited opportunities to express their views about the care provided at the home.

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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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

This inspection was carried out on 23 April 2014. During the inspection we spent time talking with people who used the service, members of staff and visitors to the home. Some people who lived at the home were unable to verbally express their views. We therefore spent time observing care practices and interactions in the home.

The inspection team consisted of a two inspectors and an expert by experience. The expert had personal experience of caring for older people.

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Before the inspection we reviewed the information we held about the home. At our last inspection on 26 September 2013 we did not identify any concerns with the care provided to people who lived at the home.

During this inspection we looked around the premises, spent time with people in their personal rooms and in communal areas. We observed the main meal of the day in both dining rooms in the home. We also looked at records which related to people's individual care and to the running of the home.

At the time of the inspection there were 56 people living at the home. We spoke with seven of these people and others briefly. We spoke with four visiting relatives and nine staff members throughout the visit.

The acting manager was not available during the inspection. We spoke with the deputy manager and a representative of the provider who made themselves available to us during the inspection.

During the inspection visit we reviewed seven people's care records and a selection of the home's policies and procedures.

Following our inspection we spoke with healthcare professionals who were involved in the care of people living at the home and members of the local safeguarding authority.

Are services safe?

Our findings

We spoke with seven people living at the home. They told us that they felt safe living at the home and that staff treated them well. One person said “the staff are very kind and help me when I become anxious”. One person told us about how they were unsafe living in their own home and how much safer it was for them to be living at Sunnymead.

People did not receive consistent support from staff when they experienced behaviour that challenged the staff or others. During the inspection we observed that one person living with dementia had a bruised and swollen eye. We looked at the person’s care records that contained an incident report that attributed this as ‘unwitnessed self-abuse’. We spoke with the registered nurse on duty in this area who told us they had not considered a safeguarding referral as the incident was unwitnessed. It was unclear in the person’s care records if this level of self-harm was related to their dementia or if there were other possible reasons. This meant that unwitnessed injuries were not fully considered to enable staff to minimise the risk of harm for this person.

People were not protected from harm. The provider had a clear policy and procedure regarding safeguarding vulnerable adults. We spoke with five staff about their understanding of abuse and how and what to do if they had concerns. From our conversations it was clear that they would report concerns, but the staff were less clear about who they should report to. The management of the home had informed the Care Quality Commission and other relevant authorities when allegations of abuse had been made. However during a local authority’s investigation of one reported incident the acting manager was not able to produce a person’s care records, in relation to the period of concern, as they had been mislaid. This meant that the local authority did not have the relevant information to conduct its enquiries and reach a conclusion to the allegation. This is a breach of regulation 11(1)(a)(b). You can see what action we told the provider to take at the back of the full version of the report.

The home was not clean. We spoke with three of the care staff in the area of the home which cared for people living with dementia. They told us of their concerns over the cleanliness of the home. They told us “I think the environment is disgusting. Sometimes we have no soap or paper towels” and “the cleaning is terrible”.

During the inspection visit we looked at seven people’s bedrooms, with their permission, two dining rooms, two lounge areas, all corridors and shared bathrooms, laundry facilities, cleaning cupboards and outside area. We found that the home had an unpleasant smell in most areas. The dining rooms and adjoining lounges were not clean. The dining room tables and seats were dirty and sticky to the touch. This meant that the tables where food was served had not been cleaned effectively.

The communal showering facilities were dirty. One shared shower room had a dirty floor. The underside of the shower seat, used by people to sit on whilst being supported to shower, had brown stains and had not been cleaned for an extended period. The toilet used by kitchen staff was dirty. The sink where staff washed their hands was not clean; the inside of the door was stained with grease and dirt. The care staff we spoke with confirmed this toilet was used by kitchen staff. This area was not kept to an appropriate standard of cleanliness.

