South West Care Homes Limited

Sunningdale House

Inspection report

Boscawen Road
Perranporth
Cornwall
TR6 0EP

Tel: 01872571151
Website: www.southwestcarehomes.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Sunningdale House is a care home which offers care and support for up to 36 predominately older people. Some of these people were living with dementia.

The service was last inspected in July 2017 and was rated as Good. In February 2018 we received serious concerns from health and social care professionals about the care that people received. The concerns were in relation to end of life planning, personal care needs not being met, medication, medical concerns not being escalated to health professionals in a timely manner, staffing levels, staff culture, infection control practices, lack of confidence in record keeping, and a higher than expected number of deaths. Due to these concerns we brought our inspection forward.

This comprehensive inspection took place on 26 March and 3 April 2018 and was unannounced. Two inspectors and a Specialist Advisor visited the service on the 26 March 2018. At that time 19 people were living at the service. Two inspectors visited the service on the 3 April 2018, at that time 6 people were living at Sunningdale house.

Due to the high level of concerns commissioners reviewed all people they funded. Prior to the inspection 11 people were moved to nursing home provision so that their health and social care needs could be met. From the 26 March 2018 a further 16 people were moved to other care provision.

The service is required to have a registered manager. The registered manager handed in their notice in January 2018. On being informed of the concerns, the provider promptly deployed their operational management team to address the concerns and support the service. On the 3 April 2018 an interim manager was appointed at the service.
Care staff had not received training in safeguarding and had limited or no knowledge about the safeguarding process and how to recognise potential signs of abuse or mistreatment. They were unable to tell us who they would report concerns to outside of the service. A staff member commented "People have been unsafe but we didn't know. Even the things we thought we were doing right we weren't."

Care records were kept electronically and stored securely on computers and laptops. Staff recorded on hand held electronic devices when they had supported people with personal care. The devices were also used to update any monitoring records such as food and fluid charts and repositioning records. All staff were required to record on the devices when they had completed a task which sometimes meant tasks were recorded twice if two staff had been involved in the delivery of care.

Some people's care plans, were not effectively updated to ensure they were reflective of people's current care needs. Following commissioner's reviews of people's care needs, it was evident that some people's health needs had changed. This meant that people's health needs had not been reviewed appropriately by the service to ensure they could continue to meet the person's current health and care needs.

People's risks were not safely managed at the service. For example, a number of people were at risk of falling out of bed. There was no relevant risk assessment in place or documentary evidence to support how the risks could be minimised to keep the person safe. Consultation with those involved with the person was not evident. Therefore we were not assured that risks had been properly considered and addressed.

The operations manager had developed a new handover system as they were aware that, due to the lack of accurate care plans, staff had limited guidance, information or direction in how to meet people's needs. The operations manager was aware that this needed to be developed further.

Arrangements for the management of medicines were ineffective. There were some gaps in Medicine Administration Records (MAR) charts. The management of Controlled Drugs (CD) were not robust. This meant that it was not always possible to identify if people had received their medicines as prescribed.

There was no evidence that medicines that were logged as no longer required had been returned to the pharmacy. This raised concerns regarding the accountability of medicines. Some medicines required refrigeration. Fridge temperatures were inconsistently logged which meant that the medicines may not have been correctly stored. An internal medicines audit had not identified any of these concerns.

People were not protected from the risks associated with cross infection. The service had notified us of two incidents relating to infection control since December 2017. As local commissioners were reviewing people's care needs it became apparent that a high number of people had contracted oral thrush. The provider had arranged for an external contractor to come into the service to provide a deep clean which was in progress on the first day of our inspection.

Staff had not received infection control training and lacked knowledge, skill and expertise in this area. For example, we saw staff support a person with personal care and did not wash their hands before assisting the person with their food. The service also had shared slings to use when transferring people. We noted mops were not colour coded to clearly indicate what they should be used for. These examples demonstrated that there continued to be a risk of cross infection.

Due to the concerns in how people's care needs were being met the provider had recently increased staffing levels. As the numbers of people they supported declined the provider recalculated staffing levels using a dependency tool. Staff said they felt there were sufficient staff levels on duty to meet people's current care needs.

The managers were unable to locate any mental capacity assessments (MCA) or evidence of any applications submitted to the Deprivation of Liberties Safeguard (DoLS) team. The managers were unsure who, if anyone, was subject to a DoLS authorisation. This meant it was not possible to understand what decisions the service had taken on behalf of others or to assess whether these decisions were in the person's best interest and the least restrictive available.

