Eldercare (Halifax) Limited

Sun Woodhouse Care Home

Inspection report

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23 August 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Sun Woodhouse Care Home (called 'Sun Woodhouse' by the people who live and work there) on 18, 19, 22 and 23 August 2016. The first day of the inspection was unannounced, which meant the home did not know we were coming.

At the last inspection in July 2015 we rated the home as 'requires improvement' overall and as inadequate in the effective domain of care. We identified breaches of the regulations so at this inspection we checked to see whether the issues had been resolved.

Sun Woodhouse provides residential care and accommodation for up to 24 older people. Accommodation is arranged over two floors and there is a lounge and dining room on the ground floor. All bedrooms are single occupancy and a stair lift on the main staircase is used by some of the people to access their bedrooms upstairs. At the start of this inspection there were 15 people using the service and one more person was admitted for respite during the inspection.

The service did not have a registered manager in post; the last manager to be registered with the Care Quality Commission (CQC) left in April 2015. The current home manager had been appointed in March 2016 but had yet to de-register from their previous home and apply to be registered manager at Sun Woodhouse. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of this inspection the home manager was on annual leave for 27 days and a senior care worker was acting manager. The area manager, home manager and nominated individual had considered various options to cover the home manager's annual leave before approving the senior care worker's acting manager status. We saw the acting manager was receiving support, however no risk assessment or support plan had been produced for this period and CQC had not been advised of the home manager's extended period of absence.

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 inspecting 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 so that there is still a rating of inadequate in 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. This service will continue to be kept

under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

We saw medicines were administered in a person-centred way; however, we did find issues with the way they were managed. The home did not have protocols in place for 'as required' medicines, the application of topical creams was not recorded and the temperature of the clinic room where medicines were stored was not monitored.

There were issues with the way some risks were assessed and managed at the home. A risk assessment had not been done for a person with bedrails and no risk assessments had been undertaken for the people who used a hoist to access the bath. Personal emergency evacuation plans or PEEPs would not be useable in an emergency as they were kept in people's care files which were locked in a cupboard.

People said there were enough staff to support their basic care needs. However, staff told us and we observed, the care workers did not have time to provide activities for the people, which was also part of their role.

The accidents and incidents that had occurred were recorded; however, we found that one person who had experienced numerous falls in the five months prior to the inspection had not been referred to their GP or had their care plan reviewed.

Not all of the staff had received the training they needed to support people safely. There was no central record of when care staff last had supervision and records we saw showed this was not happening regularly.

Feedback about the food was positive and we saw people were given choices over what to eat and drink. However, care files for people at risk of weight loss showed they were not weighed according to their care plans and their food and fluid charts were not completed with sufficient detail to make them meaningful.

People's confidentiality was not always respected by staff. We found boxes of people's care plans and staff personnel files unsecured in a communal area and meetings involving discussion of people's personal health and wellbeing were not held in private.

Care was not always person-centred. Care plans were not evaluated regularly and people did not have appropriate access to meaningful activities.

The home manager had not undertaken regular audits of the safety and quality of the service since they started in the role in March 2016. Residents and relatives were not asked to feedback on the service so that improvements could be made.

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Care workers' knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) had improved and applications for DoLS authorisations had been submitted to the local authority for people who needed them. However, no assessments of people's capacity to make other decisions had been made.

People's care plans were person-centred, however not all people said they had been involved in designing them and few people had signed them. People's relatives told us it had been over a year since they had last been asked about their family members' care plans.

Most interactions we saw between care workers and people were respectful, although we did observe some care workers providing support to people without speaking to them.

People still did not have end of life or future wishes care plans in place. The acting manager said people had been asked but had not wished to speak about this aspect of their care. They said in future if people were consulted but chose not to discuss their future wishes, it would be documented in their care file.

Records showed regular safety checks had been made on the building, equipment and utilities to make sure they were safe.

Care workers could describe the different forms of abuse and explain how they would report any concerns appropriately.

Recruitment documentation we saw showed the home made the right checks to make sure new staff employed were suitable to work with vulnerable people.

Care workers supported people to maintain their dignity and independence. We saw, and people told us, staff also respected their privacy.

People had access to advocacy services and staff could describe when and how to refer people to independent advocates if they needed them.

The complaints policy was displayed at the home and none of the people or relatives we spoke with said they had complained since the last inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines administration was person-centred; however, we identified issues with medicines management at the home.

Not all risks to people at the home had been assessed and mitigated or minimised. A person who had experienced multiple falls had not been referred to a GP or had their care plan reviewed and updated.