There was a colour coding system for the use of mops and buckets throughout the home (This is designed to prevent cross infection by ensuring that mops used in the toilet areas or to clean people’s spillages are not used in areas such as dining rooms and kitchens.) We observed that this code was not been followed and three mops and buckets in the cleaning cupboards were not stored as per the coding system. For example a red mop was in a green bucket and blue mop in a red bucket. This meant that systems to prevent the risk of cross infection and health acquired illness were not being followed.

We asked the area manager to see the cleaning schedules. The records relating to the past two months cleaning did not exist. We spoke with two of the cleaning staff who told us they had not been provided with cleaning schedules to complete. The area manager was unable to demonstrate how the homes management ensured that the appropriate standard of cleanliness was monitored at the home. The above demonstrates a breach of Regulation 12 (1)(a)(b) 2(a)(c)(i)(ii)(iii). As a result of this inspection we sent the provider a warning notice telling them they had to make improvements in relation to the cleanliness and infection control practices within the home.

While no applications for Deprivation of Liberty Safeguards had been submitted, proper policies and procedures were in place. Staff told us they had received training on the Mental Capacity Act 2005 and Deprivation of Liberty

Are services safe?

Safeguards. We spoke with three staff about these issues and they were able to talk about how consent worked in practice. Their knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was limited. We requested the staff training records at the time of the inspection but these could not be produced. We did however have sight of the training schedule which recorded what training staff had received or were planning to attend. We were not able to verify if the training recorded had actually been carried out with regards to these issues that protect people's rights.

Some of the people living at the home did not have capacity to make decisions about their own care. We saw that the home worked in accordance with the principles of the Mental Capacity Act 2005 to ensure decisions were

made in people's best interests. An example of this was that one person would not take medicines prescribed to them. There was sufficient recorded evidence informing that a relative, staff at the home and the person's GP had been involved in a decision to administer medicines covertly by putting the medicine in the person's drink. The home had a policy and best interest decision recording forms in relation to administering covert medicines which stated that a best interest decision should be formally recorded. A best interest decision had not been formally recorded as described. This meant that whilst staff were acting in accordance with the Mental Capacity Act they were not following the provider's policies and guidance as directed by the homes policy.

Are services effective?

(for example, treatment is effective)

Our findings

People were not provided with choices about their lives. We looked at seven people's care records. Whilst there were sections in these care records to record people's life history, personal preferences and daily routines these were not being effectively used. In one example we noted that the records included documents entitled "My preferences – things that are important to me and significant life events". These recording documents simply stated the person "is unable to communicate". There was no evidence that the staff had attempted to establish the person's background or personal preferences. This meant that the person's plan of care was not personalised to them and failed to acknowledge that this person had a life before coming into the home. The above demonstrates a breach of Regulation 17(1)(a)(b)2(a)(b)(i)(ii)(d). You can see what action we told the provider to take at the back of the full version of the report.

People's care and support needs were not effectively planned. We looked at seven people's care records. There was a lack of consistency found in the care planning documentation. There was no process in place which encouraged people, and those that matter to them to make their views known about their care, treatment and support. Some of the people living at the home did not know about their care plans. The staff we spoke with were unsure as to how people were consulted about their needs after the initial assessment of need when they came to live at the home. We looked at the care records for three people living with dementia to establish if their end of life wishes were recorded. We found these did not contain information on the person's wishes. We spoke with a member of nursing staff on duty to discuss why this was the case. They told us that this matter is discussed when people's health deteriorates. This was not an effective way to establish people's wishes at the end of their lives' as it fails to recognise that people's ability to communicate may be impaired prior to them reaching the latter stages of their life. The above demonstrates a breach of Regulation 17(1)(b). You can see what action we told the provider to take at the back of the full version of the report.

