Sunbury Nursing Homes Limited

Sunbury Nursing Homes

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 16 March 2016.

Sunbury Nursing Home is registered to provide accommodation with nursing care for up to 81 people. At the time of our visit, there were 56 older people living at the home. Some of the people who live at the home are living with dementia, whilst others had complex needs as a result from living with Parkinson's disease, stroke and epilepsy. We noted that an application to change their registration to a maximum of 57 instead of 81 people being accommodated had been approved on 28 April 2016.

The service offers 6 "step-down" beds, which is an interim accommodation arrangement with the local hospital and social services to provide care between the discharge from hospital and people moving back to their own home or elsewhere. We noted that the "step-down" bed contract ended on 30th April 2016 and all places are now occupied by long term residents. The service also provided end of life care. The accommodation is provided over three floors that were accessible by stairs and a lift.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission 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.

Staff knew what to do to support people to make decisions. The registered manager and staff understood their role and responsibilities with regards to the Mental Capacity Act and Deprivation of Liberty Safeguard. However not everyone who lacked capacity was fully assessed and if necessary DoLS application completed and submitted to the local authority in accordance with current legislation.

Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place. There were systems and processes in place to protect people from harm.

There was sufficient numbers of staff deployed who had the necessary skills and knowledge to meet people's needs. Recruitment practices were safe and relevant checks had been completed before staff started work. Staff worked within best practice guidelines to ensure people's care and support promoted well-being and independence.

Medicines were administered, managed, stored and disposed of safely. Any changes to people's medicines were prescribed by the person's GP and administered appropriately.

Fire safety arrangements and risk assessments for the environment were in place to help keep people safe. The service had a business contingency plan that identified how the home would function in the event of an emergency such as fire, adverse weather conditions, flooding or power cuts.

Staff had the skills and experience which were necessary to carry out their role. Staff had received appropriate support that promoted their development. The staff team were knowledgeable about people's care needs. People told us they felt supported and staff knew what they were doing.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk. People were supported to have access to healthcare services and were involved in the regular monitoring of their health. The provider worked effectively with healthcare professionals and was pro-active in referring people for assessment or treatment.

Staff involved and treated people with compassion, kindness, dignity and respect. People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's privacy and dignity were respected and promoted when personal care was undertaken.

People received comfortable and dignified end of life care. The service obtained guidance and best practice techniques from professional bodies to assist them in providing good quality end of life care.

People's needs were assessed when they entered the home and on a continuous basis to reflect changings in their needs.

People were encouraged to voice their concerns or complaints about the home and there were different ways for their voice to be heard. Suggestions, concerns and complaints were used as an opportunity to learn and improve the service.

People had access to activities that were important and relevant to them. People were protected from social isolation through systems the service had in place. There were a range of activities available within the home and community.

The provider actively sought, encouraged and supported people's involvement in the improvement of the service.

People's care and welfare was monitored regularly to ensure their needs were met within a safe environment. The provider had systems in place to regularly assess and monitor the quality of the care provided.

People told us the staff were friendly and management were always approachable. Staff were encouraged to contribute to the improvement of the service. Staff told us they would report any concerns to their manager. Staff felt that management were very supportive.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were cared for and supported by a consistent staff team to keep people safe and meet their individual needs.

People had risk assessments based on their individual care and support needs which were reviewed on a regular basis.

Medicines were managed, administered, stored and disposed of safely.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff understood and knew how to apply legislation that supported people to consent to treatment. Where restrictions were in place, this was not always in line with appropriate guidelines.

People's care and support promoted a good quality of life based on good practice guidance. People were supported to have access to healthcare services.

People were supported by staff that had the necessary skills and knowledge to meet their assessed needs.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk.

Is the service caring?

Good

The service was caring.

Staff treated people with compassion, kindness, dignity and respect. People's privacy were respected and promoted.

Staff were cheerful and caring towards people.

People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes.

People's relatives and friends were able to visit when they wished.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed when they entered the home and on a continuous basis. Information regarding people's treatment, care and support was reviewed regularly.