Care staff told us they were too busy meeting people's basic care needs to provide other support. Our observations during the inspection confirmed this.

Appropriate checks were made of the building, equipment and facilities to make sure they were safe. The recruitment process at the home was robust.

Is the service effective?

Inadequate

The service was not effective.

Not all staff had received the training and supervision they needed to support people safely.

People liked the food at the home; however, we found people at risk of weight loss were not weighed according to their care plans and the food and fluids they consumed were not recorded properly.

Mental capacity assessments had been completed to establish if people could consent to living at the home and Deprivation of Liberty Safeguards applications submitted for those who lacked capacity. However, no other assessments of capacity had been completed.

Is the service caring?

Requires Improvement

The service was not always caring.

Information about people and staff was not always treated

confidentially.

People and their relatives told us they were not always involved in planning their care. End of life care plans were still not in place although we were told by the acting manager this was because people did not wish to discuss this aspect of their care.

People said staff were caring, respected their privacy and promoted their dignity and independence. We saw they had access to advocacy services and staff gave examples of when they would consider referring a person to an independent advocate.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans we saw had not been evaluated regularly and were not always updated when people's needs changed.

People still did not have access to meaningful activities as care workers were too busy with other tasks to provide them.

Care plans were detailed and person-centred. They included people's likes, dislikes and preferences.

A complaints system was in place and clearly displayed in the home. None of the people or relatives we spoke with had made a complaint since the last inspection.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of audit and monitoring of safety and quality at the home.

People and their relatives had not been asked to feedback about the service so improvements could be made.

Multiple breaches of regulation were identified at this inspection and at the two preceding inspections; this included some continuous breaches of the same regulation.

Sun Woodhouse Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 18, 19, 22, and 23 August 2016. The inspection was undertaken by one adult social care inspector. An inspection manager also attended the feedback meeting with the area manager, nominated individual and acting manager.

Before the inspection we reviewed the information we held about the service. This included the Provider Information Return (PIR) we asked the registered provider to complete before the inspection. This is a form that asks the registered provider to give some key information about the service, such as what the service does well and the improvements they plan to make.

We also contacted a range of organisations and stakeholders, including Healthwatch Kirklees, the local authority safeguarding team and the local clinical commissioning group (CCG). We did not receive any information of concern from any of these organisations.

During our inspection we spoke with five people who used the service; we also spoke with three people's relatives over the telephone after the inspection. We spoke with the acting manager, two of the provider's area managers and the nominated individual. We also spoke with a cook, the maintenance worker and three care workers. During the inspection we spoke with one visiting healthcare professional and after the inspection we contacted one other for feedback about the home.

Some of the people using the service were living with dementia. We made observations during the inspection to try and understand their experience of living at the home. This included an observation in the communal lounge using the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

As part of the inspection we reviewed nine people's care files, three care workers' recruitment records, supervision and appraisal records, five people's medicines administration records, audit and monitoring records and other documents relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Sun Woodhouse. One person said, "Well yes I feel safe", and a second told us, "I would tell the staff if I was worried." Relatives also thought their family members who lived at the home were safe. One relative commented, "Every time I go down [my relative] looks fine and settled", then added, "If [my relative] wasn't safe [they'd] be upset."

As part of the inspection we checked how medicines were managed and administered at Sun Woodhouse. Most medicines came from pharmacy in pre-filled dosettes although some were supplied in boxes or bottles. We observed care workers administering medicines to people during the inspection and saw it was done in a person-centred way. People's medicines were recorded on medicines administration records or MARs. We looked at five people's MARs to see if the medicines they had been administered were recorded properly and saw that they were. We also checked the controlled drugs stored on the premises and found they were stored and recorded correctly.

We found some issues with how medicines were managed at the home. Medicines should be stored at the correct temperature; this is usually less than 25°C unless the medicine needs to be refrigerated. The temperature of the clinic room at Sun Woodhouse was not checked and recorded and on the first day of inspection we saw it was 25°C. The temperature of the fridge was recorded but not always on a daily basis. This meant the service could not evidence medicines were being stored at the correct temperature and there was therefore the risk that medicines may become ineffective.

Some people were prescribed medicines on an 'as required' basis, which meant they only took them when they needed them. In order to administer medicines 'as directed' care workers need a medicine care plan or protocol which is individualised for the specific person and medicine so it is clear how much of the medicine can be given and how often. There were no medicines protocols for 'as required' medicines at the start of the inspection, although the acting manager had put them in place by the third day of this inspection. This meant care workers had lacked the guidance they needed to administer 'as required' medicines safely.

