Woodean Limited

Sunhill Court Nursing Home

Inspection report

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Date of inspection visit:
12 February 2019
14 February 2019

Date of publication:
03 April 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:

Sunhill Court Nursing Home is a 'care home.' Sunhill Court Nursing Home accommodates 40 people in one adapted building. At the time of this inspection 37 people lived at the home. People were supported who lived with different long-term conditions. Most people at the home lived with dementia. The home also supported people with diabetes and Parkinson's disease.

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

People's experience of using this service:

People were not always kept safe from avoidable harm. Diabetes management and the management of medicines were not always safe.

Other risks to people were assessed, although lacked personalised detail for each person living at the home.

People enjoyed meals that appeared appetising, varied and of their choosing. The mealtime experience was not rushed and there were enough staff to support people's individual needs.

People had access to healthcare support outside of the home. Although the timeliness of this was being addressed by the home and procedures were being implemented to ensure that these services were followed up by the home promptly.

Staff were seen to be very caring and compassionate towards people. People received appropriate emotional support from staff who knew them well. Agency staff were sometimes used to cover shifts at the home. The electronic records for people did not always provide sufficient person-centred details about their needs. This was being explored and improved by the home's registered manager.

People were not always fully supported to have maximum choice and control of their lives. Staff aimed to support people in the least restrictive way possible; the policies and systems in the service supported this practice. However, people's ability to make choices in their best interests was not always reviewed appropriately when their ability to do this changed. Staff ensured that they asked people for their consent before they supported them with any activities of daily living.

Staff had some basic understanding of the Mental Capacity Act [2005] and Deprivation of Liberty Safeguards [DoLS], but records for people were not always updated to reflect when their needs had changed regarding their ability to make decisions for themselves.

Safeguarding reporting procedures were understood by staff on a basic level. Staff had access on their hand-

held devices that enabled them to find out information about how to report safeguarding concerns should this be required.

However, staff did not always receive sufficient training to enable them to fully understand the individual and specific needs of people they supported at the home. Such as diabetes care.

People were supported with individual, stimulating and engaging activities which were led by a highly motivated and dedicated activities coordinator. The home had linked up with a local children's nursery and had participated in 'intergenerational' activities which involved four people visiting the nursery to enjoy activities with the children. This was very beneficial to all involved.

People had access to the complaints procedure. A board containing 'you said, we did' information was displayed in the communal lounge area. This showed actions the provider had taken to respond to people's feedback. The provider understood the duty of candour process.

People were supported at the end of their lives to receive dignified, pain free care. The registered manager had completed detailed training with a local hospice which enabled them to identify and meet people's needs at the end of their lives. Relatives felt supported and involved when their loved ones passed away.

The home was not always well managed. Systems and processes were not always effective and had not always identified some areas of concern regarding medicines management and diabetes care.

Rating at last inspection:

The service was rated as 'Good' at our last inspection (report published 18 May 2017). The overall rating has changed to 'Requires Improvement'.

Why we inspected:

We conducted a responsive, comprehensive inspection to this service. This means that we brought our planned inspection forward due to concerns that we received of alleged risks to people.

Enforcement:

We found breaches of Regulations at this inspection. Please refer to the end of the full report for further details.

Follow up:

We will continue to monitor the service and inspect within 12 months of the report being published. This is in line with our methodology for services rated as 'Requires improvement.'

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 Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was not always well-led Details are in our Well-led findings below.	**Requires Improvement**

Sunhill 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by the notification of an incident when a person using the service sustained a serious injury. This incident is subject to a safeguarding investigation by the local safeguarding authority [social services] and the Clinical Commissioning Group [CCG] safeguarding nurse at the time of this inspection. The outcomes of the investigation were not known during this inspection process and the case remained active.

The information shared with CQC about the incident indicated potential concerns about the management of risk for diabetes care and wound care management as well as the provider's response times to a person's deteriorating health. This inspection examined those risks.