People were protected from social isolation and there were a range of activities available within the home and community.

People were encouraged to voice their concerns or complaints about the service they received.

Is the service well-led?

Good

The service was well- led.

The provider had systems in place to regularly assess and monitor the quality of care the home provided.

The provider actively sought, encouraged and supported people's involvement in the improvement of the service.

People told us the staff were friendly, supportive and management were always visible and approachable.

Sunbury Nursing Homes

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 16 March 2016 and it was unannounced.

The inspection was conducted by two inspectors and a specialist advisor who reviewed the clinical management of the home.

We spoke to nine people living at the home, six relatives, eight staff including nurses, care workers, housekeeping staff, the registered manager and registered providers. We observed care and support in communal areas; looked at 12 bedrooms with the agreement of the relevant person. We looked at ten care records, risk assessments, medicines administration records, accident and incident records, minutes of meetings, complaints records, policies and procedures and external and internal audits.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

Before the inspection we gathered information about the home by contacting the local authority safeguarding and quality assurance team. We also contacted four healthcare and three social care professionals who were involved with the home. We reviewed records we held which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the home is required to send us by law.

Our previous inspection of the service was on 16 June 2014, where no concerns were identified.

Good

Is the service safe?

Our findings

Relatives told us they felt their family members were very safe at the home and with the staff who provided care and support.

Staff knew what to do if they suspected any abuse. A member of staff told us, "We know people, so if there was anything wrong we would report it to sister." The service had the most recent local authority multi-agency safeguarding policy as well as current company policies on safeguarding adults. This provided staff with guidance about what to do in the event of suspected abuse. Staff confirmed that they had received safeguarding training within the last year. Information on identifying abuse and the action that should be taken was also freely available for people to look at through posters on display throughout the home. In addition, people were provided with guidance in a picture format about what to do if they suspected abuse was taking place.

Risks to people were managed safely and in accordance with their assessed needs. Risk assessments and any healthcare issues that arose were discussed with the involvement of a relative, social or health care professionals such as GP, hospice care staff or speech and language therapist. Staff were knowledgeable about people's needs, and what techniques to use when people were distressed or at risk of harm. Risk assessments clearly detailed the support needs, views, wishes, likes, dislikes and routines of people. Risk assessments and protocols identified the level of concern, risks and how to manage the risks. For example where people had been identified as high risk of malnutrition or at risk of injuries they had risk assessments in place which gave staff guidance about how to support them safely. This information enabled care and treatment to be planned in accordance to people's needs.

Where people had mobility needs or were susceptible to falls, information was recorded to help staff take action to minimise these risks. People had access to bathrooms that had been adapted to meet their needs; people had specialist equipment such as wheelchairs, sensory mats, specialist beds or bathing aids to use whilst having a bath or shower. All communal areas, stairs and hall ways were free from obstacles which may present an environmental risk.

Fire safety arrangements and risk assessments for the environment were in place to keep people safe. Each person had a personalised emergency evacuation plan that was regularly reviewed. This provided staff with information on how to support people in the event of an evacuation. A business contingency plan was in place; staff had a clear understanding of what to do in the event of an emergency such as fire, adverse weather conditions, power cuts or flooding. The provider had identified alternative locations which would be used if the home was unable to be used. This would minimise the impact to people if emergencies occurred.

Entry to the home was through a bell system managed by staff. We saw a book that recorded all visitors to the home. The entrance to the garden was secure through a locked gate. There were arrangements in place for the security of the home and people who lived there.

There was a staff recruitment and selection policy in place and was being followed. Staff records contained an application form which recorded their employment and training history, provided proof of identification and contact details for references. There were gaps in employment history in three out of the five files we reviewed. After the inspection the provider provided information about people's employment history and the checks they had conducted on their recruitment records. There was current information on people's files of their eligibility to work in the UK. The registered provider conducted checks to ensure that staff were of good character. Staff confirmed they were not allowed to commence employment until satisfactory Disclosure and Barring System (DBS) check and references had been obtained. DBS checks identify if prospective staff had a criminal record or were barred from working with vulnerable people.

