

Hartwood Care (2) Limited

Sunnybank House

Inspection report

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Ratings

Overall rating for this service

Good



Is the service safe?

Requires improvement



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Good



Is the service well-led?

Good



Overall summary

This inspection took place on the 9 November 2015 and was unannounced. The home provides accommodation for up to 60 people, including people living with nursing, dementia and mental health care needs. There were 45 people living at the home when we visited, but two of those were in hospital.

Sunnybank House is a purpose built home which is spread out over three floors. The top floor was for people

who required nursing care, the middle floor for people living with dementia but did not yet require nursing care and the ground floor was for people who required residential care.

There was a new manager in post who was in the process of applying to become registered with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Arrangements to manage medicines safely were not robust. For three days one person was not given their medicine as they were asleep. The service had not recorded whether any attempts had been made to give the medicine at a different time.

The infection control practices in the home put people at risk of cross infection. The provider had not taken adequate precautions to ensure infection control practices were safe and measures put into place to minimise the spread of infection. We found the clinical waste areas were not secure and bags of waste were left on the floor and on top of overflowing bins. This was identified to the manager, who took immediate action.

We found accident and incidents were recorded, action had been taken to reduce the risk of recurrence. There were appropriate risk assessments in place, but people were put at risks where store cupboards containing hazardous items were left unlocked.

Staff were supported through formal supervision, were able to approach the manager with any concerns and felt they would be acted on. The home had adequate staffing levels and all new starters had completed a training programme during their induction. All staff had

completed updates in dementia training and safeguarding adults training in accordance with the provider's policy. Staff were also able to identify different types of abuse and what actions they would take.

Assessments of people's needs were completed. Care plans had been developed to identify the care and support people required and how to meet those needs. People's healthcare was managed appropriately and specialist advice sought when required.

People's needs were reviewed regularly. If the reviewed identified a need for nursing care, then a discussion was held with the person (if possible) and their family members.

People were treated with privacy and dignity at all times. Staff kept relatives informed of any changes in people's health.

Consent documents within the people's care files, had not always been completed and a decision had not been made by staff to show that the care and support planned was in their best interests. Staff sought verbal consent from people before providing care or support and were able to explain the principles of the Mental Capacity Act, 2005 (MCA).

There were systems in place for monitoring the quality of the service provision and regular audits were completed. The service had a system in place for responding to complaints. Complaints were recorded along with information about the investigation and outcome as well as any feedback which had been provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Infection control practices did not protect people from the risk of cross infection.

People did not always receive their medicines as prescribed.

Accidents and incidents were followed up and action plans were developed to maintain people's safety.

People told us they felt safe and staff knew how to identify and report abuse. Staff knew how to respond to an emergency situation and both individual and environmental risks were managed appropriately.

There were enough staff employed to meet people's needs at all times and the recruitment process was robust and helped ensure that people were suitable for their role.

Requires improvement



Is the service effective?

The service was effective.

Staff were clear how to apply legislation designed to protect the rights and liberty of people.

All staff had received training to support them in their roles. Staff were appropriately supported through regular supervision.

People were offered choices with their meals and they were supported to make the choice.

People were supported to access appropriate healthcare services when needed.

Good



Is the service caring?

The service was caring.

People were treated with kindness and staff respected their privacy and dignity.

Staff understood people's needs and knew their preferences. Staff were caring and showed respect, calling people by their preferred names.

People were involved in assessing and planning the care and support they received.

Relatives were able to visit and were made to feel welcome.

Good



Is the service responsive?

The service was responsive.

Good



Summary of findings

People had access to activities; the service was looking at ways to include those who were restricted to being cared for in bed.

There was an effective complaints procedure in place.

People's care plans and assessments were reviewed and updated to reflect changes in people's needs.

Is the service well-led?

The service was well-led

There were quality assurance systems in place and a number of audits completed. However, the audit system did not identify the issues with infection control or with missed medicines.

There was an open and transparent culture within the home.

Good



Sunnybank House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 November 2015 and was unannounced.

