Luminous Care Group Limited

# Sun Court Nursing Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
Sun Court Nursing Home is a care home providing nursing care up to 29 people. The service provides support to older and younger people who may be living with dementia, a physical need or sensory impairment. At the time of our inspection there were 22 people using the service.

The care home accommodates people across 3 separate floors with a communal dining room and lounge on the ground floor.

People's experience of using this service and what we found
People were not always 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 to promote their independence in a person-centred way. The majority of people remained in their rooms without much interaction apart from care tasks. Activities and stimulation for people was limited.

There was a lack of provider oversight of the service and support for the registered manager. The governance systems were not effective at identifying issues and what actions were needed to rectify them. If there were actions identified, these were not followed up to ensure changes were made. This put people at risk of receiving unsafe or inappropriate care.

People's care records contained contradictory details and were not always accurate or up to date with some assessments missing, especially in relation to how to support people who became distressed and agitated. This put people at risk of staff not having the correct information regarding the care people needed.

The provider had recently taken over the service. There had been staffing issues when they first took on the service. To help alleviate this they had recently employed staff from overseas. We were told by people and their relatives these staff were caring, however, they did not always have a good understanding of English and had poor communication due to this. This impacted on how they communicated with people, and we were not assured that their induction and the training had assessed their competence and given them the knowledge and skills required.

The provider had invested in new furniture, equipment and was in the process of redecorating and replacing the carpets.

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

Rating at last inspection
This service was registered with us on 21 February 2023, and this was the first inspection. The last rating for the service under the previous provider was requires improvement, published on 10 June 2022.

Why we inspected
The inspection was prompted in part due to concerns received about staff's skills and experience, standard of care, food and management. A decision was made for us to inspect and examine these risks.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to assessing risk to the environment; staffing levels to meet all people's needs; staff having up to date knowledge, skills and experience to deliver effective care including medication; ensuring all people's needs were assessed, and appropriate, consistent and accurate plans put in place so they received person centred support for all their needs; staff providing effective communication; requirements of the Mental Capacity Act; end of life planning; provider oversight, management and governance systems, and meeting nutrition and fluid requirements at this inspection.

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
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.

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|---|---|
| **Is the service safe?**<br>The service was not always safe. | **Requires Improvement** |
| **Is the service effective?**<br>The service was not always effective | **Requires Improvement** |
| **Is the service caring?**<br>The service was not always caring. | **Requires Improvement** |
| **Is the service responsive?**<br>The service was not responsive. | **Inadequate** |
| **Is the service well-led?**<br>The service was not well-led. | **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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 3 inspectors.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.  Inspection activity started on 17 October 2023 and ended on 28 November 2023, when final feedback was given. We visited the location's service on 17 October 2023.

What we did before the inspection
We reviewed information we had received about the service. We sought information from the local authority.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with 2 relatives, 4 people who lived in the service and observed care provided in the communal areas and staff giving people their medicines. We spoke with 7 members of staff including the registered manager, registered nurse, carers, domestic, kitchen assistant and maintenance staff.

We reviewed a range of records including 3 staff files in relation to recruitment and a variety of governance and maintenance records.

After the inspection
We spoke with 3 relatives and 7 members of staff including the registered manager. We also received feedback from 3 health care professionals who visited the service.

We reviewed further records after the inspection including 10 care records including medication records and a variety of records relating to the management of the service, including policies and procedures.

Requires Improvement

# Is the service safe?

## Our findings

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

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- People's current needs and risks were not always assessed and managed. Risk assessments did not always contain enough information to guide staff on how to support people safely.
- Environmental risk assessments did not identify all risks and were not audited regularly to ensure they were complied with. On inspection we identified doors unlocked and left open which meant people had access to stairs and to the unmanned laundry with chemicals accessible.
- People who lived at the service did not have all their risks identified and appropriate measure put in place to manage them. For example, a person did not have a risk management plan to help staff support them when they became distressed and their care plan lacked detail on how to provide this support. Their daily notes referred to behaviour, for example hallucinations, which were not mentioned in their care records, so staff did not have the guidance on how to respond. Health care professionals involved said they felt, "staff were very task orientated and were not helping mitigate the abnormal behaviour exhibited".
- Some people lived with diabetes. Their care plans and risk assessments were not detailed enough to inform staff how this was managed. A person's care plans and risk assessments were not clear about what medication dosage they were on, what should be done when blood sugars were too low, and when to inform the GP, ring 111 or 999. This put them at risk of not receiving the appropriate care to manage their diabetes in a timely manner.
- A number of people were cared for in their bed on the second floor of the service. The lift was not big enough to take adapted chairs, which were larger than standard wheelchairs. We also had concerns about how they accessed the ground floor in the event of an emergency at night with minimal staff.