There were sufficient numbers of staff deployed to keep people safe. A relative told us, "Yes there is enough staff and they are consistent. They know me and I know them." Another relative told us, "[Family member] never has to wait, they are so good and they know her so well." The consistent staff team were able to build up a rapport with people who lived at the home. This enabled staff to acquire an understanding of people's care and support needs. The registered manager informed us that staffing levels were determined based on people's assessed needs, if changes in people's needs occurred then staffing levels would be reviewed. This included, supporting people to attend appointments and activities in the local community.

The registered manager told us that were always a minimum of 2 trained nurses on duty who provided 24 hour care and support. During the day staffing levels ranged from 15 to 20 carers on duty depending on the time of day. From 10am and 2pm there was 20 carers on duty. From 7.30pm staffing levels were reduced to 6. There was also a nursing manager on duty who was an additional resource that could be used when necessary. The registered manager was also a trained nurse. The service also employed auxiliary staff that covered kitchen, pantry, housekeeping and laundry duties; they also employed a part-time activities co-ordinator. We reviewed the staffing rota and saw that additional duties had been added. The registered manager was proud of the fact they do not use agency staff. She told us, "We never have agency staff. We have enough staff and we cover for each other." We noted on the day of our visit, that people's needs were met promptly.

Medicines were administered by competent staff. Only staff who had attended training in the safe management of medicines were authorised to administer medicines to people. Staff attended regular refresher training in this area and after completing this training, the registered manager observed staff administering medicines to assess their competency before they were authorised to do this without supervision. When staff administered medicines to people, they explained the medicine to them and why they needed to take it. Staff waited patiently until the person had taken their medicines. Staff used a clean plastic spoon when administering tablets and capsules to people this helped people to swallow them with ease.

A medicines profile had been completed for each person, and any allergies to medicines recorded so that staff knew which medicines people received. The medicines administration records (MAR) were accurate and contained no gaps or errors. A photograph of each person was on their MAR to ensure that staff were giving the medicine to the correct person. There was guidance for staff about the recording of medicines if a person was away from the home or if they refused to take their medicine. All medicines coming into the home were recorded and medicines returned for disposal were recorded in a register. Medicines were checked at each handover and these checks were recorded. Any changes to people's medicines were verified and prescribed by the person's GP.

The storage and administration of all drugs were in accordance with National Institute for Health and Care Excellence (NICE) guidelines and the requirements of the Misuse of drugs (Safe Custody) Regulations 1973.

There were written individual PRN [medicines to be taken as required] protocols for each medicine that people took. These provided information to staff about the person taking the medicine, the type of medicine, maximum dose, the reason for taking the medicine and any possible side effects to be aware of. This demonstrated that staff were administering medicines in line with best practice techniques and current guidelines.

Requires Improvement

Is the service effective?

Our findings

People and relatives spoke highly of the staff working at the home. People were supported by competent staff who provided individualised care and support to promote a good quality of life. They felt that they were well trained and had sufficient knowledge to keep people safe. A person told us, "Staff know how to help me." A relative told us, "They really care and look after her so well." Another relative told us, "I think the staff are suitably trained."

Staff had an understanding of their responsibilities under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. People should be enabled to make decisions themselves and where this was not possible any decisions made on their behalf should be made in their best interests.

Staff obtained consent prior to support being given, we observed that staff checked with people that they were happy with support being provided on a regular basis and attempted to gain their consent. During our inspection we observed staff seeking people's agreement before supporting them and then waiting for a response before acting on their wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them. They repeated questions if necessary in order to be satisfied that the person understood the options available. Where people declined assistance or choices offered, staff respected these decisions.