Inspection team:

The inspection team consisted of a lead inspector and a second inspector. There was also a medicines inspector and a specialist nurse advisor who had expertise in dementia care for older people. The team attended on the first day of inspection. On the second day of the inspection, the lead inspector and the medicines inspector visited the service.

Service and service type:

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

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

Notice of inspection:

This inspection took place on the 12 and 14 February 2019. The first day of inspection was unannounced. The second day of inspection was announced.

What we did:

We reviewed information we had received about the service. This included details about incidents the provider must notify us about by law. We sought feedback from the local authority and health professionals who worked with the service.

Because we brought this inspection forward, the provider was not asked to complete a Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we spoke with people's relatives and professionals and also reviewed:
• Notifications we received from the service
• Twelve people's care records which included risk assessments
• 12 people's medicines records
• Three staff members' recruitment and training records
• Records of accidents, incidents, complaints and compliments
• Audits and quality assurance reports
• Minutes from meetings with staff and people
• We observed activities and the lunch time meal experience for people
• Observed the care of people using the service and spoke with four people's relatives
• Spoke with three members of care staff, the activities coordinator, two trained nurses, the registered care manager, the administrator, the area manager and the provider
• We spoke with West Sussex County Council's [WSCC] social worker and safeguarding adults nurse specialist for the Clinical Commissioning Group [CCG], investigating the current safeguarding concerns.

Following the inspection, we spoke with the nursery school manager to corroborate the information shared with us by the home regarding the experiences of people visiting the day nursery.

Requires Improvement

Is the service safe?

Our findings

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

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. Regulations may or may not have been met.

Assessing risk, safety monitoring and management; Preventing and controlling infection; Using medicines safely; Staffing and recruitment:

• People did not always receive their medicines safely and risks were not always assessed appropriately or well managed.
• Risks to people who were prescribed high risk medicines such as insulin and anticoagulants were not always fully assessed. For example, for people who lived with diabetes, there were no assessments or management plans for action to take if their blood sugar levels became too high. This is known as 'hyperglycaemia.'
• Hyperglycaemia if untreated can lead to serious health conditions.
• One person's care plan and daily records showed that no action was taken on more than one occasion when their blood sugar levels were much higher than was expected for them. The registered manager told us that the person's normal blood sugar range was up to a maximum of 20 millimoles [mmol]. The records showed that the blood sugar recording for them had been recorded above 20mmol regularly. On one occasion this was recorded at 33.3mmols with no action taken to address this by staff. This may have placed the person at risk of harm.
• For one person, we found that the home did not have any stock of their 'as required' medicines which were to be given in the event of an angina attack. This may mean that they could experience distressing symptoms without the 'as required' medicine being available to relieve their symptoms.
• This was addressed with the registered manager who ensured that this medicine was then obtained for them the following day.
• Safe systems of giving prescribed medicines to people were not always followed. We found that when changes had been made to people's medicines that this had been accepted 'verbally' by the registered nurse on duty. Best practice states that changes to people's medicines made by the prescriber also be received in writing to confirm the accuracy of the changes to be made.
• We addressed this with the registered manager who contacted the GP to ask that all future changes to people's medicines were also received in writing.
• Staff members had hand written Medication Administration Records (MARs) for some people. These were not always signed by the member of staff who had written them. Also, a second member of staff had not always checked them as per guidance issued by the National Institute for Clinical Excellence (NICE). This practice placed people at risk of not receiving their medicines as prescribed.
• Some people had been assessed as requiring their medicines to be given to them covertly, that is without their knowledge. Records did not provide sufficient information regarding how or when the medicines were to be given to people covertly. The registered manager was not clear about who had covert medicines authorised and which specific medicines were to be given covertly.