Some people at the home were prescribed topical creams and lotions by their GP. Three of the MARs we looked at had topical creams and none had been signed to say they had been administered; we saw 'administered by carers' had been written instead. When we checked people's care files and daily records to see where the application of topical creams had been recorded, we found it was not done. This meant at the time of our inspection the home could not evidence whether people were receiving their topical medicines as prescribed. The acting manager made sure charts for the recording of topical creams were in place by the third day of our inspection.

We saw some people's allergies were either not recorded on their MARs or information about people's allergies contradicted that documented in other records. For example, one person's MAR said they had no allergies, whereas in their care file it clearly stated they had a penicillin allergy. We saw the allergies section of a second person's MAR was blank and a third person's MAR summary sheet stated they had no allergies, whereas a second laminated sheet was included in the medicine folder which clearly stated the person had

a penicillin allergy. This meant people were at risk of receiving medicines they may be allergic to because records were not accurate or consistent.

Issues with medicines at the home constituted a breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We wanted to see how the home managed the risks to people so we checked people's care files and other risk assessment documentation at the home. We found most people were assessed for their risk of various hazards, such as pressure ulcers, falls and weight loss, but some were missing. For example, one person had bed rails fitted to their bed after they had fallen from their bed. Bed rails themselves can also pose a risk to people, as they could get trapped down the side of them if they are not fitted correctly or try to climb over them, so it is important for such risks to be assessed prior to their fitting. We saw there was no risk assessment in place for this person's bed rails. People who needed assistance with hoists and other moving and handling equipment had risk assessments for these; however, none of the people at the home who were assisted to bathe with the bath hoist had a risk assessment in place. Another person who needed some support with moving and handling but also used equipment to self-transfer had no falls risk assessment in place. This meant the risks to people were not always assessed so that risks could be controlled or minimised.

We looked at the risk assessments the home had in place for the general tasks and building maintenance and to manage the risk of fire. Building maintenance and risk assessments we saw had last been completed in October 2013 and had a review date of October 2014. This had not been done. A fire risk assessment had been undertaken by an external contractor in April 2016 and an action plan of works required produced for the home manager to follow up. We checked whether actions listed in the plan had been completed. According to the action plan there was a requirement for carbon dioxide fire extinguishers to be fitted in three locations around the home; this was deemed to be of medium priority with a timescale of three months from April 2016. At the time of this inspection in August 2016 we saw these fire extinguishers were yet to be fitted.

We checked to see if people had a personal emergency evacuation plan or PEEP. PEEPs provide information for staff or emergency services about what support people need to mobilise plus any other considerations to be taken into account when trying to assist a person to exit the building. We looked in five people's care files to see if they had PEEPs; three people had PEEPs but two people did not. There was an emergency bag in the main reception area which contained evacuation equipment and information; it also contained a one page tick list of room numbers and issues which might affect a person's ability to evacuate. For example, wheelchair users, breathing problems, visual impairments and 'mental health problems'. This list had last been updated on 20 July 2016 and did not include people admitted to Sun Woodhouse since that date, it also did not include people's names, state what assistance they needed to mobilise or a photograph of them to assist emergency services should they need to evacuate the building. We also noted people's PEEPs were not included in the emergency bag; they were kept in individuals' care files which were locked in a cupboard and so would not be useful in an emergency situation. This meant some people did not have individualised emergency evacuation plans; in addition, people would be at risk in event of an emergency incident as suitable measures had not be taken to minimise such concerns.

We asked to see records of fire drills and staff fire safety training at the home. There were no documented fire drills although the acting manager told us the home manager had held three fire drills in one week in August 2016 so that different staff would receive the training. Care workers we spoke with said they had taken part in the fire drills but were not sure when the last fire drill had been prior to this. We checked the home's training matrix to see when staff had last received fire safety training. According to the matrix, of the

16 regular care workers at the home, only five had up to date fire safety training. We also asked five care workers if they had been trained to use the fire evacuation chairs at the top of each staircase. Fire evacuation chairs would be required to assist those people who normally used the stair lift to access their upstairs bedrooms. Of the five care workers we asked, two said they had not been trained to use the fire evacuation chairs and three said they had and thought it had been about one year earlier. This meant staff had not all been trained in fire safety or to use the fire evacuation equipment in place to support people to leave the building in the event of an emergency.