Where people lacked capacity their rights were not fully protected and best practices were not being followed in accordance with the MCA. The registered manager informed us that at least half of the people living at the home did not have capacity to make decisions. Where important decisions needed to be made there had not been a full mental capacity assessment completed to see if people could make the decision for themselves. This would include information about day to day decisions such as what to wear or eat, through to more serious or complex decisions, about, where to live, whether to have surgery or how to manage finances or property. For example where the registered manager told us that X lacked capacity there was not a MCA for consent to care, managing finances or moving and handling. Some people had appointed one or more people to help them make decisions or to make decisions on their behalf. Although there were documentation was in place about who was able to make decisions on their behalf, there was no information recorded about the process of how this decision was made.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm, and are the least restrictive option. Some people had been assessed to ascertain whether a DoLS application was necessary, these were completed and submitted to the local authority. Whereas other people who had similar circumstances had not been assessed and thus a DoLS applications had not been completed or submitted. This would include people who used bed rails or a wheelchair belt. Although bed rails or wheelchair belts were used to prevent people from falling, it could

also restrict people's freedom.

Failure to gain appropriate consent in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager ensured staff had the skills and experience which were necessary to carry out their responsibilities through regular training and supervision. All new staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role. Sickness and holidays were covered by existing staff within the home as they were knowledgeable about people and understood their individual needs.

Staff confirmed that staff had received training and that they had sufficient knowledge to enable them to carry out their role safely and effectively. Staff received mandatory training such as safeguarding adults; dementia awareness; health and safety and infection prevention and control and Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The registered manager verified staff's clinical qualifications and membership to professional bodies were up to date.

Staff had received support that promoted their professional development. Staff told us they had regular meetings with their line manager to discuss their work and performance. A member of staff said, "The staff team is great and the sisters (head of nurses) are so supportive." The registered manager confirmed that regular supervision and annual appraisals took place with staff to discuss issues and development needs. We reviewed the provider's records which reflected what staff had told us. Management observed staff in practice and any observations were discussed with staff, this was to review the quality of care delivered.

People told us about the food at the home. One person told us, "I like the food." A relative told us, "The food here is amazing. So much so I have a Sunday roast meal here." The chef prepared and cooked all of the meals in the home. People were involved in the consultation about the choice of menu for breakfast, lunch and tea. There was a choice of nutritious food and drink available throughout the day; an alternative option was available if people did not like what was on offer.

Lunchtime was observed as a social occasion. People were able to choose who they sat with and some people enjoyed their lunch together in the dining room, communal lounges or in their room. We observed people were provided with pureed meals, in accordance with their care plan, to reduce the risks of choking. We observed the meals were well presented. People had their dietary needs assessed and specific care records had been developed in relation to this. Where people needed assistance with eating or had special dietary requirements, information and guidelines were recorded to ensure their needs were met. Some people required products to be added to their food and drink to enable them to swallow without harm and instructions were given to staff regarding the dosage and consistency required.

We saw that food and fluid charts were completed for people who needed their nutritional intake monitored. Staff had records of people's individuals requirements in relation to their allergies, likes and dislikes and if people required softer food that was easier to swallow. Staff confirmed that a dietician or speech and language therapy team were involved with people who had special dietary requirements.

People had access to healthcare professionals such as GP's, nurse specialists such as tissue viability (manages and treats people's wounds), incontinence, community psychiatric and palliative care (manages pain and other distressing symptoms for incurable or terminal illnesses) nurses, occupational therapist, dieticians, physiotherapists, speech and a language therapist and social care professionals. A person told us,

"I see the GP when I need to." A healthcare professional who is involved with the home told us, "The sisters (head of nurses) are incredibly caring and knowledgeable. They follow all recommendations given and regularly make appropriate referrals regarding people they are concerned about." We saw from care records that if people's needs had changed, staff had obtained guidance or advice from the person's doctor or other healthcare professionals. People were supported by staff or relatives to attend their health appointments. Outcomes of people's visits to healthcare professionals were recorded in their care records. Staff were given clear guidance from healthcare professionals about people's care needs and what they needed to do to support them.

It was easy for people living with dementia to find their rooms or their way around the home. Staff used different visual aids to help people orientate around the home. Each wing of the home had a different colour scheme, toilet seats were different colours to the toilet basin these helped people living with dementia or sensory impairment to be able to identify items. People's bedrooms were personalised with pictures, photographs and items of religious sentiment and personal interest.