The system for assessing risk was not robust. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not always safely managed due to inconsistent and missing guidance and lack of oversight of the system and staff who administered medicines.
- Nurses employed from an agency were not assessed for their competency to administer medicines and we were not assured all nursing staff employed by the service had received competency assessments to ensure their skills and knowledge were at required level for administering medicines.
- We found inconsistencies in care plans which were not person-centred, with key information missing or assumed for such things as oxygen therapy, nutrition and seizure management. Allergies were not consistently recorded. Protocols on when to give 'as and when' medication (PRN) were not consistently recorded and risk assessments did not give enough detail to support staff.

● There was a lack of management oversight on the medication system to look at trends and lessons learnt from medicine errors and a lack of shared learning.

The provider failed to ensure the safe management of medicines. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager responded promptly to some of the issues raised and submitted updated documents. However, there were still some inconsistencies with information contained in other records.

Learning lessons when things go wrong

● There was not a robust, consistent system in place to document and learn from events such as accident, complaints and incidents. There had only been 2 events where there had been lessons learnt since May 2023 although there had been a number of complaints, safeguarding concerns and incidents recorded.

● Incidents were not always recorded especially in relation to staff, for example, if staff were hit by a person due to distressed behaviour. This meant events leading to incidents, any trends, or triggers to behaviour and responses were not being reviewed. We could not be assured that appropriate measures were being put in place to support staff to manage people's needs and keep them safe due to this.

The registered person failed to assess the risks to ensure measures were put in place to keep people safe from potential harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The tool used to work out the number of staff required on the needs of people was unclear. We were not assured the staffing levels were sufficient to meet all people's needs. On the ground floor there was 2 staff allocated, 1 of whom provided 24 hour support to a person. This left the other staff member to provide support to the remaining people, some of whom required 2 staff to support them to move out of bed. This staff member also was responsible for the morning beverage round. This meant the nurse had to support on some care deliveries which stopped them completing their tasks. Due to the lack of time the care provided was task focussed and did not meet emotional or wellbeing needs.

● Person's relative said, "There's no one about at the time [person] is most anxious', 'I've gone to leave before and said to carers, 'please can you sit with [person] whilst I leave, so she isn't upset?', and they say, 'we are sorry, we can't, we are busy elsewhere'. Staff don't know people, and do not give that reassurance or emotional support especially to people living with dementia."

Staffing levels were not sufficient to meet all people's needs. This is a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment files were reviewed and we found gaps in employment history which were not clarified. The application form did not have space to record the employer for the past employment history, although in each case a curriculum vitae (CV) had been submitted which detailed the employment history.

● When the provider took over the service there was a lack of staff and agency staff were used to help ensure shifts were covered. Substantive staffing levels had increased by recruitment including sponsored staff from abroad and the use of agency staff had reduced.

Systems and processes to safeguard people from the risk of abuse

● Staff had a poor understanding of safeguarding, what abuse was, who people were at risk from and who to report it outside of the service. There was a training matrix in place which showed not all staff had

undertaken on-line learning. There was evidence safeguarding had been discussed at meetings and during supervision.

● There was a safeguarding log in place which detailed safeguarding referrals which had been notified to the Care Quality Commission.

● Staff felt reassured if they raised concerns to the registered manager they would be acted upon.

Preventing and controlling infection

● There were infection control policies and procedures in place. Staff received training on infection control and it had been discussed at some staff meetings.

● When visiting we found the service to be overall clean. There were cleaning schedules in place with housekeepers and night staff undertaking cleaning tasks.

Visiting in care homes

● Families and friends were able to visit people. However, there were posters in the service to say there was a protected mealtimes between 12-2 pm meaning no visits, but we were assured this practice had stopped.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes and was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were not always robustly assessed. Assessments were not always present or fully completed. A couple of people displayed distressed behaviour. However, there were no assessments in place to identify what were their triggers and there was a lack of details about the impact to them and support they needed. Incidents forms were not being completed if staff were being hit by people, and behavioural charts were not being used to capture events to help assess and plan the support they needed.