The inspection team consisted of an inspector, a specialist advisor in dementia nursing care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to

make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 10 people living at the home; we also spoke with seven relatives, the manager, the deputy manager, a nurse, the dementia lead staff member and two members of care staff. We also spoke with the chef and the activities coordinator. We looked at five care plans and associated records, along with records relating to the management of the service. We also looked at 29 Medication Administration records (MAR). We looked at staff recruitment files as well as their training records. We observed interactions between the manager, staff and the people within the home environment. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of the people who could not talk to us.

This was the first inspection of the service since they were registered in September 2014.

Is the service safe?

Our findings

People said they felt safe at Sunnybank House, when asked, one person said “Yes, I feel safe here”. Another person said “I feel safe and comfortable, and would rather be here than anywhere else.” A third person said “I feel safe and looked after”.

However we found not all aspects of the service were safe. In the external waste storage area, we found yellow clinical waste storage bins were overflowing and bags of clinical waste had been put on the floor. The general waste bins were also overflowing and there was no lock to the waste storage area meaning there was a risk that people could come into contact with potentially contaminated material. This was highlighted to the manager, who explained there was to be a pre-arranged collection later that morning and would arrange for waste collection to be increased to twice a week to ensure clinical and general waste could be safely stored. The Department of Health’s Infection Control Guidance for Care Homes states ‘Waste must be stored in a designated area which is secure and not accessible to scavenging animals’ and ‘Clinical waste in yellow bags must be kept separate from general waste’. This could pose a risk of infection to the people in the home.

There were a number of storage cupboards unlocked, one contained craft items such as glue and paints, another contained workman’s tools. The deputy manager explained these were used with one of the people who had worked with tools. There was a risk that anyone could have access to these tools and could cause harm to people. Another storage cupboard which gave access to electrical boxes was also unlocked. The deputy manager told us this should be kept locked, but staff kept it open as other equipment was stored in there. All doors were painted white (except the toilet doors) and did not have signs on them; this would make it difficult for a person with dementia to differentiate between a bathroom, and a store cupboard. This posed a risk, people may wander into what they thought was a bathroom, when it was in fact a store cupboard containing electrical items as these store cupboards were not being kept locked liked they should have been .

The arrangements in place to record and administer medicines were not always effective. Not everyone received their medicines as prescribed. The MAR charts showed one person had not received their morning medicine for three consecutive mornings as they were asleep at the time of

the medicines round. Staff had failed to take any action in relation to this, there were no records detailing any further attempts had been made to give the person their medicine when they were awake, or that staff had made contact with the GP to discuss the missed medicines and review whether the administration was changed to a later point in the day, reducing the risk of important medicines being missed. Audits on the medicines had not identified the management of medicines were not always safe; or the risks to people were not always managed effectively.

We observed the lunchtime medicines round and saw staff administering the medicines as prescribed. They explained what they were giving to the person and asked if they required any additional pain relief. Medication administration records (MAR) were being used by staff. The MAR chart provided a record of which medicines were prescribed to a person and when they were given. Rather than use antipsychotic or sedative medicines to manage people when they displayed distressed behaviour, the service would contact the persons GP or community mental health teams for additional support. Medicines were stored and on the whole administered safely. We saw there were ‘as required’ (PRN) protocols, but one person who had been given PRN paracetamol did not have a PRN protocol on file. Consequently, the person may not have received their medicines consistently when needed. Staff were using a pain assessment tool to help identify when people were unable to verbalise their pain, needed their pain relief.

The service had an emergency ‘grab bag’ which contained details about the people living in the service should the home need to be evacuated in the event of a fire. People who were in hospital, names were colour coded. However, it was not clear to distinguish those people as the list kept in the ‘grab bag’ was a photocopy. This could mean emergency services staff could be searching the home for people who were not there as they would not be able to see from the list, also any staff who worked on different floors may not be aware of everyone who was in hospital. The Personal Emergency Evacuation Plans (PEEPS) which kept vital information about each person and their needs were kept separate from the grab bag which meant important information about the people was not with the emergency bag. This meant that in the event of an emergency, staff would have to try and locate two items, rather than just grabbing one. This could cause a time

Is the service safe?

delay and may result in important information about a person, not being readily available to the emergency services or staff. We raised this with the manager who was going to address this concern.