Good

Is the service caring?

Our findings

Staff were kind and caring. The atmosphere in the home was calm and relaxed during our inspection. Staff showed kindness to people and interacted with them in a positive and proactive way. People were happy and laughing whilst enjoying being in the company of staff. A person told us, "I like the Home. The staff are not far short of excellent." Another person told us, "They are amazing." A relative told us, "They are wonderful." Another relative told us, "My [family member] is very well looked after; they are a lovely bunch of staff."

A person told us, "I can get up when you want to." People were able to make choices about when to get up in the morning, what to eat, what to wear and activities they would like to participate in, so they could maintain their independence. People were able to personalise their room with their own furniture and personal items so that they were surrounded by things that were familiar to them. People had the right to refuse treatment or care and this information was recorded in their care plans. Guidance was also given to staff about what to do in these situations. Staff also ensured where people were anxious about treatment that they liaised with specialists who had experience of working with frail people to ease the transition from refusal to having treatment.

Staff knew about the people they supported. A relative told us, "They know my [family member]; they are very patient with them when dealing with their medicines, because they have good and bad days." They were able to talk about people, their likes, dislikes and interests and the care and support they needed. There was detailed information in care records that highlighted people's personal preferences, and also what constituted as a good or bad day for people, so that staff would know what people needed from them. Information was recorded in people's plans about the way they would like to be spoken to and how they would react to questions or situations. We saw good examples of person centred care. During the inspection we observed people's behaviour and how staff responded to help them calm down. Staff knew people's personal and social needs and preferences from reading their care records and getting to know them. Care records were reviewed on a regular basis or when care needs changed.

Information about people's care and support needs was made available to hospital staff if they required hospitalisation. This enabled hospital staff to know important things about people's medicines, allergies, medical history, mental and physical needs and how to keep them safe.

Staff approached people with kindness and compassion. A relative told us, "Everyone is treated brilliantly." We saw that staff treated people with dignity and respect. Personal care was provided in private. Staff called people by their preferred names. Staff interacted with people throughout the day. For example when attending activities in the home, helping them eat and drink, and watching television, at each stage they checked that the person was happy with what was being done. Staff spoke to people in a respectful and friendly manner. A healthcare professional told us, "I can tell that the staff care about the people living here and have only ever seen them treated with dignity and respect. For example, if I am seeing a patient I often get interrupted by HCA's (Health Care Assistant) coming in to check on the patient, asking if they need anything."

People were involved in making decisions about their care. A relative told us, "I know who to speak to about her care as they can't speak and I know her better, I am involved in her care plans." Another relative told us, "I am totally involved in my [family member]'s care." We observed that when staff asked people questions, they were given time to respond. For example, when being offered drinks. Staff did not rush people for a response, nor did they make the choice for the person. Relatives, health and social care professionals were involved in individual's care planning. Staff were knowledgeable about how to support each person in ways that were right for them and how they were involved in their care.

People were protected from social isolation with the activities, interests and hobbies they were involved with. A relative told us, "I come here every day and spend hours with my [family member], the staff are ok with this, there has never been an issue." Relatives and friends were encouraged to visit and maintain relationships with people. Religious services were held in the home and these were open to those who wished to attend. People were able to practice their religious beliefs ranging from having items of religious sentiment, praying, to the omission of items such as a television in their room. This demonstrated that care and support was provided with due regard for people's religious persuasion.

People received comfortable and dignified end of life care. A healthcare professional told us, "One of my patients died in the home last year and I feel that the staff ensured that they had a dignified and peaceful death. He was on oral tasters for pleasure and they appeared to use their common sense when offering these or not when he was getting towards the ends of his life." The home obtained guidance and best practice techniques from professional bodies to assist them in providing good quality end of life care.

Good

Is the service responsive?

Our findings

People told us they were happy with the support they received. One person told us, "The care is wonderful. They take great care of me." A relative told us, "Can't complain about the care. It is very good. Carers make a real fuss of Mum."