• The electronic care planning system used at the home contained information and timings of when people's medicines had been given to them. However, paper-based MARs were also completed by the registered nurse to record medicines given to people.
• These two parallel systems provided conflicting records for people regarding the timings of medicines given to them. We discussed the care plan and MAR records with the registered manager and the registered provider.
• The records did not provide clarity to show a person had their medicines administered at a certain time. Guidance was not included in people's care plans who were prescribed time sensitive medicines to ensure these medicines were given as prescribed.
• People did not always receive pain relief on an 'as required' basis.
• 'As required' (PRN) protocols did not match the MARs for people. The registered manager told us that people did not have pain relief on an 'as required' basis and said that people had homely remedies instead. We asked to see evidence of when a person had been given a homely remedy for pain in the current cycle of medicines. The registered manager could not find evidence of this.
• People were living with dementia and were not always able to clearly communicate their pain need with staff. Information was not recorded in people's care plans to ensure staff could give 'as required' pain relief medicines consistently.
• We were told that one person experienced significant back pain. We saw the person became distressed and agitated during the inspection. We asked the registered manager if this may have been caused by pain. The person was not able to verbally tell staff if they were in pain due to the fact they were living with advanced dementia. Their care plan did not show this, and they were not offered pain relief during the first day of inspection when they were seen to be distressed. The registered manager confirmed they would explore this to ensure the person received pain relief if it was required.
• Copies of nationally recognised pain assessment tools were held in the treatment room. These tools were used to assess people's pain levels when they may be unable to communicate this to staff. However, these remained blank and had not been completed for people living at the home. Therefore, we could not be assured that people always received pain relief when needed.
• There was a medicines policy in place. However, staff members did not always follow it.
• Medicines audits completed by the registered manager had not been effective and had not identified the shortfalls in medicines management that were identified at this inspection.
• There were not always enough staff to meet people's needs. There was only one trained nurse on duty at each shift throughout the day and night. The registered manager stated this was sufficient nurse cover to give all prescribed medicines to people in a timely way. However, we received concerns from a previous staff member that stated people were not adequately supported by this number of trained nursing staff on each shift.

The provider had failed to ensure that systems, measures and actions taken consistently ensured people were given their medicines when required. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Risks were assessed for people and held within the electronic care planning system. These assessments were limited in personalised content for people. The registered manager said they were planning to improve this information. This is an area that required improvement.
• Staff had access to the electronic records for people via a hand-held device. This enabled them to access useful information about people's needs quickly.
• Accidents and incidents were recorded within the electronic monitoring system which enabled them to be reviewed in one place. The area manager completed audits of all incidents which supported the monitoring of these events and the actions taken to reduce further risks.
• We observed that staff used personal protective equipment [PPE], such as disposable gloves and aprons to

support people from the risks of infection.
• The home was clean and tidy and free of unpleasant odours throughout the inspection.
• Sensor lighting and sensor mats were used to reduce the risks of falling for some people when this was required.
• There were enough care staff. Throughout the inspection we observed care staff responded to people's needs promptly.
• Staff did not appear hurried and had time to sit with people.
• Staff were recruited safely. Appropriate checks were completed which included the Disclosure and Barring [DBS] checks which ensured staff were of good character.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong:

• Despite the fact that staff had received current training to inform them of how to identify and report safeguarding concerns appropriately, some staff were unclear of how to report concerns outside of their immediate management structure.
• However, staff on duty had hand held electronic devices which gave them immediate access to an 'NHS' safeguarding 'App.' This enabled staff to make contact with appropriate external agencies should they need to raise concerns about people's safety. This included adult and children safeguarding concerns.
• Lessons had been learned following some incidents at the home.
• The registered manager had sent notifications to us as they are required to do so by law and demonstrated that appropriate action had been taken to mitigate future risks of a similar nature from reoccurring. For example, in December 2018, one person had left the building unaccompanied. The registered manager had ensured a sensor mat was installed to alert staff if the person attempted to leave unaccompanied in future. This showed that there was learning and positive changes to some practice following incidents.
• Learning had begun following the recent safeguarding concern which remained ongoing at the time of this inspection. The registered manager stated that they had worked to improve systems following the current safeguarding concern for one person. The concern highlighted a lack of staff knowledge or clear understanding of diabetes management. A training course had been booked for staff to attend to improve their awareness of the condition.