● Assessments did not always hold up to date information. A person's records had not been updated and referred to a pressure sore which had healed 2 months before. Another person's record had contradictory information saying they were chair bound but then in another record said they were independent to move from place to place.

● Assessments were not always accurate. A relative told us, "I don't think the staff know [person] very well. One of the nurses had a meeting with the Deprivation of Liberty Safeguards (DOLS) team when I was on holiday. When I received the report, I'd never read a bigger load of rubbish about my [person]. It read [they] had a background of depression – this is not true. It said [they] was able to communicate with gestures – again, not true. They also didn't have a record of [their] seizures". The relative paid for a private, independent social worker to review the care plan. The report was provided to the registered manager.

The registered person failed to ensure all people's needs were assessed and appropriate plans put in place so they received the support they needed. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff used recognised national tools to support assessment of the person. For example, people had MUST assessments in place to help assessed their risk of malnutrition. MUST is a five-step screening tool to identify adults, who are malnourished or at risk of malnutrition.

● National patient safety alerts were discussed at health and safety meetings for such things as risk of death from bed rails and equipment, to ensure the service complied.

Staff support: induction, training, skills and experience

● The service did not ensure staff had the skills, knowledge and experience to deliver effective care and support.

● Inductions for new staff were in place but they were insufficient in ensuring staff were competent on starting. In July and August 2023, a number of staff on sponsored employment visas from abroad commenced employment. They were given no extra support in relation to language and culture differences.

We were not assured their competencies were assessed adequately on starting to assess their capabilities to provide care, especially as induction forms were not fully completed and signed off.
● The training matrix did not cover all training required and training was not completed, for example, no dignity training and only 10 out of 25 staff had completed communication training.
● The training matrix contained details for nurse's competency, which had gaps and were over a year old. There was no schedule for carers competency. The competency assessments for nurses were completed by the registered manager. However, no details of their competency to practice were provided.
● Agency staff did not have any competency checks completed and their induction was poor, consisting of a list of a number of points which they signed to say they have been explained to them. There were no additional points for nurses as opposed to care staff even though they had different areas of responsibility. The registered manager said she checked agency staff's competency by asking the nurse at the daily meeting. However, the nurse could be from an agency, so had not had their own competency assessed.
● A person said, "There are a lot of language issues. I tell them what I need but they just look at me blankly. Staff are not well equipped to care for people (referring to sponsored staff). My water jug is left on the opposite side of the room. Continence aids are thrown on the carpet. I feel like I've had to train a lot of new staff."

Systems were not in place to ensure staff had up to date knowledge, skills and experience to deliver effective care. This place people at increased risk of harm. This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following inspection the registered manager started to develop a list of competencies for agency staff and improve the induction and support for sponsored staff new to England to ensure staff had the training, skills and competency they needed to undertake the roles. They also wanted to develop staff so they become champions in such areas as catheter care and dementia.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● Staff did not always understand and implement the principles of MCA. They did not all understand it was decision specific, that you assumed capacity and felt people either had capacity or did not. This put people at risk of decisions being made for them when they were capable of being involved in the decision-making process.
● People's records were not consistent about whether a person had capacity or not. A person had signed a form to say they consented to staff administering their medicines. However, on the electronic records there was a mental capacity assessment saying they did not have capacity for this.
● People's mental capacity assessment covered more than one decision, so they were not specific. For

example, 1 assessment covered the decision of personal hygiene, oral, dressing, continence needs, and safe from harm by not letting them leave Suncourt without assistance.
● There was no evidence of best interest meetings being held and appropriate people including health professionals being involved. A person's record had a best interest checklist dated with a date of a best interest meeting 2 years previous. The majority did not have dates for best interest meetings taking place.
● We were concerned about practices not being implemented in the least restrictive way. For example, due to a person being scalded with a hot drink, all people were not allowed very hot drinks, with some complaints being received about cold drinks. People were being checked every hour at night unless they had the capacity to decline, without reasons documented to state why this was happening.

The registered person failed to put into practice the requirements of the MCA. This is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Staff spoken with told us they asked people's permission before entering people's bedrooms and providing care.