We looked at the seven care records of people who were having their food and fluid intake monitored. We looked at these people's care reviews and weight monitoring records. The weight monitoring records of two people evidenced that they were losing weight; the care reviews did not offer staff guidance on how to support these people with the exception of continued monitoring. The monitoring records demonstrated that people were given food and fluids. However there was no evidence that these records were being used to evaluate if people received the food and fluids that they needed. We spoke with four members of care staff about what was the expected amount of fluid each individual should receive to support their needs. The staff demonstrated a poor knowledge of what a person's daily requirements were and what would be seen as an insufficient level of food or fluid intake. One staff member told us "a lot of residents are on food and fluid charts. I don't know why." We asked a member of nursing staff how the monitoring charts were used to inform people's plans of care. They told us they were not evaluated and as far as they knew were not checked on a daily or weekly basis. This meant that the plans in place to support people with an identified need were not effective and put them at risk of harm. The above demonstrates a breach of Regulation 14(1)(c). You can see what action we told the provider to take at the back of the full version of the report.

People and their relatives did not consistently have an opportunity to express their views about the service they received. One relative we spoke with, who had lasting power of attorney regarding their relative's care and welfare, was not aware of the content of their relative's care plan and told us they had not been involved with the decision making. They told us they had asked to be involved in the planning of their relative's care but this has not happened. We saw that during the inspection a GP visited together with a speech and language therapist. The speech and language therapist told us the plan of care based on their assessment was working well. The person's relative was available to discuss the person's needs and was involved in the review of this part of the care plan.

Are services caring?

Our findings

People told us that they considered they were well cared for however, our findings did not find this to be the case.

The systems used by staff to monitor and support people with specific needs did not promote people's dignity. When we entered the home at 9am we noted that there were folders outside people's private rooms in the corridors behind the hand rails and not kept in the nursing station or in the person's room. We looked at the content of these folders and found they contained confidential personal information relating to the people living in the area. On one person's bedroom wardrobe, in full view of people walking down the corridor was a document entitled 'feeding regime'. The display of this document in such a manner undermined the person's dignity. We spoke to staff who confirmed these records were for them to use during the day but did not say why. We noted at 3.30 pm these folders were still in the corridors. This meant that people's confidential personal information was not kept securely. The above demonstrates a breach of regulation 20 (2)(a). You can see what action we told the provider to take at the back of the full version of the report.

We saw that people living with dementia were offered some choice at meal times. We observed that staff showed some people what was on offer so that they could choose but did not show all people. For example people were offered a choice of sauce to accompany their food, but not what they would like to drink. We observed that staff did not talk with people or encourage them to eat. We noted that the only questions used when speaking to people were "what would you like for your lunch?" We observed a person eating their lunch who was struggling to swallow. This was noticed by a staff member who said "Bit tough for you is it?", and gave the person a drink. The staff member then left to find an alternative meal, but there was alternatives, so asked the kitchen for something different. The staff did not communicate with each other about the change to the person's meal as shortly afterwards another staff member then gave the person a pudding without speaking with them. The person fell asleep for a while but then woke up and started to eat the pudding. The first staff member then returned with the alternative meal which was left on the person's table. When the person finished their pudding they then ate the alternative main course. These interactions did not offer the person any respect or choice.

It may also have undermined the person's wellbeing as the sequence the food was given may have reinforced any confusion and memory problems. The above demonstrates a breach of Regulation 17(1)(a)(b)). You can see what action we told the provider to take at the back of the full version of the report.

We spoke with a visiting relative whose family member lived in the home. They told us their family member "was in a terrible state when they came in to Sunnymead" and "the physical and nursing care is great and I have great respect for the nurses". However they did make us aware that they considered their family member's mental and spiritual needs need were not fulfilled. They considered that inadequate consideration had been given to their relative's religious faith, which had been important to them throughout their life. This meant that this person's specific needs may not have been met.

