Eldercare (Halifax) Limited

Sun Woodhouse Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced focused inspection of Sun Woodhouse Care Home (known to the people who live and work there as 'Sun Woodhouse') on 03 July 2017. At the previous comprehensive inspection on 16 and 17 May 2017 we found continuous breaches of regulation 11 (consent) and regulation 12 (safe care and treatment). After that inspection, the provider told us what they would do to meet legal requirements in relation to these breaches. The focused inspection on 03 July 2017 was carried out to confirm the breaches of regulation had been resolved.

This report therefore only covers our findings in relation to these aspects. You can read the report from our last comprehensive inspection in May 2017, by selecting the 'all reports' link for 'Sun Woodhouse Care Home' on our website at www.cqc.org.uk.

Sun Woodhouse is a residential care home registered for up to 24 people. It consists of one building with two floors. There were 15 people living at the home at the time of this inspection; three of these people were using the service for respite care.

At our last comprehensive inspection in May 2017, Sun Woodhouse was rated as Requires Improvement overall, as it was judged to be Requires Improvement in the key questions of Safe, Effective and Well-led, and, Good in Caring and Responsive. As a result of this rating the home was taken out of special measures.

At this inspection in July 2017 we identified continuous breaches of regulation 11 (consent) and regulation 12 (safe care and treatment). We also identified a new breach of regulation 17 (good governance).

The home had a registered manager. A registered manager is a person who has registered with CQC to manage the service. Like 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.

Carpeting in a communal area still presented a trip hazard. Since the last inspection in May 2017 it had been re-fitted and glued down, but had come loose again in the two weeks prior to this inspection in July 2017. Following this inspection, the carpet has been replaced.

Records showed hot water in one hand-basin was found to exceed the maximum recommended temperature 10 days prior to this inspection and appropriate action had not been taken to fix it. We also found regular checks on the temperature of hot water in baths and showers were not made.

Records to evidence people's topical creams were applied as prescribed were now in place.

Mental Capacity Act 2005 (MCA) assessments and best interest decisions for people thought to lack capacity were still not in place. Work to assess people's capacity in accordance with the MCA had not commenced

after the last inspection as outlined in the action plan provided by the registered provider. Decision-specific MCA assessments and best interest decisions were put in place for the people who needed them within three days of this inspection.

The registered manager and registered provider had failed to resolve continuous breaches of the regulations identified at previous inspections. They also lacked oversight of safety checks at the home.

People told us they thought the service was well managed and gave positive feedback about the atmosphere at the home.

A range of audits were in place, although this inspection highlighted they were not always effective. The home had an action plan where all actions were logged and progress recorded.

Staff meetings and meetings for residents and relatives were held regularly and provided opportunities for attendees to feedback to managers.

Statutory notifications had been made and the ratings of the last CQC inspection were displayed at the home and on the provider's website, as is required by the regulations.

We found continuing breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. We are in the process of taking enforcement action against the registered provider. Details will be added to this report when the process has concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

A carpet identified as unsafe at the last inspection in May 2017 was still unsafe at this inspection.

We identified further concerns around the monitoring of hot water temperatures.

Records for the application of people's prescribed creams were now robust.

Is the service effective?

Requires Improvement

The service was not always effective.

The home was still not compliant with the Mental Capacity Act (2005).

Capacity assessments for people known to have problems making decisions had not been started.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Breaches of regulation identified at previous inspections had not been resolved. The registered manager and registered provider lacked oversight of safety checks.

People gave us positive feedback about the atmosphere at the home. They all said they were happy to be there.

The culture at the home and morale of its staff was still much improved. Feedback about the registered manager was good.

Sun Woodhouse Care Home

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 03 July 2017 and was unannounced. The inspection was carried out by one adult social care inspector.

We did not ask the provider to update their Provider Information Return (PIR) prior to this inspection. 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.

As part of the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Kirklees, the local authority safeguarding team and the Clinical Commissioning Group. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They did not share any concerns with us.

During the inspection we spoke with three people who used the service, two members of care staff, the registered manager and the area manager.

As part of the inspection we looked at selected care plans from seven people's care files. We also inspected three people's topical medicines administration records, accident and incident records, and audit and monitoring records for the home.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in May 2017 we found a continuous breach of the regulation relating to safe care and treatment, as a carpet in the downstairs communal lounge of the home was ridged and posed a trip hazard. This was the result of steam cleaning a few weeks earlier. Accident records showed none of the people at the home had fallen in the lounge since the carpet was steam cleaned, but we asked the registered provider to make sure the carpet was made safe.

Shortly after the inspection, the area manager informed us the carpet had been re-fitted and glued down to make it safe, although during this process they had identified that steam cleaning had damaged the carpet such that it needed to be replaced.