Staff were aware of different types of abuse and how to report concerns. One staff member said “If I was concerned about the care, I would report it to my supervisor. If nothing was done, then I would go to management and if still nothing was done then I would report it to CQC.”

One care plan we reviewed showed the person had been involved in a number of safeguarding incidents. Referrals had been made to appropriate professionals and action plans put into place to manage the concerns.

Risk assessments had been accurately completed and were up to date. Where one person had been identified as resistive to care, staff were encouraged to leave them if it was safe to do so, and then return a little later. One person on the ground floor had a patio door leading to the secure gardens. This door was alarmed and required the person to press a switch before it was opened. The person kept forgetting to press the switch so staff would turn the alarm off in the morning and switch it back on in the evening. This

could pose a risk to other people who were mobile and could possibly leave the building through this door without staff being aware. The home had put a risk assessment in place after identifying this as a possible risk to others.

There were sufficient staff numbers to meet the needs of the people, at the time of the inspection the service were staffing each floor as though the home had maximum people living there. Agency staff were used when required, though permanent staff were offered overtime in the first instance to keep familiar staff on shift. Following feedback from people, the provider had increased staffing levels in the early morning to meet people’s needs better at this time.

Staff were subject to checks to see if they were suitable to work in care. Checks with the Disclosure and Barring Service (DBS) were carried out before staff were employed to provide support to people living in the home. The DBS helps employers make safer decisions when recruiting staff to work in the provision of care. References as to the conduct of staff in previous employment were obtained to check they were suitable to work with the people living at the home.

Is the service effective?

Our findings

Consent documents within the people's care files, had not always been completed and a decision had not been made by staff to show that the care and support planned, was in their best interests. We raised this with the manager, who said they will address this and all care files are reviewed and best interests' decisions recorded where necessary. Staff sought verbal consent from people before providing care or support and were able to explain the principles of the Mental Capacity Act, 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. One staff member was able to describe what the MCA meant but was uncertain to how often the person may need to be assessed and wasn't able to describe what the Deprivation of Liberty Safeguards (DoLS) might be, or how it applied to people living with dementia.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The provider had followed the process for those who required a DoLS application to be made to the Supervisory Body for authority to do so. The provider was complying with the conditions applied to the applications which had been approved.

Staff received appropriate training. One staff member said they "had previous experience and had undertaken essential training since starting at Sunnybank and further support with the service's own dementia training". Staff confirmed they had a full induction and training record showed all staff had completed the home's induction programme. This meant that all staff had had initial training in essential areas such as safeguarding and dementia care. The training rota showed staff had undertaken refresher training as required. A staff member confirmed they had received all the required training but for their own personal

development they had identified that they needed some additional training around DoLS and would be asking for this. New staff completed a minimum of three shifts shadowing a more experienced member of staff. During this time, the manager would ensure that the care staff worked on each of the three floors in the service. Once their induction was complete, they were allocated to a particular floor but were flexible and able to work throughout the home. New care staff were going to be undertaking the Care Certificate during their probationary period. The Care Certificate is the standards which all health and social care workers need to complete during their induction.

Staff had completed, or were undertaking, vocational qualifications in health and social care. Two staff members were being supported to complete higher level diplomas to develop their supervisory skills and enable them to undertake some management responsibilities. The service had introduced the role of dementia lead. The dementia lead said they were "keen to start making positive changes to the care and support being provided in the service". They role modelled good dementia practice and offered support and guidance to the other care staff when needed. The dementia lead had studied for an additional dementia qualification. Additional training had also been provided to staff for a person who required insulin to be given as this person wasn't on the nursing unit. The registered nurses were supported to ensure they met with the requirements of their continual professional development.

Staff received regular supervisions and an annual appraisal. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop. Records of supervisions showed a formal system was used to ensure all relevant topics were discussed. Where actions were identified the process ensured these were reviewed at the subsequent supervision meetings. Staff said they were able to approach the manager outside of the scheduled supervision if they needed to discuss anything.