Pre assessments were carried out before people moved into the home and then were reviewed once the person had settled into the home. The information recorded included people's personal details, care needs, and details of health and social care professionals involved in supporting the person such as a doctor and a care manager. Other information about people's medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were also recorded. This information was used to develop care and support in accordance to people's needs to ensure staff had the most up to date information.

There were detailed care records which outlined individual's care and support. For example, personal hygiene, medicine, health, dietary needs, sleep patterns, safety and environmental issues, emotional and behavioural issues and mobility. Any changes to people's care was updated in their care record and ensured that staff had up to date information. The registered manager confirmed that they involved people, health care professionals and relatives in the decisions and planning of care. A healthcare professional told us, "I had a patient who I recommended therapy exercises for her speech and the HCA's would come in every day and do the exercises with the patient which was fabulous."

Arrangements were in place to monitor and review people who had pressure ulcers. Information was detailed and provided guidelines for staff to follow when people were at risk. Action plans were put in place in accordance with people's care and support needs. Information was recorded about how often people were repositioned to alleviate pressure and minimise the risk of a pressure ulcers. People also were also using specialist equipment such as pressure mattresses or pressure cushions.
People had their needs assessed and care plans had been developed in relation to their individual needs. For example, where people had specific dietary needs relating to their condition, guidelines were in place to monitor and review their needs.

Care given was based on individual's care and support needs. Where people displayed behaviour that was challenging, guidelines were provided to staff to minimise risk, whilst ensuring the person was safe. Staff were quick to respond to people's needs. They told us by having a consistent staff team they were able to build up a rapport with people and staff knew people well and understood their needs. A relative told us, "The sister (head of nurses) heard my [family member] sneezed and as she knows my [family member] she immediately placed a call to the doctor." They went onto say, "They are so good with her."

Needs assessments recorded individual's personal details and were reviewed on a regular basis. Details of health and social care professionals, information about any medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were documented. This information was reviewed before a care plan was developed and care and support given. Staff were able to build a picture of the person's support needs based on the information provided.

Staff told us that they completed a handover sheet after each shift which outlined changes to people's needs. We looked at these sheets and saw that the information related to a change in people's medicine, healthcare appointments and messages to staff. Daily records were also completed to record each person's daily activities, personal care given, what went well and what did not and any action taken. The staff had up to date information relating to peoples care needs.

There was a call bell system in place; the system was easy for people to use. We saw that the information displayed on the call unit indicated in which room the call button had been activated. We observed there were call bells in communal areas as well as in people's bedrooms. We observed that the call bells or requests for help were responded to quickly.

People confirmed that they took part in the activities in the home and outside in their community. Activities included going for walks with staff, Shakespeare sessions (people from the community to perform plays), pampering afternoons, afternoon teas crosswords and board games. People also celebrated their birthdays and other festive occasions at the home and participated in activities in the local community. We saw feedback from a birthday party hosted by a resident for their spouse. We saw the staff had supported them to arrange the surprise party.

People who were cared for in bed were offered one to one time with the activities co-ordinator or staff. There was an activities programme which was displayed throughout the home and each person received a copy of the activity programme, in a format which supported their needs to identify relevant activities they were interested in.

People were provided with the necessary equipment, to assist with their care and support needs. For example, different types of wheelchairs for use, pressure mattresses and cushions, recliner chairs, specialist baths and bathrooms adapted to people's needs. The home also has two new wet rooms for people to use instead of having a bath; they are easily accessible for people with mobility issues. Information regarding people's individual needs and treatment was recorded in their care records; and staff were knowledgeable about their needs.

People were made aware of the complaints system. A relative told us, "This is an old-fashioned home with old-fashioned values. I have no complaints." Another relative told us, "I would tell them if something wasn't right but I have never had to make complaint." There was various ways that someone could voice their opinion about the home. For example completing a form, discuss the issue with staff, the registered manager or at the relatives and residents meetings. People had their comments and complaints listened to and acted upon. We looked at the provider's complaints policy and procedure which was displayed at key points around the home. When people first moved in there was a copy provided in the resident's guide which people kept in their rooms.

