Parfen Limited

Sunnyside Residential Home

Inspection report

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Date of inspection visit:
29 June 2021
20 July 2021

Date of publication:
24 February 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Sunnyside Residential Home is a care home providing personal and nursing care for up to 27 people over three floors. At the time of the inspection, 20 people were living at the home.

People's experience of using this service and what we found
People were not always kept safe from the risk of harm, we identified appropriate steps had not been taken following a serious safeguarding incident. The local authority had requested the provider undertake a formal investigation into the incident and specialist training be identified and implemented for staff. Neither of these had been actioned. Medicine records had gaps and people's medicines were not always stored safely; however, we found no evidence of impact on people and felt this was an issue around auditing and quality assurance. We found concerns within the environment and building relating to fire and legionella's disease safety. In the home's external areas, which could be accessed by people who use the service, we found significant levels of uncleanliness which could've potentially caused harm. People's dependency to ensure the appropriate level of staffing had not been assessed for several months, although this had been started recently. Some staff had not received appropriate levels of supervision or training and the provider had not carried out appraisals with the management team. Infection control practice within the home had improved since our last inspection but remained unsafe.

The registered manager had implemented new auditing systems; however, in some cases these were ineffective and didn't reflect the findings on this inspection. The provider had failed to implement their own quality assurance processes and staff consistently felt more support and management of the internal management team was needed. There were inconsistencies across several records, including monitoring charts, risk assessments, care plans and incident reports. The provider had failed to inform CQC and relevant partners of notifiable incidents. Records were not stored or disposed of securely, we found a person's medication care plan in the car park, on arrival at the service. The provider had failed to display their most recent inspection report and rating both in the home and on their website.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. Staff had not been provided with specific training around supporting people with autism. One person had been recorded as being non-compliant with engaging with services from other professionals and in leaving the home. We discussed this with the registered manager to understand what steps had been taken to support the person with this; however, no plans had been implemented, despite one member of staff telling inspectors, "Yes we could try that, because he used to love

walking." This was in response to the inspector signposting to relevant services and support that could help and enable the person to access activities, treatment and the local community.

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

Rating at last inspection (and update)
The last rating for this service was Inadequate (31 March 2021) and there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to harm caused to a person in relation to specific support needs not being met or understood. Other concerns raised included an unsafe environment, insufficient support for people with behavioural needs and cleanliness. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has remained as Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

In January 2021 we inspected the service and found issues relating to infection control, we sought immediate reassurance which was provided. In March 2021, we received further concerns relating to infection control, so decided to carry out a targeted inspection where we identified further non-compliance with infection control guidance. We took enforcement action, which included a notice of decision to add conditions to the providers registration stating the management and practice of infection control needed to be improved. We received reassurances risk had been mitigated so withdrew the conditions from the registration. However, we have found further concerns relating to infection control practice at this inspection.

We have identified breaches in relation to safe care and treatment, safeguarding service users from abuse

and improper treatment, good governance, staffing, notifications of incidents and requirement as to display of performance assets at this inspection.

The provider submitted an appeal against our notice of decision to cancel their registration.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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 it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Sunnyside Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors, this included one inspector working remotely.

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

Notice of inspection
This inspection was unannounced.

Inspection activity started on 29 June and ended on 20 July 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to

complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with two people who used the service and three relatives about their experience of the care provided. We spoke with eight staff including the registered manager, deputy manager, senior care workers and care workers. Some staff we spoke with were not happy for their job titles to be used in this report. We made observations of care being provided to help us understand the experience of people who could not talk to us.

After the inspection
We continued to seek clarification from the provider to validate the evidence found. We looked at training data and quality assurance records. We also reviewed policies, risk assessments and care records. We sought regular feedback from visiting professionals to better understand whether improvements had been sustained.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure consistent and accurate records were in place. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Risks to people's physical and mental wellbeing were not always accurately assessed. We found information recorded in monitoring forms which did not correlate with information in people's risk assessments.
● Information used to analyse incidents had been recorded; however, this did not always accurately reflect the record of the incident.
● Inaccurate record keeping had been identified consistently by the registered and deputy manager through auditing. However, no support or learning for staff relating to this was evident. It was unclear as to what action had been taken.
● A conversation record relating to a serious safeguarding incident, evidenced actions being identified for the management team to undertake. However, this action wasn't taken until a visiting professional highlighted the importance and timeliness needed, several weeks later.

Management oversight did not ensure consistent and accurate records were in place or used to identify learning and inform improvement. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

● The provider had failed to ensure the premises were safe and action had not been completed identified in the services legionella risk assessment. We also found evidence of breaches relating to fire safety, which had been identified in the services most recent fire risk assessment. We requested a visit from the fire service to assess the safety of the building and practice within the home. We had not received feedback at the time of this report.

The provider had failed to ensure the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were not kept safe from the risk of abuse and harm. The provider had failed to respond to a serious substantiated safeguarding incident. The local authority had requested an investigation into the incident and identified training around specific support needs be implemented. At the time of inspection neither had been started or actioned.

The provider had failed to ensure safeguarding systems and processes were established and operated effectively to prevent abuse of service users and investigate immediately upon becoming aware of any allegation of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

● Staff had a good understanding of different types of abuse and how to keep people safe. One staff said, "I'd go to my management, if I don't feel like it's been dealt with in the correct manner, I'd come straight to CQC."

● Relatives felt people were safe. One relative said, "Yes I do think they are safe."

Staffing and recruitment

● Staffing levels had not been assessed, training was not always completed and supervisions and appraisals had not been completed consistently.