Staff showed a good understanding of the needs of people who lived with dementia. They knew how to adapt the care to meet the changes in their dementia as it occurred. Staff were seen making visual contact with the person first, before following this by touch and then speaking to them. On occasion this was done a little too quickly, which may

Is the service effective?

have prevented the person from having time to acknowledge and process the information or respond. However, staff showed a willingness to take this on board, and slow the process down when this was pointed out to them.

Pre-assessment documents before people were admitted to the home were fully completed and care plans had been written for those areas where people were assessed as having a need. The care plans were personalised to each person with clear guidance to staff. For example, one person with dementia's care plan said [the person] can communicate their needs, but may get confused with their words. Staff are to give this person X amount of time to respond and converse as she can struggle with conversation at times. The care plan also referred to alternative methods to be used for communicating including pictures and actions. All staff demonstrated good communication skills and knew the people's preferences.

Mealtimes at Sunnybank House were social occasions. The staff ensured the majority of the people had their meals together in the dining area, sitting with their friends grouped around either a large table or in clusters of smaller tables. People were also able to eat in their rooms if they wanted to. Prior to the meal being served the menu was written on a white board, we saw staff showing people plates of the different choices.

Menus were on a four week rolling rota system, with the main meals changed every two to three weeks to reflect seasonal changes. Fresh food was delivered to the service three to four times a week to ensure its freshness. The chef had a folder which detailed people's dietary requirements

and was updated when a new person arrived at the service. It was also updated if any changes had been identified to people's requirements; these were discussed as part of the senior team meetings which were held three times a week. A recent initiative within the service was the introduction of a snack table on one of the floors where residents had a diagnosis of dementia. Healthy snacks were set out so people could "graze all day". People living with dementia can often lose weight due to their condition. By leaving out snacks the service were reducing the risk of this occurring. People were able to request anything they wished to eat throughout the day. One person liked to have a 'bacon butty' later in the morning rather than first thing and we saw they received this.

The service had invested in crockery with coloured rims to help people with visual and cognitive impairment to see food on their plates. Plate guards and adapted cutlery were also readily available and used by the care staff when a need was identified. Tables were not fully laid until about 20 minutes before lunch was about to start, indicating to people that it was soon to be a meal time. Lunchtime was a relaxed experience with classical music playing in the background.

People were able to access healthcare services when required. People said they could see the doctor during their regular visits to the service; if they needed to see the doctor more urgently, then staff arranged an additional visit. People's care files also showed referrals and involvement from Speech and Language Therapist (SaLT), Community nurses, and mental health teams when required.

Is the service caring?

Our findings

Confidential information was not always held securely. We found the care plans were being kept in open cupboards, but as the inspection progressed the cupboards were locked.

People were spoken to in a kind, compassionate manner. They were consistently treated with dignity and respect. Staff were patient and kind in all their interactions. They clearly knew the people, made every effort to listen to what they were trying to say and responded in a caring way. One person said “I always get respect from the staff”, and another said “They always knock before they come in my room”. One relative said “The staff are very gentle and loving”. Throughout the day, relatives and friends were able to visit and were welcomed; they were able to discuss their relative’s needs with the care staff in an unhurried way. Care was provided in an unhurried way, no one was rushed to get up, washed and dressed in the morning, and there were sufficient staff members to support with the care required and in the afternoon staff had time to sit and chat with the people who lived there.

People and their relatives were involved in developing their care plans. One relative confirmed they had been involved

in the creation of their loved one’s care plan, and had been involved in the reviews. Each care plan was individual to the person, and they showed that people had been supported to contribute whenever possible. The care plans contained information about the person’s abilities, what they could do for themselves and what support they needed this promoted the persons independence and showed what they were able to do for themselves.