Supporting people to eat and drink enough to maintain a balanced diet
● People were not always supported with enough to drink and maintain a balanced diet. This put them at the potential risk to their health.
● People's record of fluid intake showed they regularly did not meet the targets set. The management team could not demonstrate people were being protected from the risk of dehydration and associated illness.
● Agency staff had been employed to prepare meals in the absence of a consistent permanent cook. A new cook had recently started and people gave positive comments about the food. However, they did not stay and agency staff were used again. The leadership team were unable to demonstrate how they made sure meals were consistently nutritious and planned for people.
● People told us the food had been very poor with lack of choices. People had to choose what they wanted to eat the day before. The menu was often simplified when there were new or agency staff working in the kitchen. There had also been issues with limited stock. There were no menus displayed or ways to show people what the meals looked like, to help their choice or give them an opportunity to change their mind on the day.
● Relatives of people had concerns about the standard and quality of food. One said, "I have a big issue with food. [Person] has a pureed diet. They plate up and puree two meal portions for [them] from the lunch, and [they] have one at lunch and one at teatime, every single day, so two same meals. It's always very carb heavy – mostly mash potatoes and pureed meat, twice every day. There has to be alternatives available for [person] surely? [They] are diabetic too, so I worry about the high amount of carbs [they] have."

The provider had failed to ensure people were always supported to drink adequate amounts and maintain a balanced diet. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● An overview of people's nutritional needs was available for the kitchen staff. Following our inspection menus were introduced for mealtimes and management oversight of the standard, choice and quality of food improved, with feedback being gained from people via the mealtime experience forms.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Health care professionals involved with people were not always recorded accurately or only first names used in their records. This could lead to confusion about who to contact in the event of queries or advice

needed.
● People were supported to access healthcare services via the GP. Staff from the GP surgery visited regularly, and good relationships had been built between the surgery and the long-standing nurses. A dentist and chiropodist also visited the service regularly.
● A nurse said, "We have a good relationship with the GP and we put through falls referrals after a couple of falls and the GP practice are responsive. They visit every week and will add people to the list." This ensured referrals were made as needed.

Adapting service, design, decoration to meet people's needs
● The provider was in the process of making improvements to the service with redecoration, new furniture, equipment, nurse call system and replacing carpets, to make the environment more dementia friendly, which was needed.
● Stairways and doors had key codes put on recently to keep people safe who may be at risk of stairs or leaving the home on their own. People personalised their rooms with their own items.
● We had concerns about the size of the lift for people who had mobility issues to access the ground floor for the dining room and communal areas who were on the top floor, which lead them to being isolated and lonely with lack of activities and stimulation.

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.

This is the first inspection for this newly registered service. This key question has been rated 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

- Staff did not always remember people's preferences or have enough time to find out what they were. Staff were more focused on tasks than people and their wellbeing. Support could be inconsistent and not always respectful.
- People's records identified if they could become anxious or be non-complaint with care. However, they did not detail what made the person distressed or what staff might do to alleviate their stress. There were no clear strategies in place.
- Staff did not always show respect to people's property. A relative told us, "[Person's] clothes are sometimes chucked into [their] wardrobe rather than hung up – it's disrespectful to [person's] things and I wonder would they do this if [person] was able to speak and had capacity?"
- Relatives said the staff were friendly, however, there was a language barrier with the newly appointed sponsored staff. They said, "I like the staff, they are fine, they are happy, smiley, but I know they can't understand much, especially not people with dementia."

The provider did not take all reasonable steps to ensure people received person-centred care meeting the support they needed. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

- People and their relatives were not involved in their care and support in a way that made them feel they matter. They were not involved with the reviews of their care plans. This was completed mainly by agency nurses working on nights. Without people's involvement the details in the plan were not always up to date or accurate.
- A relative who was concerned about the inaccurate content of an assessment employed a private social worker to review the care plan. This was sent to the registered manager. They were told there would be a meeting to update the person's care plan together, but it had not happened.
- Relatives were not kept up to date with changes to care. A relative told us that they had found out about a change of medication, but the service had not told them.