In the last five months the service had employed a number of new staff who had no previous experience of working in care. South West Care Homes had an organisational induction process but it had not been followed. Staff said the induction was not comprehensive and commented "We learnt everything by doing things wrong, or not doing them at all and getting blasted for it."

People were not always supported by staff who had received training in order to carry out their role effectively. Training records showed that care staff had not received training in the areas of challenging behaviour, communication or pressure relief. There were significant gaps in training for care staff. For

example safeguarding training, medicines and MCA. Staff told us that moving and handling training had occurred the previous month but this had not been well organised or effective. Staff confirmed they had been in post for "some months" before they had been provided with moving and handling training. However, they had been using equipment and supporting people to transfer since they started work. The lack of training and induction meant that staff did not have the correct skills and knowledge to safely care for people's needs.

Following our inspection visit on the 26 March we raised our concerns regarding the lack of induction and training for staff. The provider contacted an external training company and sourced an intensive training programme for the staff team. Whilst the provider had responded to the lack of training, it is of serious concern that staff were not equipped with the correct skills and knowledge to undertake their role to ensure that people received effective and safe care.

Health and social care professionals had raised concerns prior to the inspection that the service was not following advice that they provided. We found that monitoring records were not consistently completed so that it was not possible to understand the care that was being provided and whether people's health concerns were being addressed appropriately.

People's fluid and food intake was recorded on a computerised system. However, the amounts recorded were not always accurate and staff would then not be aware when people were at risk due to poor nutrition and hydration. Due to this the operational manager implemented a paper record of food and fluid chart. Records showed peoples weights increased. This demonstrated that the focus on people's food and fluid intake had contributed to an increase in people's weight.

Staff spoke to us about people fondly and went out of their way to support people. However people's privacy was not always respected. For example access to bathroom areas in private, and ensuring people wore their own clothes.

There were currently no activities arranged by Sunningdale house for people. There was no evidence people's preferences were taken into account when organising their routines.

There had been a number of staff changes at the service since October 2017. The deputy manager had left, as had experienced care staff, and the registered manager had handed their notice in. New staff had been recruited but some were new to care. With a lack of leadership, new staff not receiving an induction or training to their role, they were unable to provide effective care that met the needs of the people they supported. Staff did not feel able to approach the registered manager and there was a breakdown of communication between the registered manager, staff and people they supported. Health and social care professionals also gave a mixed response to the registered manager's approach and how the service responded to advice given to ensure people's needs were met.

Some staff were kind and compassionate and committed to improving standards. We witnessed some examples of positive interactions between people and staff. Some staff shared appropriate humour and affection with people.

There were quality assurance systems in place to make sure that any areas for improvement were identified and addressed. However, these had been ineffective and had not highlighted all of the issues raised in this report.

Following this inspection the overall rating for this service is 'Inadequate' and the service is therefore in

'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe, and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected against the risk of abuse or mistreatment because not all staff had received recent training in this area.

Risks to people were not being adequately assessed or addressed to keep people safe.

Medicines were not always administered correctly, managed or stored securely. This meant there was a potential risk of errors and people might not receive their medicines safely

People who used the service were put at risk because cleanliness and hygiene standards were not maintained. We observed poor infection control practices which put people at risk.

Is the service effective?

Inadequate

Staff did not have an understanding of the legal requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards. For some people restrictive practices were in place without evidence of consent or adequate assessment and authorisation.

Staff did not receive appropriate induction and training so they had the up to date skills and knowledge to provide effective care.

People's healthcare needs were not always met, for example around pressure area care. We received mixed feedback from health professionals, with both of those we spoke with raising concerns over some aspects of care.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always protected.

Staff did not always know the needs of the people they supported.

Staff spoke about people fondly

Is the service responsive?

Inadequate

The service was not responsive.

The service failed to respond to people's changing needs by ensuring amended plans of care were put in place. This meant people did not always receive support in the way they needed it.

People had no access to activities within the service.

There was a system in place for receiving and investigating complaints. However people and relatives stated they were uncertain how to access it.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of communication and involvement from the manager to staff.

Staff felt disempowered and unable to raise suggestions.

We found a number of concerns during our inspection which had not been identified by the provider or manager. This showed a lack of robust quality assurance systems.