As part of the inspection we looked at records the home kept of any accidents and incidents that had occurred. We saw that when people had experienced a fall records showed they had been checked at regular intervals afterwards and that injuries had on occasion required a GP visit or a trip to the accident and emergency department at the hospital. We noted one person had fallen seven times in the five months prior to this inspection, one of which had required hospital treatment. When we checked the person's falls risk assessment we saw that it had only been updated twice since the first recorded fall. The person's mobility and falls care plan had not been amended since the first recorded fall and evaluations of the care plan which occurred in April, May and June 2016 did not state the person had fallen. An evaluation of the care plan in August 2016 did refer to the most recent fall, but did not trigger an update to the care plan. We checked the person's records of healthcare professional visits and could find no record they had been referred to their GP or another healthcare professional as a result of their falls. This meant there was no evidence of pro-active management to minimise the risk of falls.

Issues with risk assessment and mitigation at the home constituted a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and their relatives if they thought there were sufficient staff on duty at the home. People told us, "I think so, yes", "I haven't felt the need to complain (about insufficient staff)", and, "Well yes, I think so." Relatives we asked if there were sufficient staff said, "There's always two or three walking about, busy or writing reports", "If the place was full they'd need more staff but there's adequate for the people there now", and, "To be honest no. They always seem to be charging around. They always do seem to be a little bit stretched."

Day shifts were staffed by three care workers, one of whom was a senior, and at night there were two care workers on duty. The home had no activities coordinator and care staff were expected to provide activities for the people as part of their role. We spent three days observing the care and support people received in communal areas of the home. This included an observation in the communal lounge using the Short Observational Framework for Inspections (SOFI) We noted that whilst people's care needs were met in a timely way and call bells were answered, staff were busy supporting people or with domestic tasks and did not have time to spend interacting with people. For example, care workers were expected to do the home's laundry. At the time of the inspection the home's tumble dryer had been out of order for three weeks so care workers had been hanging washing out to dry outside; this was time they could have spent interacting with the people. We noted the dryer was fixed on the third day of our inspection.

Staff at the home told us they could meet people's needs but struggled to provide activities and other social stimulations as they were too busy. They told us, "As far as day-to-day activities go, there's not enough (staff)", "We do our best (to provide activities)", and, "You don't have enough time to spend with the residents."

By speaking with people, their relatives and staff, and by observing the interactions between staff and the people at the home, it was clear that whilst people's basic care needs were being met, care workers did not

have time to provide engagement and stimulus to the people living at the home.

This constituted a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as sufficient numbers of care staff were not deployed at the home.

At the last inspection in July 2015 we found a breach of regulation as care workers had not received safeguarding training and could not demonstrate an understanding of how to protect vulnerable people. At this inspection care workers we spoke with could describe the different forms of abuse people might be vulnerable to and all said they would report any concerns appropriately. One care worker said, "I'd tell my manager and report it to safeguarding (the local authority)." Care workers told us and we saw from records they had attended safeguarding training. This meant people were being kept safe by care workers who knew how to recognise and report safeguarding concerns.

At the last inspection in July 2015 we found some parts of the home were not clean. At this inspection we looked in people's rooms (with their permission), in communal areas, the kitchen and in shared and ensuite bathrooms. We saw the home was now clean. People and their relatives also told us they thought the home was clean, although one person asked if the home was clean commented, "Yes I think so. It can be untidy." Relatives told us, "I'm quite happy with the cleanliness of the place", and, "It's a lot better than it used to be." We walked around the home with the acting manager to check equipment such as wheelchairs, hoists and commodes. We saw they were free from any marks or staining.

Records showed safety checks had been made on all of the equipment, facilities and utilities used to support the people at the home or keep them safe. This included checks of gas and electrical appliances, water temperatures, existing fire extinguishers, moving and handling equipment and the fire alarm. This meant the appropriate checks and assessments had been undertaken to make sure the building and equipment at the home was safe.

We wanted to see if the home recruited staff safely so we checked the personnel records of three care workers. We saw recruitment files included all the necessary documents, including a Disclosure and Barring Service check, proof of identity and references from previous employers. The home had also investigated any gaps in prospective employees' employment history. This meant that the home made all the right checks to ensure new employees were suitable to work with vulnerable people.

Inadequate

Is the service effective?

Our findings

People told us they thought the staff were well trained and knew how to support them. Relatives agreed. One told us, "They seem to know what [my relative] needs."

At the last inspection in July 2015 we found a breach in regulation as staff had not received the training or support they needed to do their jobs. At this inspection we checked the training matrix to see what training the staff had attended and asked the acting manager about the measures in place to ensure staff received training. Staff were paid to attend the training courses they attended. Although the majority of care workers had attended training on dementia, safeguarding, the Mental Capacity Act 2005 and moving and handling, which were specific concerns at the last inspection, according to the training matrix some issues remained. For example, of the 16 regular care staff listed on the training matrix, including the home manager, seven had not done health and safety training or nutrition training and nine had not done infection control training. This meant care workers were still not up to date with the training they needed to support people safely and effectively.