● People's dependency levels had not been assessed to ensure there were enough staff to meet people's needs for several months. However, this had recently been started. Feedback from staff on staffing levels was consistently negative and staff felt this was a funding issue.

● There were significant gaps in the providers training matrix. We discussed this with the registered manager, who said, "[Consultant] is going to be doing all our training. They have started to arrange some training and they're doing three courses on the 28th July. They're going to look at other training that they can access for us."

● Recent recruitment records showed staff being recruited safely with appropriate checks and a formal induction process. However due to gaps in training records we could not be sure an appropriate induction had been completed for all staff.

The provider had failed to ensure staff received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider had failed to ensure robust infection control practices were in place and manage the risk of infectious diseases appropriately. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Infection control practices were not robust. We found areas of the home which were highly unhygienic. Staff use of PPE had improved; however, we received feedback following our inspection that staff had been observed not using or changing PPE appropriately.

● One of the fire exits that could be accessed by people from a fire exit, which had the alarm disabled, led to

a staircase where there was a significant amount of bird faeces. This staircase was also accessible to people from the communal garden as a gate had been propped open. We discussed this with the registered manager who said, "I know, I know, we try and keep on top of it, but I'll get it cleaned, yes I will." We received feedback from a visiting professional, approximately 3 weeks after our visit that there was still evidence of bird faeces.

Infection control practice was not robust and the provider had failed in assessing the risk of, and preventing, detecting and controlling the spread of, infections. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Information in people's medication records was not recorded consistently. We found gaps in peoples records and some people's medication care plans did not always reflect information in people's administration records. However, we did not find evidence that this had impacted safe administration.

● Medicines were not always stored safely. Some people's stock of medicines had been mixed with new stock meaning we could not be sure whether stock was in date or not.

● Information in people's care plans relating to what medicines they were on was inconsistent. In one person's record there was conflicting information; it stated they were not on medication in the first section of the care plan and later it was recorded they had an 'as required' medication.

● We felt the issues we identified around the recording of medicines related to the governance of the service. The issues were not always identified through the providers auditing systems and when issues had been identified, improvements were not made. Please refer to the well-led section of this report.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to ensure auditing and quality assurance systems were robust. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The provider had failed to implement any oversight or support relating to management within the home. Some improvement had been made with internal audits; however, they remained ineffective and didn't highlight the issues we found on this inspection. Information wasn't always recorded accurately.
● Observations of staffs use of PPE had been implemented since our last inspection and action was taken by the management team against staff who were repeatedly non-compliant with current guidance. However, following our inspection we received feedback the management team were not maintaining observations of staffs PPE use.
● Staff and management felt support was needed at provider level to support and guide the management team in addressing areas of non-compliance with regulations.
● One staff said, "[The registered manager's] trying their hardest, we've got support, they've got nobody. They don't know if they're doing it right or wrong, they're just guessing, because they've got no support at all. Their told to just get on with it yeah, no help off the provider whatsoever. It's a shame, they really do want this home to be a success, but if they don't get the support?"
● Historical recruitment records showed significant gaps in reference checks and where necessary risk assessments. The provider had not identified gaps in some staff's recruitment records and addressed this.

Auditing and quality monitoring was not robust. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
● Learning was not used to inform improvements. Systems to analyse incidents had been implemented since our last inspection; however, these were sometimes ineffective as the analysis did not always reflect the incident.

● Important training had not been identified to support people with specific needs such as autism and mental health. We discussed this with the management team and they said this would be actioned along with bring other training up to date.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Person centred care had deteriorated since our last inspection. Staff reported not having enough time to support people, due to insufficient staffing levels and newly implemented systems.
● One staff said, "We do need more help. At the moment there's that much paperwork to fill in, so we can't concentrate on the residents."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had failed to display their most recent inspection report in the home and on their website. The report on both was of an inspection published on the 03 June 2019. The service had been inspected on three occasions since that date.

The provider had failed to ensure the most recent rating was displayed at the premises and on their website. This was a breach of regulation 20a (Requirement as to display of performance assets) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not always notified CQC of notifiable incidents.

The registered person had failed to notify the Commission without delay of notifiable incidents. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Staff demonstrated a good understanding of how to support people with specific cultural needs. One staff said, "You make sure you know all the differences in how they want to be supported. So, we make sure we're respecting their religion or culture."
● Relatives felt involved in peoples care. One relative said, "They are accessible, I can get hold of [the registered manager]. I've not been in to take part in any reviews since COVID-19, but I'm involved, so feel I have enough involvement. I have seen [persons] care plan."

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 18 Registration Regulations 2009 Notifications of other incidents The registered person had failed to notify the Commission without delay of notifiable incidents.

The enforcement action we took:

A notice of decision to cancel the providers registration is at first tier tribunal stage.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. The provider had failed in assessing the risk of, and preventing, detecting and controlling the spread of, infections.

The enforcement action we took:

Notice of decision at first tier tribunal stage to cancel the registration for the provider.

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 The provider had failed to ensure safeguarding systems and processes were established and operated effectively to prevent abuse of service users and investigate immediately upon becoming aware of any allegation of abuse.

The enforcement action we took:

Notice of decision at first tier tribunal stage to cancel the registration for the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance The provider had failed to ensure consistent and accurate records were in place or used to inform improvement. The provider had failed to ensure auditing and quality monitoring was not robust.

The enforcement action we took:

Notice of decision to cancel the providers registration at first tier tribunal to stage

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to ensure the most recent rating was displayed at the premises and on their website.

The enforcement action we took:

Notice of decision to cancel the providers registration at first tier tribunal stage.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

The enforcement action we took:

Notice of decision to cancel the providers registration at first tier tribunal stage.