Records relating to the management and running of the service and people's care were not consistently or adequately maintained.

Sunningdale House

Detailed findings

Background to this inspection

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

The service was last inspected in July 2017 and was rated as Good. In February 2018 we received serious concerns from health and social care professionals about the care that people received. The concerns were in relation to end of life planning. Personal care needs not being me, medication concerns, medical concerns not being escalated to health professionals in a timely manner, staffing levels, staff culture, infection control practices, lack of confidence in record keeping, and a higher than expected number of deaths. Due to these concerns we brought our inspection forward.

This comprehensive inspection took place on 26 March and 3 April 2018 and was unannounced. Two inspectors and a Specialist Advisor visited the service on the 26 March 2018. At that time 19 people were living at the service. Two inspectors visited the service on the 3 April 2018, at that time 6 people were living at Sunningdale house.

Before visiting the service we reviewed information we kept about the service such as previous inspection reports and notifications of incidents. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern.

During the inspection, we looked around the premises. We observed the lunchtime experience and interactions between people and staff. We spoke with seven people who lived at the service and observed others who could not communicate their wishes and feelings verbally. We also spoke with four relatives. Throughout the inspection, we spoke with 12 members of staff and three visiting health and social care professionals.

We looked at seven records relating to people's individual care, training records for all staff, staff personnel files, policies and procedures and a range of further documents relating to the running of the service.

Inadequate

Is the service safe?

Our findings

Care staff had not received any training in safeguarding and had limited or no knowledge about the safeguarding process and how to recognise potential signs of abuse or mistreatment. They were unable to tell us who they would report concerns to outside of the service. On the 26 March we spoke to four care staff who were newly recruited to care. One commented; "People have been unsafe but we didn't know. Even the things we thought we were doing right we weren't."

Care staff did not know when to report suspicions of abuse. For example, staff had recorded that a person had alleged they had been assaulted by staff. This had not been reported to the manager and had not been discussed with or reported to commissioners or considered as a safeguarding concern. This meant that the safeguarding process had not been followed .Staff were not up to date with current best practice and local processes for safeguarding adults.

We concluded that this was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records were kept electronically and stored securely on computers and laptops which were accessed using passwords. Staff recorded on hand held electronic devices when they had supported people with personal care. This meant they were able to record immediately when a task, such as helping someone to wash, had been completed. The devices were also used to update any monitoring records such as food and fluid charts and repositioning records. All staff were required to record on the devices when they had completed a task which sometimes meant tasks were recorded twice if two staff had been involved in the delivery of care.

The operations manager acknowledged that care plans were not up to date and did not reflect people's current care needs. Some people could become anxious or distressed leading them to behave in a way which could be difficult for staff to manage. There were no care plans in place to guide to staff on how to support people during these times. Care staff did know the people they supported well but acknowledged that they might provide support in a different way to their colleagues. This meant staff may have been inconsistent in their approach to people which could have resulted in them becoming increasingly confused and anxious.

Risk assessments are important when identifying the appropriate measures to be put in place to minimise risks to people. For example, how staff should support people when using equipment, reducing the risks of falls, the use of bed rails and reducing the risk of pressure ulcers. We had concerns in relation to the management of identified risk. Guidance contained in risk assessments did not always reflect the actions being taken by staff to protect people.

Systems for assessing risk were not robust. For example, a number of people were at risk of falling out of bed. Staff had placed mattresses on the floor next to each person's bed in order to keep them safe. However there was no relevant risk assessment in place. There was no documentary evidence to support why or how

these decisions had been reached or if the person, their family or other health or care professionals from outside the service were involved in this decision. There was no evidence to show this action had been effective. Therefore we were not assured that the risk had been properly considered and addressed.

Arrangements for the management of medicines were ineffective. There were some gaps in Medicine Administration Records (MAR) charts. Therefore we could not be confident that medicines were administered as prescribed. The management of Controlled Drugs (CD), which require stricter controls by law, were not robust. The CD register did not tally with the CD medicines in stock. This meant that it was not always possible to identify if people had received their medicines as prescribed.

The medicines cupboard was disorganised. For example, MAR sheets were spilling from shelves to the floor and it was hard to find relevant paperwork. Medicines that were logged as no longer required had been recorded in the medicines return log book. The return log book was last signed as used on 16 January 2018 but staff said that more medicines had been collected since then. However, there was no evidence to support this. This raised concerns regarding the accountability of medicines.