Respecting and promoting people's privacy, dignity and independence

- Staff spoken with understood they needed to close curtain and doors to protect people's privacy and dignity. There was less understanding of promoting their independence.
- Care plans did not routinely describe what people could do for themselves to keep them independent and

did not all give guidance to staff on what people were capable of doing and what support they required from staff.

Inadequate

# Is the service responsive?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care needs were not regularly reviewed with them or their relatives. The majority of the care plans were inaccurate or out of date and did not sufficiently guide staff on people's current care, treatment and support needs.
- Care was not always personalised and planned to meet people's needs and preferences. People were not always supported to follow their interests or participate in activities relevant to them.
- Care plans did not include many details about people's past history, family details or their interests. Staff spoken with struggled to give specifics about people's likes, dislikes or routines and did not have a full understanding of what person-centred care was. A staff member definition was, "Caring from head to foot emotional and physical support them."

The provider did not take all reasonable steps to ensure people received person-centred care meeting their social and emotional needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Sponsored Staff newly appointed from India had difficulties communicating with people. Some staff were not explaining to people what they were going to do and were unable to provide the reassurance needed. This had impacted on a person's distressed behaviour as staff did not have the communication skills to reassure and be understood by them.
- Staff who had worked at the service a long time said about the newly appointed staff, "The staff we have are very willing and hardworking, but some lack understanding and experience. They frequently speak in their own language despite being asked not to do so in front of residents. They do need to communicate in this way sometimes to ensure they have understood. Some do not communicate well with the residents and explain what they are doing."
- Some people had hearing aids. However, when we visited we noticed a person was not using their hearing aids even though their care plan said they should be. A relative also told us, "[Person's] hearing aid batteries are not changed, which affects [them] as [they] cannot hear people. [Person] has dementia and this makes

things worse for [them]. It is even written in [their] notes to change batteries every Wednesday."

Staff not being able to communicate with people in a way that they understood their preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Families said the communication could be improved as they were not receiving regular updates on their relative living at the service. They were aware of who the registered manager was but said they were sometimes hard to contact.

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
● The service did not meet people's individual needs in relation to maintaining interests and hobbies and there was a lack of maintaining relationships or contact with the community.
● Most people remained in their rooms with limited stimulation apart from care tasks. A person we observed was in their room which was quite bare, with no television or music on. They sat by the window holding the curtain. We asked staff about them and they said the person did not leave their room as they could become aggressive and grind their teeth which upset other people. The carer knew very little about the person's life history and appeared to have little understanding of their needs or what emotional support was required.
● We spoke to people about staying in their rooms most of the time. A person said, "I am fed up, I gave up a long time ago as there is nothing happening. But I have got used to it". Another person said, "I guess I am lonely. Yes, I am used to it now. It shouldn't be this way though."
● We were concerned about a person whose bedroom was off a lounge with regards to their privacy and dignity. The service had spoken to them and their relative about this, but they wanted to remain in this bedroom. Due to the location, they could stay in their bedroom and have conversations with people who were in the lounge. However, we felt this could impact on the privacy and dignity offered to them.

Care did not meet people's emotional needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We had been concerned to see posters in the service about protected meals times between 12-2 pm, which meant relatives and friends could not visit during this time. This was also raised with us by a family member as they were concerned about the impact this was having on their relative who had dementia who they used to spend time with at meals times to help encourage them to eat. This was raised with the registered manager, and we were advised this practice had stopped.
● There had not been an activities co-ordinator in post until a couple of day prior to the inspection started. Families and residents were pleased with this addition to improve the home as there had been no programme of activities.
● A hairdresser visited the service regularly.

End of life care and support
● People's end of life care needs were not assessed regularly. Their end of life care plans were found to be inaccurate and missing important information.
● The care plans lacked personal details of people's wishes, needs and preferences for how they would like to be cared for, although some referred to following their wishes and needs without stating what they were.
● Families wishes stated at a review regarding whether the person should be hospitalised or not were not reflected in the care plan. There was also missing information in 1 care plan about a person being on a syringe driver and what health care professionals was supporting them. This could impact on their wishes and preferences being followed and the care they received.

People's records did not meet their needs or reflect their personal preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns

- The complaints system was managed inconsistently and there was little evidence of the learning applied to practice within the service.
- The provider's complaints records did not fully reflect the feedback we received around the number of complaints made to the service. There was a lack of robust systems in place to record, investigate and respond to complaints fully.
- A relative had raised a complaint about drinks not being given regularly and gaps in fluid charts. A meeting was held with staff where this was discussed, and staff reminded to encourage fluids. However, from a clinical audit, fluid charts were below the targets set out on a regular basis for all those people with targets, which showed actions were not put in place.