At this inspection on 03 July 2017 we found the original carpet was still in place and it was still ridged, although not to the same extent it had been in May 2017. When we asked three people if they had experienced problems mobilising over the carpet, all said they had not noticed it and did not think the carpet was unsafe. The registered manager said the carpet had started to lift again due to vacuuming about two weeks prior to this inspection. Although records showed there had been no falls during this time, the ridged carpet still presented a trip hazard, thereby leaving the people at risk of falls.

This was a continuous breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as measures had not been taken to ensure people were safe.

We received photographic evidence to show the carpet had been replaced three days after this inspection.

At the last inspection in May 2017 we found a continuous breach of the regulation relating to safe care and treatment as hot water temperatures in people's bedrooms and in shared bath and shower rooms at times exceeded maximum temperatures recommended by the Health and Safety Executive (HSE) in health and social care settings. HSE guidance states hot water should not exceed 44°C where there is the possibility for full body immersion (bath and shower rooms) or where it can be accessed by vulnerable people. The maintenance worker had not adjusted thermal mixing valves when water temperatures above 44°C were recorded, although this was corrected on the day of inspection.

At this inspection on 03 July 2017 we found the temperature of one hand-basin in a shower room near the main downstairs communal area had been recorded as 48.8°C ten days earlier and appropriate action had not been taken. The registered manager and area manager were not aware of the problem. The hot water valve for the hand-basin was located and adjusted the same day by a plumber and the maintenance worker was shown where the valve was for future reference.

Whilst investigating the shower room and comparing it to records made, we identified the maintenance worker was not regularly testing and recording the temperature of baths and showers in the home; they were just testing hand-basin water temperatures. The registered manager and area manager were not aware of this, even though records had been revised after the last inspection in May 2017. Care workers

tested the water temperature before people used baths and showers using thermometers located in bath and shower rooms, however, records for this were not always kept. Those that had been made showed temperatures had not exceeded 44°C. People we spoke with told us they had never had a problem with water being too hot at the home and records showed no one had been scalded. After the inspection the registered manager told us water temperature records for people's use of the bath and showers had been moved to so they would be more accessible to care workers and their completion would be checked via audit.

During the day of inspection the water temperatures of all baths and showers were tested and found to be less than 44°C. The registered manager discussed the purpose and importance of water temperature testing with the maintenance worker to try and prevent issues occurring again in the future. The registered manager also said she would update her audits and share them with other registered managers for the provider to make sure she, and other managers, did not make the same mistake in future. Three days after the inspection the registered manager provided updated recording sheets which included all hot water outlets in the home for the maintenance worker to use going forward.

Concerns around safety testing and recording at the home were a continuous breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as measures had not been taken to ensure people were safe.

At the last inspection in May 2017 the home could not evidence people's topical creams were applied as prescribed because records were not kept by care workers. At this inspection we found this had much improved. A new system was in place which the registered manager and senior care workers had oversight of. Care workers could explain the system to us and records we checked had been completed properly. This meant the system for the recording of people's prescribed creams was now robust.

Requires Improvement

Is the service effective?

Our findings

At the inspection in January 2017 we identified the home was not fully compliant with the Mental Capacity Act 2005 (MCA), which caused a breach of the regulation relating to consent. This was because the capacity of people known to have problems making decisions to consent to their care and treatment had not been assessed. At the inspection in May 2017 we found no improvement. This was because the registered manager had focused efforts on improving risk assessments and care plans and had not managed to start work on MCA documentation. After the inspection the registered provider gave assurances the work to complete assessments for people identified as lacking capacity would start immediately. This included writing to each person's relatives to ask if they had Lasting Power of Attorney (LPA) for their family member's finances and/or health and welfare, and to supply evidence if so.

At this inspection in July 2017 we checked again to see if MCA assessments and best interest decisions were now in place for people known to have problems making decisions. We found they were still not in place.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found people who needed DoLS authorisations had them in place and none we sampled contained additional conditions for the registered provider to abide by.

Records showed apart from assessments of capacity relating to DoLS applications, assessments of capacity to consent to other aspects of care and treatment for those known to have difficulty making decisions were still not in place. Letters asking relatives for evidence of LPA had also not been sent. The area manager had provided a training session for the registered manager and senior care workers on how to complete the documentation correctly and we found staff knowledge of the process was good. The registered manager showed us one example she had put in place for a person relating to decisions around end of life care; it was thorough, had involved the person and their relatives, and followed the correct process. The example was to guide senior care workers when completing MCA assessments and best interest decisions for other people. The registered manager told us one care worker who worked a day a week on a supernumerary basis to complete documentation had been tasked with other work since the last inspection, so assessments had not started as planned. The registered manager said work had been due to commence on 04 July 2017, the week of this inspection.

We saw people who had mental capacity or had variable capacity to make decisions had memory and understanding care plans which described what support (if any) they needed to make decisions. We checked the care files of three people who had mental capacity and saw they had signed the majority of their care plans, thereby evidencing they had been asked for consent. People we spoke with told us they made their own decisions and staff did not tell them what to do. One person said, "No one tells me what to do – I'm too old for that." A second person told us they felt confident to say whatever they wanted to the staff, commenting, "If they don't like it, they can lump it." Our observations showed people were offered choices by staff and supported to make their own decisions if they could.