Some medicines required refrigeration. Fridge temperatures were inconsistently logged which meant that the medicines may not have been correctly stored. An internal medicines audit had not identified any of these concerns.

The service had notified us of two incidents relating to infection control. In December 2017 the service had an outbreak of norovirus. In February 2018 there had been an outbreak of influenza. As local commissioners were reviewing people's care needs it became apparent that a high number of people had contracted oral thrush. Therefore there were concerns about the infection control practices at the service. The provider had arranged for an external contractor to come into the service to provide a deep clean which was in progress on the first day of our inspection.

Staff had not received infection control training and lacked knowledge, skill and expertise in this area. For example, on the 26 March 2018 we saw staff support a person with personal care and then help them with a meal. They did not wash their hands before assisting the person with their food. In another incident a member of staff administered eye drops to the person's eye and then wiped it with a tissue, the same tissue was then used when the eye drop was administered to the other eye. The service also had shared slings to use when transferring people. We noted on the 4 April 2018 a mop head that was black in colour in a bathroom, we also found mops were not colour coded to clearly indicate what they should be used for. These examples demonstrated that there continued to be a risk of cross infection.

The above was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment systems were robust and new employees underwent the relevant pre-employment checks before starting work. This included Disclosure and Barring System (DBS) checks and the provision of two references.

Due to the concerns in how people's care needs were being met the provider had recently increased staffing levels. On the 26 March they had been increased to six care staff, 1 registered general nurse, 1 team leader plus five managers from the organisation. In addition the service had domestic, catering and maintenance staff on duty. At the time the service was supporting 19 people. On the 4 April as the service were supporting 6 people, the provider had reviewed people's dependency needs and had recalculated staffing levels. Three carers, one team leader and two managers were on duty, plus domestic and catering support. Staff said they

felt there were sufficient staff levels on duty to meet people's current care needs.

Inadequate

Is the service effective?

Our findings

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 people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

The managers were unable to locate any capacity assessments or evidence of any applications submitted to the Deprivation of Liberties Safeguard (DoLS) team. The managers were unsure who, if anyone, was subject to a DoLS authorisation. On the second day of our inspection they were still unable to tell us who was subject to an authorisation or awaiting a DoLS assessment and agreed to follow this up. This meant it was not possible to understand what decisions the service had taken on behalf of others or to assess whether these decisions were in the person's best interest and the least restrictive available. The service had recorded in people's records that family members had consented to elements of their care. However, there was no confirmation in what areas of care the representative held a lasting power of attorney (LPA) for and if therefore they had the appropriate authority to make such decisions.

We found seven care staff, out of 22, had completed MCA training and staff were unclear about how the Act applied to their practice.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Sunningdale House employed 26 staff, four, of whom were domestic and catering staff. In the last five months the manager had employed a number of new staff who had no previous experience of working in care. South West Care Homes had an organisational induction process but it was evident that this had not been followed. Staff told us that their induction to their role either did not happen or had not included any training. Some staff completed a number of shadow shifts before starting to work independently. This meant they were required to work alongside another member of staff. However, they often worked alongside colleagues who were also new to care and not experienced or knowledgeable in their role. Staff said the induction was not comprehensive and commented "We learnt everything by doing things wrong, or not doing them at all and getting blasted for it."

People were not always supported by staff who had received training in order to carry out their role effectively. Training records showed that care staff had not received training in the areas of challenging behaviour, communication or pressure relief. There were significant gaps in training for care staff. For example four out of 22 had completed safeguarding training, 12 had completed medicines training and seven had completed training in the MCA. Staff told us that moving and handling training had occurred the previous month but this had not been well organised or effective. One commented; "Everyone was laughing, nothing was taken seriously, it lasted an hour and we just sat in a hoist and went up and down. One member

of staff had never done care before." Staff confirmed they had been in post for "some months" before they had been provided with moving and handling training. However, they had been using equipment and supporting people to transfer since they started work. Staff said they learnt how to do moving and handling by "copying" other staff and were not sure if that was the right technique to use. The lack of training and induction meant that staff did not have the correct skills and knowledge to safely care for people's needs.

The amount of supervision meetings staff had with the registered manager varied. Some said they had none; others had received supervision although one told us this was rushed. Supervision records showed staff had requested training and staff confirmed this. Comments included "It wasn't for the lack of asking" and "We asked and asked to start training." They told us, and the supervision records showed the registered manager assured them training would be provided but this did not occur.