We spoke with a person living with dementia who told us "the staff work very hard. They haven't got time to chat. I've always liked it here, the girls are lovely. Life is a struggle but I just get on with it". We spoke with this person's relative who told us "I think it's a mixed bag. Some staff are gentle; some others are hurried and rushed. There is no mistreatment but the quality of care is not as one would like. The staff seem quite stressed and there is low morale". The relative told us they had on occasion had to inform staff of their relative's need for personal care support as it was not forthcoming. They told us that they felt this was because staff were so busy.

Staff met people's basic care needs such as help to go to the toilet or help to stand in a caring manner. We observed that staff ensured people were made comfortable when sitting in the lounge by the use of blankets and extra cushions to support the person as required. We spoke with two people in the lounge who told us staff are very caring. One person told us "they (staff) never rush me and are very patient".

Five care staff working at the home told us they would like to take people out more, or at least into the garden. They told us that occasionally they did go into the garden but due to the complex needs of some of the people, and the staffing levels, only two or three people can go out at any one time. This demonstrated that staff were aware of the benefits to people to have the opportunity to be away from their immediate environment, but had little support in achieving.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The home was not responsive to the needs of people.

We spoke with a visitor about their relative living with dementia and what activities they were involved in. They told us there was an activities coordinator sometimes but they were unsure if the activities met their relative's needs.

People living with dementia were not supported to take part in activities important to them. We observed there were no activities taking place for people living with dementia during the inspection. There was little for people to do and keep themselves occupied. People were walking around, remaining in their room or sitting in the lounge.

We spoke with three staff about what activities were on offer. They told us "people have nothing to do" and "people get agitated". One staff member told us when there was an activities coordinator available the activity mainly involved clapping hands and singing. The staff member told us that people did not appear to enjoy this. The staff working in this area did not sit and talk with people as they were too busy with other support tasks such as personal care.

When activities were provided they did not appear to be based on people's likes and interests. We observed one activity taking place during the inspection; a staff member was playing cards with two people. We spoke with two people who were sitting in the reception area during the morning. We asked them what they liked to do with their time. One person told us "I look after my friend here; there is nothing for us to do except get up, eat and fall asleep". We asked them what they wanted to do and they replied "I don't know, no one has asked".

For people living with dementia there was some recognition of the role a person's environment played in their wellbeing. In the corridors there were tactile objects on the wall and pictures of world events in the past. These provided people with objects to touch and feel or to stimulate memories. However the lounges and dining rooms contained little for people to do except watch television. In the communal areas we did not see resources such as reminiscence objects that are often used to help people to remember their past.

People's care records did not always contain sufficient information about what people wanted to do, nor did they describe people's interests that would have provided guidance to staff about what things people liked. This meant that people's welfare needs were not being met.

We spoke with three staff who worked with people who had nursing care needs. Staff knew people well and some of their preferences in relation to care and support needs such as how they liked to be assisted with their personal care and about when people needed support to eat. We observed that staff were patient and showed understanding to individuals they supported. They gave people time to speak and they listened and acted on what individuals said. However there was a culture of doing things to people rather than for them. Staff could tell us about what tasks people needed to support their physical wellbeing but were less clear about meeting people's social and emotional needs. People's care records lacked the guidance to support staff to be responsive to people's needs in a personalised way. This meant that people's welfare needs were not being met. The above demonstrates a breach of Regulation 9 (1)(b)(i). You can see what action we told the provider to take at the back of the full version of the report.

We found that people who required support from nursing staff did not always have their health care needs met. We looked at the plans of care for people who required a catheter. (A catheter is used to support people with their continence associated with their health care needs. The manufacturers of catheters provide strict guidance about how long the catheter can remain in place called a 'licence'. To leave a catheter in place beyond its licence puts people at risk of serious infection) We asked nursing staff how they ensured that catheter changes were made in line with the licence. They told us that the change date was recorded in a diary. We looked at the diary to confirm that the planned date was within the licence. There was no record of the changes required as described by the staff. The staff then entered the dates in the diary in front of the inspector, but these were inaccurate as the proposed change date would have been outside of the licence.