At the last inspection in July 2015 not all staff said they had regular supervision or an annual appraisal. 'Supervision' describes a regular meeting between a worker and a manager or more senior worker to discuss work-related issues, training and development or performance. We asked care workers if they received regular supervision. One care worker said they had not had one in 2016, a second care worker told us they had had one or two so far in 2016 and a third said they were due one with the home manager and had had another with the acting manager in 2016. Only one care worker could recall having an annual appraisal sometime in the past but when we checked care workers' personnel records we could find none documented. Care workers did feel this aspect of support had improved since the current home manager started in March 2016. One said, "Things are better now with [home manager's name] in place." We checked three staff files; records showed none of these care workers had received supervision or an annual appraisal so far in 2016. Supervision dates provided by the acting manager shortly after the inspection showed eight staff members had had one supervision up to August 2016 and five had had two. Seven other regular care workers had not had any supervision or appraisal in 2016. This meant although some improvements with training were seen, care staff were still not receiving the training and support they needed to do their jobs safely and effectively.

This constituted a continuous of breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in July 2015 we found a breach of regulation as staff had failed to meet people's nutritional needs. This was due to poor quality food, the lack of people's involvement in designing the menu and issues with the documentation of people's food and fluid intake. At this inspection we asked people what they thought of the food and drinks they received at the home and the feedback was positive. People told us, "It's all right. They've got some good cooks", "I had bacon and fried egg for my breakfast", "I find it (the food) quite good", and, "I had fish and chips and it wasn't bad."

The main meal of the day was served at lunchtime. We observed people were asked for their choice of two meals mid-morning and then their choice was confirmed when they sat down to eat. If a person had changed their mind they were offered the alternative. People told us they got a choice of food and were offered something else if they did not like either option. One person said, "Owt (anything) you like they'll make it for you", and a second said, "I decide what I want to eat." People's relatives were also positive about the food at the home. They told us, "They have quite a good choice and [my relative's] put on weight, which is good", "I'm happy with the diet [my relative's] getting", "[My relative] always says [they] like the food", and, "[My relative's] eating better than [they] were at home and has certainly put on weight." We ate a meal with the people. The dining room was pleasantly decorated and tables were set with cutlery and clean tablecloths. People were seen to be enjoying their food and the meat stew we tried was very tender and tasty. This showed us people enjoyed the food they were offered and were given choices.

We spoke with a cook who had worked three or four days a week in that capacity since January 2016 and had previously been a senior care worker at the home. The cook described how they had consulted the people at the home in order to find out their preferences and drawn up a four weekly menu. The meals we observed being served were largely cooked from scratch, including homemade battered and oven-baked fish, meat stew, fresh vegetables (although some tinned were used) and home baked cakes. The cook had an adequate stock of foods stored in the kitchen and could describe how to prepare foods for people with special dietary requirements, including pureed, diabetic and halal. The cook also had an excellent knowledge of individuals' food likes, dislikes and preferences. However, according to the home's training matrix the cook we spoke with had received no training to ensure they had the skills and knowledge to cook for the people living at Sun Woodhouse. This meant that whilst the cook could demonstrate the skills and knowledge required for their role they had received no formal training.

We checked records for people thought to be at risk of weight loss to see if their nutritional needs were being met. One person's nutritional risk assessment showed they were at high risk of weight loss and had a very low body mass index or BMI. Their accompanying care plan stated the person was to be weighed weekly and have their diet recorded on food and fluid charts. Records showed the person had been weighed a total of five times since their care plan was implemented in April 2016, their care plan had been evaluated three times and their nutritional risk reassessed once. Food and fluid balance charts we saw for the person had been completed but were not sufficiently detailed to determine how much they had eaten.

A second person, also with a low BMI, had a care plan which stated they should be weighed weekly and have their diet recorded on food and fluid charts. Records showed they had been weighed once in the three months prior to this inspection and the evaluation of the care plan completed on 11 August 2016 recorded the person 'remains on a weekly weight chart' even though this clearly was not happening. This person's food and fluid charts also lacked the detail they needed to make them meaningful. For example, on 01 August 2016 the person was recorded to have eaten '3/4' of 'toast', 'all' of 'corn beef hash' and 'B+B pudding' (bread and butter pudding) and 'all' of 'biscuits'. Without recording how much food a person was offered to start with, recording amounts like 'all' or 'half' lacks any real meaning. We also noted that despite the person's steady weight loss since September 2015 there was no record in the healthcare professionals notes, care plan or care plan evaluation to evidence they had been referred to or seen their GP or a dietician.