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Ensuring consent to care and treatment in line with law and guidance; Assessing people's needs and choices; delivering care in line with standards, guidance and the law:

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• People's needs were not always assessed when their health condition had changed.
• For instance, one person had become less mentally aware over time. The registered manager told us that their mental capacity had started to fluctuate. A person with fluctuating mental capacity may not always be able to have a full understanding or insight of risks to themselves.
• If a person is assessed as having fluctuating capacity, in line with best practice guidance [Mental Capacity Act; Codes of Practice], staff may need to reassess people's decision-making abilities and make 'best interests' decisions if required. This action had not been taken for the person which meant that they may not have given full and informed consent to decisions about their day to day care.
• Records had not been updated regarding the person's mental capacity. There was a mental capacity assessment completed on the 16 October 2018 which indicated the person had the mental capacity to make the decision to move into Sunhill Court Nursing Home. This had not been updated when the persons mental capacity had started to "fluctuate."
• Staff were observed to ask for people's consent before they supported them with planned care needs such as support to eat their meals.
• However, care staff had limited understanding of the MCA and how this may impact upon a person's ability to make informed decisions about their daily care needs and risks to them.
• Evidence of how staff who completed MCA assessments had come to the conclusion that a person may lack the mental capacity to consent to a specific decision lacked detail and clarity.

• Not all restrictions for people, including the use of covert medicines for instance, had always clearly been detailed within DoLS applications.
Despite receiving training in MCA and DoLS practice, staff had a limited understanding of DoLS and MCA procedures.
• The above evidence placed people at risk of not receiving the appropriate support, in their best interests, if they lacked the mental capacity to make informed decisions about their care needs.

The provider had failed to adequately assess or obtain appropriate consent. This is a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• For other people, their physical health needs had been assessed. However, information contained within care plans was not person-centred.
• We could not be assured that people's needs were fully assessed before they moved into the home. For one person the registered manager was unable to provide evidence that their needs had been assessed before they moved into Sunhill Court.
• This meant that the registered manager could not provide assurances that the person's needs could be met fully at the time they were admitted.
• People at the home lived with dementia. People were not always able to verbally tell staff their needs and preferences. The lack of personalised information in their care plans may have made it difficult for agency staff to know and respond to people's needs in their preferred ways.
• However, during the inspection process we observed that staff on duty knew people well and provided personalised care and support.
• Brief MCA assessments had been completed for people for some aspects of their care and treatment. This included an appropriate MCA assessment for the correct use of bed rails.
• One registered nurse on duty on the first day of inspection had received training in this area and demonstrated a good understanding of DoLS.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support:

• A safeguarding adults concern that was in progress at the time of this inspection found that staff had not always followed up with healthcare professionals as needed. There had been a delay with people receiving the support they needed from professionals outside of the home.
• At this inspection we found that people received timely and proactive access to healthcare when they needed it.
• Ten people at the home were diagnosed with diabetes. These people had received routine reviews of their health condition which included 'HBA1c' checks. The checks were completed in the week before the inspection by the visiting community diabetic nurse which showed that relevant professionals were involved in the care of people with diabetes. The HBA1c is a blood test that checks the average range of a person's blood sugars over a period of time.
• People also had access to other external healthcare professionals which included the tissue viability nurses [TVNs] to monitor the condition of people's skin.
• Staff used technology including the internet and emails to review people's skin integrity and any wounds or ulcers present by sending the TVN's photographs of the affected area(s). This was then followed up with a telephone conversation to agree an appropriate treatment plan. Wound care plans clearly reflected the treatment given.
• We spoke with one of the community TVNs before this inspection. They told us that they did not have any concerns about the management of skin integrity for people at the home. They also confirmed that staff at the home contacted them when advice and guidance was needed.

• A community admission avoidance matron said to us, "I can't fault [registered manager]. She will call me if she's concerned. She will ring me or one of the dementia matrons."
• During the second day of our inspection we observed that a GP was visiting people at the home. We were told by the registered manager that the GP visited the home on a regular basis to respond to people's healthcare needs.