Once again we found no evidence people were being restricted or that decisions had been made for people which were not in their best interests, however, the repeated failure to comply fully with the MCA was a continuous breach of Regulation 11 (1) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We received copies of MCA assessments and best interest decisions for the three people found to lack capacity to consent to their care and treatment, within three days of this inspection. Each assessment and best interest decision was decision-specific and had involved the person and their relatives, as well as staff who knew the person well as an individual. Discussions had also been held with people known to have variable capacity to make decisions; each person was able to consent to the care and treatment they received and their care plans were updated accordingly.

Requires Improvement

Is the service well-led?

Our findings

At this inspection we found continuous breaches of regulations relating to safe care and treatment and consent. The registered manager and area manager had not identified the water temperature of baths and showers was not monitored. The risk management issue in relation to the carpet which posed a trip hazard had not been resolved in an effective or timely way. Resolving the breach of regulation relating to the lack of compliance with the Mental Capacity Act 2005 had not been prioritised, so other work had been done first.

These continuous concerns demonstrated a breach of Regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

As at the last inspection in May 2017, the registered manager, who was a peripatetic manager for the provider, reiterated their intention to stay at Sun Woodhouse until improvements had been made and sustained. The area manager for the home was the same as at the last inspection thereby providing continuity. The registered manager told us they felt supported by the registered provider and said of the area manager, "[They] know how things should be done. I like that", and added, "[They're] strict and straight down the line. Very professional."

Under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015, registered providers have a legal duty to display the ratings of CQC inspections prominently on their websites and in their care homes. At this inspection we saw the ratings from the last inspection were displayed in the home's foyer and on the provider's website. This meant the provider complied with the regulations. Registered providers are also required to report specific incidents to CQC. Notifiable incidents include safeguarding concerns, police call-outs and serious injuries. Records showed all notifications had been made as required.

A range of audits were in place, most of which were completed on a monthly basis. We checked audits of medicines, mattresses, pressure ulcers, accidents and incidents, bedrails and care plans. Action plans had been put in place when issues had been identified and we saw these actions were signed off when complete.

An action plan had been provided to the service following a recent infection control inspection. The registered manager showed us how actions from this had been transferred across from this to the home's action plan and were either complete or in progress. The home's main action plan included all actions identified in the last Care Quality Commission (CQC) inspection, actions arising from internal audits and those identified during provider visits. The area manager had completed a provider visit since the last inspection; records showed it had involved speaking to people, an examination of care records, audits, and an inspection of the premises. We went through the home's main action plan with the registered manager and she explained the improvements made and those which were planned. She updated the action plan every Friday and sent to the area manager so the registered provider was kept up to date.

The registered manager said the main challenges at the home had been, "Attention to detail", and told us, "We need to keep checking the paperwork, we need to keep on it." They said their goal was to improve the

CQC rating of the home to Good and described accessing CQC reports for similar services to get ideas for improvement. The registered manager also planned to improve staff morale further with an 'employee of the month' award and passed on positive feedback in order to motivate staff. The registered manager described sharing positive feedback with staff from one of the home's stakeholders; they told us, "I said you've done that, not me."

People we spoke with told us Sun Woodhouse was well managed. One person said, "I think they do very well", and a second person told us, "It's very well managed." A third person said they also thought the home was well managed and described the registered manager as, "A nice lady."

People were also complimentary about the atmosphere at Sun Woodhouse. Comments included, "It's pretty nice, isn't it?", "I wouldn't live anywhere else, it couldn't be more friendly", "It's nice here, I wouldn't want to go anywhere else", and, "It's homely here."

Staff we spoke with told us the culture of the home remained good and staff morale much improved. Feedback about the registered manager was also positive. One care worker said, "She's absolutely brilliant. I love her. She's always there. She looks after residents as well as your needs", and a second told us, "She's a very good manager. She guides people (staff) in the right way. She's a good role model." The registered manager told us, "We've got some great new staff. The culture is so much better now."

A full staff meeting was due to be held two days after this inspection. Care workers said they found the meetings useful and were asked for their ideas and feedback by the registered manager. One care worker told us, "Everyone's views are put together, we make decisions from there. It's nice to do it like that", and a second said, "She (the registered manager) always asks if we're OK." This meant the registered manager fostered a supportive and open culture at the home.

A residents' and relatives' meeting had been planned for the week before the inspection, but had to be rescheduled as relatives who regularly attended could not come and people at the home also declined to attend. People we spoke with said they were invited to attend the meetings. One person told us, "We have residents' meetings. We talk about what we'd like. They ask if we're satisfied with the home." A second person said, "They have the meetings but I'm not bothered." This meant people had opportunities to feedback about the service, if they chose to.