The failure to support people at risk of malnutrition according to their care plans constituted a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The failure to maintain accurate records of dietary intake for people at risk of malnutrition constituted a breach of Regulation 17 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

At the last inspection in July 2015 we found a breach of regulation as staff had failed to meet people's healthcare needs by providing poor pressure area care and not referring people to other healthcare professionals when they needed it. At this inspection we asked people if they saw a GP or other healthcare professionals when they needed to. People told us they could; they said, "I see the doctor when I need to", "A lady comes to do my feet", and, "They always offer to call a doctor if I don't feel well." We asked people's relatives if the home helped people to maintain their health and they said they did. One relative said, "I think they're very good with that", and a second told us, "If [my relative] needed the GP they'd arrange it." Care files we inspected showed people had seen a range of healthcare professionals, including community nurses, dentists, GPs, opticians and chiropodists.

We checked the care records of a person receiving treatment for a pressure ulcer during the inspection on 18 August 2016. Records showed the person had been seen by a community nurse on 01 August 2016 and they had recommended the person be supported in bed to promote wound healing, have a diet high in protein and Vitamin C and for their skin integrity to be documented daily in their care notes. The person's skin integrity care plan and nutrition care plan were both dated 29 July 2016 and so had not been updated with these instructions and did not reflect them. Repositioning charts evidenced the person had been assisted to reposition in accordance with the care plan when the person was in bed at night, but we noted the person spent a considerable amount of time out of bed during the day. The acting manager said the person could decide not to stay in bed during the day as advised by the community nurses if they wished. When we checked daily records for the person between 01 August and 08 August 2016, there was no reference to the person's skin integrity and no evidence the person had been advised to stay in bed and chosen to get up instead. This meant pressure area advice provided by the community nurses had not been adhered to.

During the inspection we noted people's special pressure relieving cushions did not always go with them when they were supported to mobilise around the home. For example, at lunchtime on the second day of the inspection we noted that when two people were assisted to the dining room their pressure relieving cushions remained in the lounge area as they sat on dining chairs during the meal. A healthcare professional who visited the home told us they had also noted pressure relieving cushions were sometimes left on wheelchairs and lounge chairs when people went to eat in the dining room and had advised staff to make sure it did not happen. This meant that care workers did not always support people in accordance with their skin integrity care plans.

Issues with pressure area care constituted a continuous breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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

At the last inspection in July 2015 we identified a breach of regulation as staff were not working within the requirements of the MCA as it was not clear how people's capacity to make decisions had been established.

Care workers' knowledge of the legislation and how it impacted upon the people they supported was also found to be poor. At this inspection we spoke with care workers about the MCA. We found they had all received training and could describe the process of establishing capacity and understood how best to support individuals to make basic decisions, such as what to eat or wear. This meant the knowledge of care workers had improved considerably since the last inspection.

We checked care files to see if capacity assessments had been undertaken for people who may lack mental capacity due to health conditions such as dementia. Records showed capacity assessments had been undertaken to establish if people had capacity to consent to living at Sun Woodhouse. Those deemed to lack capacity to make this decision had been subject to a best interest decision and DoLS application to the local authority. However, no other capacity assessments had been undertaken of the people living at the home to establish if they could consent to, for example, receive care and treatment or be supported with moving and handling equipment. The acting manager said the home had planned to put these assessments in place as soon as possible. This meant that whilst improvements had been made in terms of staff knowledge and the submission of DoLS applications, there was still work to do to ensure the home was fully compliant with the MCA.

Requires Improvement

Is the service caring?

Our findings

We asked people if they thought the staff at Sun Woodhouse were caring and they said they were. One person told us, "Yes they are", and a second person said, "Oh yeah. If they weren't they'd know about it." People's relatives agreed. One relative told us, "I have no complaints at all. They (the staff) speak well of [my relative]. They say they don't know what they'd do without [them]". A second relative said, "They're always talking nicely to [my relative]", and a third said, "They genuinely do care about [my relative]." The relatives we spoke with all told us they were made to feel welcome by staff and could visit the home any time they wished. One relative said, "Every time I go they make me a cup of tea and bring biscuits", and a second commented, "The staff are always welcoming. You never feel like you're in the way."