Following our inspection visit on the 26 March we raised our concerns regarding the lack of induction and training for staff. The provider contacted an external training company and sourced an intensive training programme for the staff team. On the 3 April we met with a member of the training company who was delivering a safeguarding course that day, with a hydration course to follow later on in the week for all staff.

Whilst the provider had responded to the lack of training, it is of serious concern that staff were not equipped with the correct skills and knowledge to undertake their role to ensure that people received effective and safe care.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received concerns about people's dietary and hydration needs. People's fluid and food intake was recorded on a computerised system. However, the amounts recorded were misleading, as where two carers' were involved in an individual's care, they both recorded the amount of food and fluids offered and consumed. This meant the records were not accurate and staff would not be aware when people were at risk due to poor nutrition and hydration.

Care records showed one person had been identified as being at risk due to poor nutrition. However, over a 24-hour period the records showed they had only eaten one meal and taken just 180 mls of fluid. In another care record it was recorded that a person had not had any drinks during the day. There was no record of any action taken by the service to address this. This meant that when issues with people's care needs had been identified that there was no action taken by the service to address concerns.

We raised this with the operations manager on the 26 March 2018 and they agreed to address this immediately. When we returned on the 3 April a paper food and fluid chart had been implemented. This recorded more clearly when food and drinks were offered, the amounts and how much was consumed. However, staff were completing this inconsistently and the food charts lacked detail. It is important records are accurate to enable staff to support people to maintain their health and identify when they are at increased risk.

On the 3 April 2018 we reviewed the weights of the six people that were living at Sunningdale House and found that five out of six people had an increase in their weight during the past few weeks. This demonstrated that the focus on people's food and fluid intake had contributed to an increase in people's weight.

We observed the lunch time experience. People were supported by suitable staffing levels to assist them

promptly when necessary. Feedback on the food was positive. Comments included; "Yes, food's good" and "I enjoy all my meals." People were not aware of what the menu was for that day and the menu board did not have the right meal displayed for the day. People said "It's a surprise." People's dietary needs were known by the cook and recorded in the kitchen. Any changes to people's dietary needs were communicated with the kitchen staff.

We saw from people's care records that they had access to a range of health care professionals including GPs, speech and language therapists, district nurses, and chiropodists. Health and social care professionals had raised concerns prior to the inspection that the service was not following advice that they provided. We found that monitoring records were not consistently completed so that it was not possible to understand the care that was being provided and whether people's health concerns were being addressed appropriately. Throughout the inspection, we observed health and social care professionals attending to review people. From these assessments and due to the concerns in how the service was meeting people's care needs, commissioners decided to move people to alternative care provision.

This contributed to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's bedrooms were personalised with personal belongings, soft furnishings and photographs and people's bedroom doors were personalised with their name and a picture. There were various areas in the building for people to spend their time including some quiet areas.

Requires Improvement

Is the service caring?

Our findings

People were positive about the care they received. Comments from people included "Staff are kind, they look after me well."

We spent time in shared lounges to observe how care was delivered and received. We observed people were comfortable in their surroundings. Staff were kind, respectful and spoke with people considerately. Staff spoke to us about people fondly and went out of their way to support people. For example, a staff member responded promptly when a person was calling out and gave appropriate reassurance and spent time with the person until their anxiety levels had reduced.

During the inspection people were moving out of the service to new care provision. Staff and people were visibly distressed by the move. When one person was leaving the service, the person had hold of the staff members hand and did not want to let go. The staff member spoke gently to the person and encouraged them to let go of their hand. As the person left the service the staff member told the person; "Bye, love you." We spoke with some relatives whose family members had left the service. All were complimentary about the staff saying; "They genuinely cared." However, they told us the service was poorly organised.

People's privacy was not always respected. For example, one person on several occasions used a bathroom which opened on to a corridor leading to a dining area, and did not close the door. We informed a member of staff who responded; "Oh that's [person's name] she always does that." There was no concern from staff about the need to protect the person's privacy or dignity during this intimate task. We observed a physiotherapist visit the service and treat a person in the main lounge. This was completed in a public area and the person's privacy was not respected.

We spoke with one person and their relative who told us they were sometimes given other people's clothing from the laundry. We observed a person who was wearing a knee length skirt with calf length odd socks. Staff confirmed the person was assisted to dress. This did not protect the person's dignity.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some care plans contained very little detail about people's personal histories or background. This is important information as it can help staff to ensure people receive care in the way they wish and help them to engage with people by providing them with areas of interest for them to use in conversation.