We observed that three people were using pressure relieving aids, such as an air mattress, to prevent skin damage. We spoke with a member of staff about how they ensured the equipment was set up correctly, taking into account the person's weight. They told us they did not have

Are services responsive to people's needs?

(for example, to feedback?)

a system to regular check that the equipment was on the right setting. As there was no recorded guidance with regards to the correct settings, as per the manufactories recommendations, it was not possible to evaluate if the equipment used was set up correctly. This put people at

risk of developing further skin damage if the equipment was set up too hard or soft to meet the person's individual requirements. The above demonstrates a breach of Regulation 20 (1)(a). You can see what action we told the provider to take at the back of the full version of the report.

Are services well-led?

Our findings

At the time of our inspection there was no registered manager in post. The acting manager was absent from the home and another manager of a care home with the provider's group of homes was overseeing Sunnymead. Good leadership could not be seen at all levels.

The people living at the home that we spoke with could not identify who the current manager was which may mean that concerns about people's care and welfare could be made to staff who were not able to respond or take action to address these concerns. Some identified the nursing staff as the leaders at the home. We spoke with relatives who could identify who was the manager and told us about some of the concerns they had raised.

We asked to see the minutes of any relatives' meetings with the management of the home. The last meeting was held on 21 February 2014. The minutes evidenced that relatives brought to the attention of the acting manager their concerns over people's laundry and how it was being stored once cleaned. It also evidenced that relatives were concerned over the use of agency staff and the lack of 'anti bacteria hand gels' within the home. There was also reference to the good catering provided at the home. Regarding the two issues relating to the laundry and use of agency staff relatives were informed that the acting manager would look into these concerns. However there were no supporting documents to indicate if this had been achieved. This meant that whilst there was an opportunity for relatives to meet and speak with the management of the home the outcome of this discussion was not followed up.

We asked and were given a report on the complaints received. There had been four recorded complaints since 30 December 2013. One had been referred to the local authority's safeguarding team in relation to inadequate care. This was stated as requiring investigation but no record was available to confirm the progress on this matter. One in relation to care and treatment of a specific condition stated it had been resolved but it was unclear how. There were two letters of concern regarding the lack of visibility of the manager over Christmas 2013. As the records relating to the outcome of these complaints could not be produced it is unclear if the issues were satisfactorily addressed. Two relatives we spoke to told us that they had raised issues with the management over the lack of

involvement in the planning of their relatives care but had not received a response to their concerns. This meant that there had been a breach of Regulation 19 (1)(2)(c)(d). You can see what action we told the provider to take at the back of the full version of the report.

We spoke with nine staff during our inspection. They all told us of their concerns over the lack of support they had from management at the home. One member of staff told us "I could do better if I was better supported". Two staff told us they had received no supervision or support and said "we do our best"; one told us "I don't understand how to use the care records; I am not sure what we are supposed to be doing". We asked them who they would go to for support when they needed advice about supporting people's emerging needs. They told us "other health care assistants". This showed that staff did not have a clear understanding of the management structure at the home and who was best placed to offer that advice and guidance.

We asked nursing staff if they received clinical supervision to support their nursing practice. This is to ensure that nursing staff practices are safe and to address any training needs in relation to people's nursing needs. We were told that it was about six months ago but this was not in relation to people's clinical needs. This meant that nursing staff were not being supervised and their practice monitored.

The health care assistants could not remember the last dates of supervision or appraisals. We asked the area manager about the clinical supervision of staff. They told us that they had been informed by the acting manager that all supervision had been carried out in line with the company's policy. We were shown a supervision planner that identified dates when all staff would receive supervision. This indicated that staff had received supervision but when we requested to see the records of the supervision events these were not available. There was no recorded evidence that formal staff supervision had taken place.