When we arrived on the first day of inspection at 7.30am there were several boxes of records in the reception area of the home. We looked through the boxes and found they contained the care files of people no longer living at the home and staff personnel files. The latter included sensitive information such as employment references and health check forms. A care worker informed us the records had been placed there the day before and were awaiting transportation to the home's archive. This meant confidential information about people and staff had been left unsecured in an area people, visitors and staff could access it. During the rest of the inspection we saw people's day-to-day records, care files and other confidential information about them was stored securely. We also sat in on two handover meetings between the night care staff and day care staff coming on duty. The meetings were held in a room off the main lounge area where people were sitting with the door open. Such meetings involve discussion of individuals' health and wellbeing and should be held in private.

Issues with confidentiality at the home constituted a breach of Regulation 17 (1) and (2) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they were involved in designing their care plans and the feedback was mixed. One person said, "They asked me questions about my care plans", and we saw this person had signed their care plans. Another person could not recall if they had been consulted about their care plans and a third person said they had not been asked. We noted both of these people's care plans were detailed and person-centred which suggested they or their relatives had been involved in designing them; however, neither person had signed them. According to a fourth person's safety care plan, bedrails had been fitted to their bed. It read, 'Now has bedsides due to previous falls', but there was no mention of the person being consulted and they had not signed the care plan. We asked the person if they had been consulted about having bedrails fitted. They told us that whilst they liked the bedrails and felt safer with them, they had not been asked about whether they should be fitted beforehand.

Two of the relatives we spoke with said they had been asked about their family member's care plans in the past by the home; both estimated it was over 12 months since they were last consulted. A third relative had not been asked to be involved in care planning for their family member. The acting manager told us people were consulted about their care plans, and their relatives too when it was appropriate. They said when care plans were next reviewed people who chose to be involved would be encouraged to sign them and it would

be documented if they chose not to. This meant people were not always consulted about the care and support they received and did not routinely sign their care plans.

At the last inspection in July 2015 we observed interactions between staff and the people at the home were not always respectful. At this inspection the majority of interactions we observed were positive. People and staff were seen chatting in a relaxed way as support was provided and it was clear care workers knew people well as individuals. One person told us, "The staff know me well, what I like."

Despite the positive interactions observed we saw that there were some occasions when interactions were less respectful. We saw care workers providing support to people without speaking with them, for example, during mealtimes and in the lounge area. We discussed this with the acting manager and they said the need for respectful interaction with people would be discussed in upcoming care worker supervisions.

People told us care workers respected their privacy. One person said, "They (the staff) knock on the door. I've got a key", and a second said, "They wouldn't just open the door." Some people had chosen to have their bedroom doors open and we saw this was documented in their care plans. We observed care workers knocking on people's doors before entering during the inspection. This showed us care workers respected people's privacy.

Care workers supported people to maintain their dignity. We saw care plans described how people liked to dress and be supported with their personal hygiene. People looked well cared for; they were dressed in clean clothes and their hair had been brushed or combed. We asked people if they could have a bath or shower when they wanted one and they said they could. One person told us, "I can have a shower whenever I want", and a second person said, "I could have a shower more often if I wanted." This meant people were supported to maintain their dignity by care workers.

People told us care workers promoted their independence. One person said, "The staff encourage me to do things for myself", and a second described how care workers would support them to maintain their personal hygiene by encouraging them to wash the parts of their body they could reach. All of the people we spoke with said they could get up and go to bed when they wished. Care workers told us they helped people to stay independent by giving them choices. One care worker said, "I ask them what they'd like to wear, how they like their hair." This showed us care workers encouraged people to maintain their independence.

Information on advocacy services was prominently displayed in the home and care workers we spoke with could give examples of when they would consider referring a person to an advocate. Not all staff knew the exact referral process but all said they would speak with a manager if they felt a person needed this type of support. None of the people at the home at the time of the inspection had an independent advocate but care staff, including the acting manager, could describe which people's relatives were involved in their care and acted as advocates for them.