People were not given information in a meaningful way. People did not have access to their care plans. There was a large menu board in the corridor with pictures of the meals on offer. However, they had not been updated with the day's meals on display. One person commented; "It's never right!"

Inadequate

Is the service responsive?

Our findings

People's care plans, which provided guidance and direction to staff about how to meet their individual needs, were not always effectively updated to ensure they were reflective of people's current care needs. The operational manager informed us that the registered manager had reviewed people's care plans monthly and recorded 'no change'. However it was evident that people's health needs had changed and therefore the care plans did not accurately reflect their current care and health needs. For example, following commissioner's reviews of people's care needs, it was evident that people's health needs had changed. Eleven people were assessed as needing nursing care and were moved to nursing services. This meant that people's health needs had not been reviewed by the service to ensure they could continue to meet the person's current health and care needs.

One person did not have a care plan in place. The operations manager told us that care plans were formulated one to two weeks after admission, however the person had been living at the service for four weeks. The initial assessment was not completed and risk assessments were also incomplete. There was information stating that the person needed two staff to assist with transfers, but the records identified nine incidents of one staff member supporting them, the latest being on the 25 March 2018. This was not being monitored to ensure that care was being provided as per the direction of the care plan. We found staff had no or limited guidance or information to provide care that would meet people's current care and health needs.

This contributed to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The operations manager was in the process of reviewing all people at the service. On the 3 April the operations manager had printed off the care plans and, as they were unfamiliar with people's needs, was asking staff to read through the current information they had. The aim was that staff would inform the operations manager of the persons likes, dislikes, social and health care needs so that an up to date and accurate care plan would be developed.

The operations manager had developed a new handover system as they were aware that, due to the lack of accurate care plans, staff had limited guidance, information or direction in how to meet people's needs. The daily handover sheet gave specific information to staff in how the person needed support and what monitoring was required to be undertaken. Staff kept daily records detailing the care and support provided each day and how people had spent their time. The information recorded was very task orientated and the operations manager was aware that this needed to be developed further.

People did not have access to activities at the service. No activity co-ordinators were employed and staff told us they were reliant on outside entertainers coming to the home. There was an activity schedule displayed on the wall at the service, however staff told us this was not accurate. For example, on both days we visited no activities were being offered. We saw the TV in a shared lounge was on during the first day, it had a blue screen and was displaying an error message and was not connected to a TV signal. This was not

tuned in for the whole day we were at the service. One member of staff who had started work the previous October told us they had taken a person for a walk around the boating lake recently. They told us this was the first time they had been able to do this since they started work at the service. They could not recall any other staff ever having an opportunity to support people in this way. On the first day of the inspection we saw one person was sitting at a table when we arrived. They remained sitting in the same place throughout the day. There was no TV in the room and we did not see them take part in any activities other than eating. There was no evidence people's preferences were taken into account when organising their routines.

This contributed to a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had call bells in their bedrooms to alert staff if they required assistance. There were pressure mats to alert staff if people were out of bed, should they be assessed as needing support to mobilise. Throughout the inspection, we saw that if bells or alarms were triggered these were answered promptly by staff.|

There was a system in place for receiving and investigating complaints. People and relatives gave a mixed response about the service complaint system. Some said they knew how and who they could complain to and felt their compliant would be listened too. Others commented they were unsure how or who to complain to if they had a concern. The provider must ensure that all people and relatives using the service are aware of the complaints procedure.

Inadequate

Is the service well-led?

Our findings

In February 2018 we received serious concerns from health and social care professionals about the care that people received. The concerns were in relation to end of life planning, personal care needs not being met, medication concerns, medical concerns not being escalated to health professionals in a timely manner, staffing levels, staff culture, infection control practices, lack of confidence in record keeping, and a higher than expected number of deaths. Due to the high level of concerns commissioners reviewed all the people whose health care they were responsible for. Prior to the inspection 11 people were moved to nursing home provision so that their health and social care needs could be met. From the 26 March 2018 a further 16 people were moved to other care services.