Staff support: induction, training, skills and experience:

• Staff received training. However, staff had not received condition specific training which included diabetes or Parkinson's disease awareness. Some nursing staff did not fully understand how to manage people's diabetes, for example, in relation to monitoring their blood sugar levels.
• Following the inspection, the registered manager had booked staff onto diabetes training.
• Staff received supervisions and appraisals on a regular basis. The management team held information to monitor how often staff received supervisions.
• Three registered nurses had received medicines competency checks. These were inconsistent. Not all registered nurses had received these checks and only one registered nurse had been checked in 2016, one in 2018 and one in 2019. The Royal Pharmaceutical Society and Royal College of Nursing guidance 'Professional Guidance on the Administration of Medicines in a Healthcare Setting' dated January 2019 states, 'Those administering medicines are appropriately trained, assessed as competent and meet relevant professional and regulatory standards and guidance.' Therefore, the provider could not be assured that registered nurses were all competent with medicines management.
• The registered manager had recently started to provide regular 'huddle' meetings with staff. These were more 'ad-hoc' meetings with varied topics for discussion. However, these were not provided to all staff to ensure consistency of practice. This was discussed with the registered manager.
Staff support and training was an area that requires improvement.

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

• One person was coughing throughout the first day of this inspection. We asked the registered manager to ensure that they were referred back to Speech and Language Therapy [SaLT] to assess their swallowing needs as a previous SaLT assessment had indicated this needed to be done if their needs changed. The person did not cough throughout the second day of this inspection process. The registered manager stated they would address this and that this was 'usual' for them.
• People were supported to eat a balanced diet and to drink enough fluids.
• Food and fluids consumed by people were monitored daily via the electronic care planning system.
• 'Graze bowls' were used in between meals for people who were able to eat these snacks safely.
• We observed the lunch time meal experience for people.
• A relative told us, "The food is excellent. The chef involved us by asking us what food my relative enjoyed and there's always something there to eat and drink in between meals.
• People's meal choices and preferences were known and respected by staff. One person did not like fish and was given an alternative meal option.
• Care staff could identify people's dietary needs by reviewing these on their hand-held electronic devices which linked to their care plans.
• People were given food in a way that they were able to eat safely. For example, if 'fork mashable' meals were needed, these was provided. Some people needed their drinks to be thickened to reduce the risk of choking. Staff ensured this was done for them.
• Staff gave the level of support needed for people to eat their meals. For some this included assistance to eat their meal. This was done sensitively and patiently. People were not rushed to eat their meals.
• People had access to equipment to support them to eat their food independently when needed. This

included the use of plate guards and adapted cups.

Adapting service, design, decoration to meet people's needs:

• The service was being refurbished at the time of this inspection. Some areas were being 'themed' which we were told supported people living with dementia to orientate themselves around the premises.
• One area had been designed to look like a beach, with a sand pit to provide a sensory experience for people. Another area was designed like a library with what appeared to be shelves of books.
• People's bedrooms that were most recently refurbished had been fitted with sensor lighting and had been imaginatively designed with feature walls. One person's bedroom had a feature wall that made the whole wall appear as though it led to an outdoor woodland area.

Good

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.

People were supported and treated with dignity and respect; and involved as partners in their care.

At our last inspection in April 2017, this key question was rated as 'Good.' At this inspection we found that people continued to receive a caring service.

Ensuring people are well treated and supported; equality and diversity; Supporting people to express their views and be involved in making decisions about their care:

• People received a caring service from kind, compassionate staff who displayed empathy towards people and their relatives.
• One person's relative said, "I know staff are caring because they respond to him when he's sad or angry in a calm and caring way. They make me aware and even the managers will take time to talk with him when he's upset."
• Another person's relative told us, "They [staff] are all loving and caring."
• The specialist nurse inspector commented that there was a, "very caring team" at the home.
• People and/or their representatives continued to be listened to and their views were acted upon.
• People had support from an external advocate as part of their DoLS [Deprivation of Liberty Safeguards] conditions. Staff at the service supported them to access their advocates. This supported people to be involved in decisions about their care. An advocate is a person who acts on behalf of another person from outside of the service.