All staff demonstrated good communication skills and knew the people’s preferences. One person said “They take time to speak to me; they always use my name and showed an interest in how I am”. Another person said “They ask if I need anything”. Staff demonstrated patience when speaking to the people. We observed caring interactions between the people, their relatives, care staff, other staff members as well as the nurse on duty. They knew the people they were caring for and this was shown by how they responded when people became upset and anxious. Staff would support and calm them by offering other activities or moving them to another room. Staff were able to do this using their understanding of the people through the information shared in their care plans and also how their dementia may be affecting them. Staff were observed interacting in a friendly manner with each other.

Is the service responsive?

Our findings

People felt they were able to complain to the staff or manager; the complaints procedure had been followed in all cases except one. This was raised with the manager and deputy manager who said this would be looked into further and action would be taken to ensure this complaint was dealt with appropriately.

Life stories were recorded at the time of the person's admission into the service, but we did not see this being used to develop lifestyle or activity plans for the people to occupy their time. Close links were maintained between care staff and most families. This was reflected by the visitors we spoke with.

The service had held regular resident and relatives meetings. The manager hadn't been in post long and hadn't had time to hold one, but had planned to hold a social event in the near future to introduce himself to the family members he had not yet met. The manager then planned to reintroduce the regular resident and relatives meetings.

People were involved in the writing of their care plans they were also involved in the reviews of these. Care plans were reviewed regularly to ensure the person's needs were still

being met. If someone's needs had increased and they required nursing care, then a discussion would be held with them and their families (when appropriate) before they were moved onto the nursing floor. People's preferences had been sought with regards to having their care provided by a male or female carer; and staff knew the people well and were aware of the person's choice. One person had requested their yellow toilet door be painted white before they moved into the service. We were able to confirm this had been done prior to the person moving in. All toilet doors in the service had been painted bright yellow to support those people who were living with dementia to identify where the toilet was.

On the day of the inspection some people were being supported to make jam. This was to be given as Christmas presents from the people to their loved ones. Staff said people had been making various items to give to their loved ones as a gift and had enjoyed doing it. People said there were a number of activities each week and they were able to choose as to whether they participated or not. For those who were less able to interact and socialise, were sat dozing or just sitting without engagement for long periods of time. However the service had appointed a dementia specialist worker to develop more engaging activities.

Is the service well-led?

Our findings

Everyone we spoke with said they would recommend the home to other people and there was nothing they would change. The new manager had been in post from September.

Regular audits were being carried out to assess, monitor and improve the quality of the service. These included care planning, medicines, recruitment, infection control and the environment. The manager was aware of areas where improvements were needed as they had not identified the issues with the medicines, and was in the process of implementing these changes.

The provider and the manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. Notifications had been received by CQC when incidents had occurred. Staff had reported issues to the manager who in turn had notified the appropriate agencies. Accidents and incidents were recorded and formed part of the provider's internal audits. These were reviewed by the quality manager and action plans developed and monitored where accidents had occurred.

Staff said there was a positive open culture in the home. They felt able to go to the manager or deputy manager about anything and were confident changes would happen. Regular staff meetings were being held monthly and senior staff meetings were held three times a week. The senior staff meetings allowed changes within the

service, to be discussed. This information was then shared with the rest of the staff team. One staff member was going on additional training on dementia to support the people. There was a culture of team working and supporting one another, regardless of their role. For example, the dementia lead suspended what they were doing during mealtimes, in order to assist and support people to have their meals.

All staff understood their roles, were motivated, committed and worked well as a team. Most staff predominantly worked on the floor they were assigned to, but were able to support staff in the neighbouring floors when needed and maintained good communications between one another. This allowed people to get to know the staff and provided a continuity of care.

The manager said the vision of the service was about "Maintaining the people's independence within a residential/nursing home setting". Development plans were in place for the future to involve people who live at the service, to be involved in the recruitment of new staff. There were plans to start holding monthly coffee mornings to which families would be invited. The first was being planned to coincide with Christmas. The service had close links with a local school and there was a pantomime and carol concert planned for the coming months.

There was a clear management structure in place. The manager told us they were supported from the head office as well as by the previous manager. There was a deputy manager in place as well as senior care staff, who supported the manager with the supervisions of other staff; this allowed the manager time to focus on strategic issues.