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.

This is the first inspection for this newly registered service. This key question has been rated 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; 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 culture of the service was not person-centred and inclusive. Most of the people we spoke with, and their relatives did not feel the care they were provided with was consistently achieving positive outcomes for them.
- There was no evidence the provider had identified all incidents or accidents. We could not be assured there were robust systems in place to ensure all events were looked into and safeguarded, if needed, investigated and appropriate actions taken. Themes and trends were not identified which meant actions were not put in place to stop reoccurrence. Complaints were also not acted upon to continually improve the service and people's experience of care.

The provider had failed to operate effective systems were in place to identify lessons learnt, themes and ensure appropriate actions were put in place to ensure people receive safe and good quality care. This was a breach of regulation 17 of the Health and Social Care Cat 2008 (Regulated Activities) Regulations 2014.

- People's relatives told us about the registered manager, "She says the right things, but I have yet to see anything she says she will do actually become effective within Sun Court".
- Staff were receiving supervisions and there were regular team meetings taking place with different staff groups. Some staff said they felt supported, others felt the registered manager was not approachable all of the time.

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

- The provider had failed to maintain effective oversight of the service and had good governance systems in place. During the inspection we identified concerns in relation to risk management, medicines management, lack of people involvement in their care, care plan reviews, record keeping, staff training and learning from incidents and accidents. These shortfalls, affecting safety and quality of people's care, had not been identified by the registered manager or provider.
- The audits did not cover all areas and lacked detail. Actions from these were not always identified, and where they were, there was a lack of follow up to ensure necessary changes were made. For example, although inadequate fluid intake had been discussed at meetings and was a lesson learnt from a complaint, fluid monitoring charts showed people were not meeting the targets set, even though they were reviewed as

part of clinical audits.
● People's records were not always detailed enough, accurate or up to date which put them at risk of not receiving safe and consistent care. Where people regularly refused care there was no follow-up to ensure actions were taken to support them to receive the care they needed. The provider had not identified issues around people's care records in relation to their eating or drinking needs and support required when expressing distressed emotions.
● The provider's governance systems did not highlight concerns relating to communication issues with the sponsored staff and the impact this had on people's care, well-being, and support.
● The provider had policies and procedures in place. However, these were not always embedded and followed within the service, especially in relation to such things as incident management and training needs.

The provider had failed to have effective governance systems in place to assess, monitor and improve the quality and safety of the service and mitigate the risk relating to the health, safety and welfare of people. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider shared an action plan which had been started, following the inspection explaining how they would improve the service and people's experience of care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People and their relatives were not always engaged and involved in the service. There had been some opportunity to share views via meetings and a questionnaire but there was limited assurance the registered manager had made improvements on people's feedback.
● The service had good relationships with the GP surgery who undertook weekly visits. They felt the staff were good at following clear and precise instructions from the clinical team. They said there were some highly experienced staff who had worked at the establishment for many years and who were very competent. Some of the newer staff were competent, however there was a challenge with some who had varying skills and less knowledge about people. This could lead to inconsistency of care.

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 | Regulation 9 HSCA RA Regulations 2014 Person-centred care |
| Treatment of disease, disorder or injury | All reasonable steps had not been taken to ensure people received person-centred care meeting all their care and support needs. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent |
| Treatment of disease, disorder or injury | The requirements of the Mental Capacity Act were not being meet in relation to assuming capacity, being decision specific and consistency of assessments |

| 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 | Systems for assessing and managing risk were poor, inconsistent and missing. Plans to support people did not cover all their needs or the support they required. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs |
| Treatment of disease, disorder or injury | People were not always supported with enough to drink and maintain a balanced diet |

| Regulated activity | Regulation |
|---|---|

| | |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure there were effective governance systems in place to assess, monitor and improve the quality and safety of the service and mitigate risks relating to health, safety and welfare of people. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staffing levels were not sufficient to meet all people's needs. Systems were not in place to ensure staff had up to date knowledge, skills and experience to deliver effective care for all people's needs |