There was a staffing structure which should have given clear lines of accountability and responsibility but staff were not following this. There was always a registered nurse on duty who took a lead role in ensuring people's clinical needs were met. There was also senior carers on

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duty who were responsible for ensuring other care staff knew what their role for each shift was. These staff did not provide consistent guidance and support to other staff members.

We asked to see records of the staff meetings. The last recorded staff meeting was on 12 March 2014. The records that we were shown did not provide evidence that this had happened. This meant that staff were not supported to carry out the roles they were employed to carry out. All of the above meant that there had been a breach of Regulation 23 (1)(a)(3)(a)(b). You can see what action we told the provider to take at the back of the full version of the report.

We looked at the auditing procedures and records at the home. There were two sets of audits carried out, one by the acting manager and one by the area manager. The audits produced by the acting manager could not be verified and did not stand up to scrutiny for example; the staff supervision planner indicated that staff had received supervision, there were no records to support this and staff told us they had not received any supervision recently.

We spoke with the area manager about the concerns we had identified at the inspection. They told us about their concerns over the leadership within the home. They showed us a copy of the remedial action plan that was in place updated 17 March 2014. This plan identified areas of concern and demonstrated issues that were being monitored such as “homes manager is failing to complete

audits, people’s care records lacking details, not all weekly and monthly cleaning has been checked and signed off (last being commented on during December 2013)”. The remedial action plan listed 21 areas of improvements required. This was broken down into 10 areas of concern regarding the management of the home mainly in relation to auditing; three areas of concern in relation to care records and documentation; seven areas of concern in relation to health and safety and environmental issues, notably fire safety; and one issue relating to staff training. We noted that of these 21 areas two issues relating to the poor state of bathrooms and one relating to the unsafe window locks on the first floor had been outstanding since August 2013. At the time of the inspection the area manager confirmed that these issues were due to be addressed.

The remedial action plan demonstrated that the provider was aware of the issues at the home. The plan in place to improve standards was not effective as it had not improved the quality of care people received or supported staff to delivery care safely and to an appropriate standard. We found the service needed to make improvements in this area. The action we have asked the provider to take can be found at the back of this report. All of the above meant that there had been a breach of Regulation 10(a)(b)(2)(a)(b)(i)(ii)(iii)(c)(i)(e). You can see what action we told the provider to take at the back of the full version of the report.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20(2)(a) People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. Records were not kept securely and could not be located promptly when needed.
Regulated activity	Regulation
	Regulation 17(1)(a)(b)2(a)(b)(i)(ii)(d) People's privacy, dignity and independence were not respected. People's views and experiences were not taken into account in the way the service was provided and delivered in relation to their care.
Regulated activity	Regulation
	Regulation 23 (1)(a)(3)(a)(b) People were not cared for by staff that were supported to deliver care and treatment safely and to an appropriate standard. The provider had not worked continuously to maintain and improve high standards of care by creating an environment where clinical excellence could do well.
Regulated activity	Regulation
	Regulation 10(a)(b)(2)(a)(b)(i)(ii)(iii)(c)(i)(e)

This section is primarily information for the provider

Compliance actions

The provider had a system to regularly assess and monitor the quality of service that people receive but this was not effective.

Regulated activity

Regulation

Regulation 11(1)(a)(b)

People who use the service were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Regulated activity

Regulation

Regulation 19 (c)(d)

People had their comments and complaints listened to but their concerns were not acted upon.

Regulated activity

Regulation

Regulation 14 (1)(c)

People were not protected from the risks of inadequate nutrition and dehydration.

Regulated activity

Regulation

Regulation 9 (1)(a)(b)(i)(ii)(iii)

Care and treatment was not planned or delivered in a way that ensured people's safety and welfare.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 (1)(a)(b) 2(a)(c)(i)(ii)(iii) People were not protected from the risk of infection because appropriate guidance had not been followed. People were not cared for in a clean, hygienic environment. Regulation 12 12 (1)(a)(b) 2(a)(c)(i)(ii)(iii)