The registered manager handed in their notice in January 2018. Due to the seriousness of the concerns the provider promptly deployed their operational management team to address the concerns and support the service. On the 3 April 2018 an interim manager was appointed at the service.
Sunningdale House is owned by South West Care Homes Limited who run a number of services within the South West. There is a clearly defined management structure and regular oversight and input from senior management. However, the registered manager appeared to not have relayed concerns from the service to the operational management team. This raises questions about how effective communication between managers, staff and people was, and how effective the oversight arrangements of the provider were.

There were systems in place to monitor the quality of the service at Sunningdale House, however these systems had failed to identify or to or address in a timely way, many of the areas of concern identified at the inspection. This included concerns with risk management, infection control, staff training, induction and supervision, medicines, MCA and DoLS, people's records and with the way in which care was provided to people who were vulnerable. For example the registered manager last audited infection control on 28 October 2017 and found no areas to be addressed. However there had been two recent outbreaks potentially due to poor infection control processes and no further review of the audit had taken place. This meant that the auditing system was not used in a proactive way when new issues had arisen and the provider's own governance and quality monitoring systems were not effective at providing checks of the service and the manager's work.

A large percentage of the staff team had been recently employed and many had not previously worked in the care sector. Staff did not complete a comprehensive induction. There was no introductory training and staff were not completing the care certificate or any similar introduction to the fundamental standards of care. This is contrary to best practice guidance and the organisations own policy. This meant that staff skill and experience was lacking and staff were unable to provide effective care that met the needs of the people they supported. Whilst staff asked for training and support this was not provided.

Staff were not positive about the previous managers' approach and felt they had limited opportunity to talk with managers in the company. Comments from staff included; "The (registered) manager was not approachable, she scared me, accused me of gossiping and was not supportive," I didn't feel well supported at all. It feels better now." This evidenced that the service did not always operate in an open and transparent

way.

We received a mixed view form health and social care professionals about the approach of the previous manager. Some were complimentary and said that the registered manager would listen to and follow through advice provided. Others felt that the registered manager's approach at times could be quite abrupt and that advice was not followed though. This demonstrated that health and social care professionals felt they did not have a consistent management response.

Staff told us they did not feel empowered to offer suggestions about the service. Staff meetings occurred. Minutes of the staff meeting on the 12 January 2018 recorded, 'all (staff) have an understanding of abuse although some need more training or need to complete on line training.' However this inspection highlighted that out of 22 care staff only four had completed safeguarding training and no action to address this had occurred. This demonstrated that when issues had been identified no follow up action was been taken in a timely manner.

The minutes also recorded 'communication is poor at the moment, care staff should report concerns of residents or family to myself [manager] or team leader on shift.' However staff told us they felt unable to approach the registered manager about the running of the service. This demonstrated that there were communication issues within the staff team and there appeared to be no plan as to how this would be addressed or resolved.

Staff meeting minutes in December 2017 identified that staff needed to ensure they accurately recorded the support and care a person received via the services care recording system. This was again raised in the January 2018 staff meeting. Staff were reminded to ensure that they inputted data into the i-pods where they recorded care tasks. However, as noted in food and fluid charts in the effective section of this report, the service was aware of errors in the system but no action plan had been formulated to look at how the issues could be addressed.

Resident/relative meetings were planned but had not occurred since 2017. People were not as involved in the day to day running of their home as found at the last inspection.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not taken proper steps to ensure that each person was protected against the risks of receiving care that was inappropriate or unsafe. Care and treatment was not planned and delivered in such a way as to meet people's individual needs

The enforcement action we took:

Imposed conditions on service registration to cease admissions on 29/03/18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users must be treated with dignity and respect.

The enforcement action we took:

Imposed conditions on service registration to cease admissions on 29/03/18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was unaware of who had been subject to a mental capacity assessment or DoLS application. There were restrictive control measures in place which had not been adequately assessed for or consented to

The enforcement action we took:

Imposed conditions on service registration to cease admissions on 29/03/18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. Including: the proper and

	safe management of medicines, risk assessments and infection control processes.

The enforcement action we took:

Imposed conditions on service registration to cease admissions on 29/03/18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users must be protected form abuse and improper treatment.

The enforcement action we took:

Imposed conditions on registration on 29 April 2018

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have an effective system in place to regularly assess and monitor the quality of service provided and identify, assess and manage risks relating to the health, welfare and safety of people who used the service.

The enforcement action we took:

Imposed conditions on service registration to cease admissions on 29/03/18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff should receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties.

The enforcement action we took:

Imposed conditions on service registration to cease admissions on 29/03/18