Respecting and promoting people's privacy, dignity and independence:

• People were valued and encouraged to maintain their independence and to engage in meaningful community based activities which included organised visits to a local children's nursery school.
• Staff showed concern for people's wellbeing. We observed a member of staff who provided very gentle, compassionate support and reassurance to a person who lived with dementia who had become distressed.
• People's privacy was respected and promoted.
• Confidential information was held securely. People's records were stored in locked cabinets in line with data protection legislation.
• People were treated with dignity. Staff addressed people in their preferred ways and knew people individually.
• The activities coordinator took time to know people very well and understood how to support them to engage and communicate in meaningful interactions.
• Relatives could visit the home flexibly. People were supported to receive their visitors in private if they chose to do so. This included quieter areas of the home and people's own bedrooms.
• One person's relative told us, "They [staff] always make me welcome and I visit twice a week, they keep me

up to date with how my mother is doing, they are brilliant."

Good

Is the service responsive?

Our findings

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

People's needs were met through good organisation and delivery.

At our last inspection in April 2017, we rated this key question as 'Good.' At this inspection we found that people continued to receive a responsive service.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; Improving care quality in response to complaints or concerns:

• People received personalised care from care staff who knew them well. Care plans contained personal histories for people.
• At the time of this inspection the registered manager told us they were developing the care plans to contain additional information about people's individual needs.
• Care staff were observed to be aware of the communication needs of people who may have a disability such as a dementia or visual or hearing impairment. This ensured people were treated equally and fairly. This is in line with national guidance of the Accessible Information Standard [AIS].
• People's communication needs were recorded in their care plans. One person's care plan stated, they would put their hand up if they needed support from staff. Care staff communicated clearly with people and regular staff appeared to know people's individual needs and preferences well.
• People and their representatives, where appropriate, were involved in the planning of care. One person's relative told us the registered manager had supported them to better understand their relative's care needs. They said, "She [registered manger] has gone through everything with us with the end of life process."
• People's relatives spoke positively about the care people received.
• One person's relative said, "They [staff] are so caring to my husband. I visit daily and would be lost without their help. It is good to know he is looked after."
• People's social and leisure needs were met in an individualised way.
• Technology was used such as electronic devices to engage people with music of their choice.
• A local children's nursery school had contacted the home to discuss the possibility of older adults being supported to visit and interact with children at the nursery. The home's activities coordinator had visited the children's nursery school before people went there to complete risk assessments. We spoke with the nursery school manager who confirmed this. They told us, "We put a trial period together and on the first occasion [activity coordinator name] came along. She came on her own to do some risk assessments."
• The activities coordinator from the home had facilitated the visits and four people visited the nursery on two occasions. They used the mini bus which had been purchased by the provider at Sunhill Court to transport them.
• We spoke with the manager of the nursery school who told us about the positive benefits to the people as well as to the children who took part in the nursery visits.
• They said that the children called the people, "Nana's and Grandpa's" who visited them and that the children would go home and speak positively about their time spent with the people from Sunhill Court.

• Children's relatives and the relatives of people made positive comments on social media about the experiences of both the children and older people who lived at the home.
• The nursery manager also told us they had observed people from the home thoroughly enjoying their interaction with the children. They saw how they had arrived in a fairly low mood and had returned to the minibus after their visit, "spritely" and "positively talking about their day."
• We observed that staff worked with dedication to support people with complex needs.
• People who lived with dementia were actively supported to participate and engage with various activities in the communal areas of the home.
• One relative told us how the activities coordinator had, "Sat downstairs with him [person] for 40 minutes today." This person was at the end of their lives and being cared for in their room.
• People were not left within their rooms without continual staff presence unless this was based on their personal choice or needs. Staff regularly checked upon and spent time with them.
• People's concerns and complaints were listened to. There was a board in the main communal area which said, 'You said, we did." This contained some of the improvements the service had made from listening to feedback from people and their relatives.
• A suggestion box was placed in the foyer area for people's comments or views to be submitted confidentially if they so wished.
• Complaints were responded to in accordance with the provider's complaints policy and procedure.
• The area manager reviewed compliments and complaints received by the home to ensure these were being addressed and responded to appropriately.