Staff told us that they were aware of the complaints policy and procedure as well as the whistle blowing policy. Staff we spoke with knew what to do if someone approached them with a concern or complaint and had confidence that the manager would take any complaint seriously. The service maintained a complaints log and these were dealt with in a timely manner, in accordance to their complaint policy. There was one complaint made in the last twelve months. We noted that response to the complaint contained action to be taken and an offer of apology. We saw information about the complaint procedure displayed in the home, which provided people with the information about the process, contact details for the registered provider, CQC, and Local Government Ombudsman. We also saw lots of compliments received by the home. For example, 'I have been comforted in the knowledge that my dad was surrounded by people who loved and cared for him.'

Good

Is the service well-led?

Our findings

People told us how they felt about the running of the home, staff and the management. A relative told us, "This is the best home on the planet. I hope it is still here when I need a home." They went on to say, "They go above and beyond, they truly care." Another relative told us, I am so pleased she is here."

People were involved in how the home was run in a number of ways. People's feedback was positive and stated that they were well looked after and encouraged to form positive relationships between healthcare professionals, staff and people. The provider had conducted a family questionnaire in 2015, people's feedback was positive and stated that they were well looked after, staff made them feel welcomed and they were satisfied with the overall care provided. As a result of the recent resident's survey carried, the home had restarted their residents and relatives forum and installed a insulation system for the conservatory after residents' commented on how hot the conservatory is in the summer.
Staff had the opportunity to help the home improve and to ensure they were meeting people's needs. This was done by a variety of methods through staff meetings, supervisions and team meeting. Staff told us that they were able to discuss the home and quality of care provided, best practices and people's care needs. We saw minutes of the staff meeting that noted items raised and discussed such as activities arrangement for people, instructions regarding infection control, and facilities used whilst performing personal care tasks. Staff told us "I am happy here, we are a good team of staff and we support each other." There were notes of senior staff meeting that took place on a weekly basis, to discuss issues regarding the home and actions agreed.

Staff had a clear vision and set of values and these were discussed with people when they moved into the home. For example, people were given information on what they could expect from the service and staff at Sunbury Nursing Home.

The provider had a system to manage and report incidents, and safeguarding concerns. Members of staff told us they would report concerns to the registered manager. We saw incidents and safeguarding concerns had been raised and dealt with and notifications regarding these had been received by the Care Quality Commission. Incidents were reviewed by the management and provider which enabled staff to take immediate action to minimise or prevent further incidents.

Regular monthly checks on the quality of service provision took place and results were actioned to improve the standard of care people received. For instances weekly spot check on rooms were conducted to check on the condition of the room in relation to health and safety needs. There were a number of systems in place to make sure the home assessed and monitored its delivery of care. Monthly audits were carried by the management team regarding people's care and support needs such as infections, pressure sores and malnutrition. The management team and the provider conducted monthly audits on health and safety of the home, management of medicines, room maintenance, housekeeping and care plans. Areas requiring review or change were identified and actioned. For example a recent bed audit had identified issues, therefore the management had commences a programme of replacing older style beds with more modern ones.

People told us that the management team were approachable and visible throughout the service. A relative told us about the registered manager, "She is a wonderful person." The registered manager was visible around the home on the day of our inspection, supporting staff and talking with people to make sure they were happy. The registered manager was very 'hands on', and helped around the home. This made them accessible to people and staff, and enabled her to observe care and practice to ensure it met the home's high standards. The registered manager had a good rapport with the people that lived here and knew them as individuals.

The provider had implemented a Duty of Candour policy. Duty of candour forms part of a new regulation which came into force in April 2015. It states that providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents. This demonstrated that the provider understood their responsibility and was working within the current regulations.

We looked at a number of policies and procedures such as environmental, complaints, consent, disciplinary, quality assurance, safeguarding and whistleblowing. The policies and procedures gave guidance to staff in a number of key areas. Staff demonstrated their knowledge regarding these policies and procedures. The policies and procedures were reviewed on a regular basis. This ensured that people continued to receive care and support safely.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Failure to gain appropriate consent in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.