End of life care and support:

• People received care at the end of their lives that was delivered in line with national best practice guidance.
• The registered manager told us that they had completed the 'six steps' end of life care pathway accreditation with a local hospice. but had not yet received their certificate at the time of this inspection.
• One person's relative told us about the care their relative received at the end of their lives at the home. They said, "It's the most amazing place ever [Sunhill Court] and the staff have been absolutely fantastic."
• Clear systems ensured that people who did not wish to be resuscitated when this had been formally agreed with them, or in their best interests, by a medical professional and appropriate others, were known to staff.
• This meant that people could die with dignity. This is known as a 'DNACPR' which stands for Do Not Attempt Cardio Pulmonary Resuscitation. Care staff knew which people had DNACPRs so that people's wishes were known and respected.
• DNACPRs were clearly highlighted within the new electronic care planning system which was accessible for care staff via their hand-held devices that were linked to this system.

Requires Improvement

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.

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Continuous learning and improving care; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

• Systems and processes did not always ensure robust oversight which led to discrepancies between electronic and paper based records.
• For example, the registered manager completed monthly medicines audits. One audit identified that a person received their medicines covertly. However, other records did not reflect this. The medicines audit did not identify the shortfalls in the management of medicines that we identified during this inspection. The medicines audit was not robust.
• Policies did not always reflect practice. For example, medicines management practices carried out by nursing staff were not always reflected within the organisation's medicines policy.
• The area manager completed weekly themed audits of the service on a rotational basis. Reports were provided to the registered manager with actions for them to complete following the audits. However, these had not always been effective and had not identified the medicines or diabetes management concerns, nor had they highlighted the shortfall in relation to mental capacity assessments and a lack of staff training and competencies in certain areas of practice such as diabetes management, that were identified during this inspection.

The provider had failed to ensure that systems and processes were robust to ensure the quality and safety of the service provided. This is a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• Despite this, the management team and provider were passionate and dedicated to the service and willing to listen, learn and adopt a continuous improvement approach.
• There was an open and transparent approach from both the registered manager and registered provider of the home.
• Audit systems and processes provided some additional oversight of accidents and incidents and other key aspects of daily care provided at the service.

• The registered manager sent notifications to CQC when specific incidents occurred as they were required to do so by law.
• The Duty of Candour Regulation was understood.
• A person's representative had been contacted in accordance with the Duty of Candour Regulation

requirements following a serious incident. This was being investigated under the local authority's safeguarding adults powers at the time of this inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others:

• People's views of the service were captured, but not analysed or responded to as needed. One person's relative had provided a low score for the food at the service. This had not been followed up with them satisfactorily to establish what their concerns were or how improvements could be implemented.
• Meetings took place with the nursing staff but there was no evidence of care staff meetings, other than the 'huddle' 'ad hoc' meetings, which not all staff attended. This approach did not provide a consistent method for staff to receive and give feedback about the service.
• The registered manager worked with health and social care professionals outside of the organisation. However, there had been delays with the registered manager following up information and outcomes for people with some health professionals. They had recognised that this was an area that required improvement and were now aware that they needed to more proactively follow up professionals' recommendations.
• Despite this, health professionals and relatives of people who lived at the home spoke highly of the registered manager.
• The specialist nurse inspector reported that the home had a, "Strong manager who leads a very caring and responsive team."
• The home's local community admission avoidance matron said, "She [registered manager] will call me if she's concerned. She will ring me or one of the dementia matrons. She's very good on planning end of life care. I think the way she discusses it with the family is good, she's so kind and empathetic."
• People's relatives collectively stated they were happy with the care received and were positive about their relative living at Sunhill Court Nursing Home.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to adequately assess or obtain appropriate consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that systems, measures and actions taken had adequately protected people from the risks of avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that systems and processes were robust to ensure the quality and safety of the service provided.