At the last inspection we noted people's care files did not contain their end of life wishes and there were no 'do not attempt cardiopulmonary resuscitation' care plans in place (or DNACPRs). At this inspection we noted people's care files still did not contain end of life care plans or record their care preferences for when they approached the end of their lives. We did see seven people now had DNACPRs in place. None of the people at the home during the inspection were receiving end of life care but the acting manager told us the home had supported people previously who were at the end of their lives. We saw positive feedback had been received from family members of people who had received end of life care at the home; care workers had been invited by families to attend funerals and had done so. The acting manager described how care plans were amended as people reached their end of life and how the home worked with the community

nursing team to ensure people were support to be comfortable and pain-free. They also explained the subject of end of life care was broached with people and their families during care planning meetings; however, the majority of people did not wish to discuss this aspect of care. The acting manager said in future any such discussions would be documented to show attempts had been made to plan people's end of life care.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in July 2015 we identified a breach in regulation as staff had failed to plan person-centred care as care plans were not all up to date, how people were involved in planning their care was not clear and the activities provided by the home were poor. During this inspection we looked in detail at two people's care files and at various aspects of seven other people's. Each care file was laid out in a consistent format and information was easy to find. People had care plans for a range of support needs, including health and wellbeing, hygiene and personal appearance, memory and understanding, and medicines. Some care plans had associated risk assessments, for example skin integrity, and mobility and falls.

Care plans we saw contained information about people's likes, dislikes and preferences. We were impressed with the level of detail some care plans contained, particularly those describing the support people needed with mental health conditions. As discussed earlier in this report, most care plans we saw were not signed by the people they pertained to; however, the level of person-centred detail they contained showed people and/or their relatives had been involved in designing them. Care workers told us if a new person was admitted to the home they would read their care plans, speak to the person to get to know them and speak to other care workers in order to learn their preferences. The training matrix showed nearly all care workers had attended training on care planning and we saw different care workers had written plans with the same level of detail and to the same high standard. This meant people's care plans were well written and individualised to suit them.

In order for care plans to remain relevant they need to be evaluated and reviewed regularly so updates can be made when people's needs change. None of the care plans we saw had been evaluated on a monthly basis since the last inspection in July 2015. For example, one person's nutrition care plan dated 09 March 2016 had not been evaluated in either June or July 2016. A second person's nutrition care plan dated 24 April 2016 had also not been evaluated in June or July 2016 and a third person's health and wellbeing care plan dated 05 March 2016 had only been evaluated three times since then. As discussed earlier in this report, we found examples where people's support needs had changed but their care plans had not. This meant people's care plans were not evaluated on a regular basis and did not always contain the correct information care workers needed to meet people's needs.

We asked people what activities were on offer at the home and if they had enough to do. One person said, "People come you see – singers and exercises. Not very often, every month or two", and a second person told us, "They (the other people) just watch television. There's no talking and it is a bit boring."

Care workers kept daily records of the activities people took part in so we looked at what five people had done in the three weeks prior to this inspection. One entertainer had visited the home within the three weeks and some people had been visited by friends or relatives. Apart from this there was no record of any other activities being provided by care workers at the home. For example, one person's record showed they had watched television or listened to music in the lounge on 10 of these days; a second person had watched television or listened to music in their room or the lounge on 18 of these days. As part of the inspection we observed the care and support people received in communal areas; apart from brief games of skittles and

dominos involving a few people in the lounge, people either watched television or listened to music all day in the lounge. Care workers told us and we saw they were too busy meeting people's care and support needs to provide activities. One person said of how often care workers provided activities, "Not very often. They're busy with other jobs."

Care plans were not always evaluated and updated when people's needs changed and people still did not have appropriate access to meaningful activities. This constituted a continuous breach of Regulation 9 (1) and (3) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A system was in place for receiving and responding to complaints. We saw the complaints policy was prominently displayed in a communal area of the home. No complaints had been received by the home since the last inspection. We asked people and their relatives if they had ever made a complaint or if they knew how to make a complaint if they needed to. One person said they had made a complaint in the past and it had been sorted out very quickly. Other people told us they had not made any complaints before but would feel happy to speak to staff if they needed to. Relatives we spoke with told us they had never had cause to complain either. One relative said, "If I thought there was something wrong I'd go straight into the office and let them know", and a second told us, "I would ring the care home manager." This meant people and their relatives knew how to complain and felt confident to do so if the need arose.

Inadequate

Is the service well-led?

Our findings

At the last inspection in July 2015 a peripatetic manager was in place; their role was to run the home and make improvements until a new manager could be recruited and become registered with the Care Quality Commission (CQC). At this inspection we found a home manager had been recruited in March 2016. However, they were still registered as manager at their previous home and had not yet applied to become registered manager at Sun Woodhouse. This meant there had been no registered manager in post at the home since April 2015 after the departure of the previous registered manager.

Feedback about the current home manager from those who knew them was relatively positive. One person told us, "[They're] all right. [They're] around yes. In the office"; the other people we spoke with did not know who the home manager was. One relative said, "I have more confidence now. The new manager impresses me"; the other relatives we spoke with did not know the home manager. Relatives did comment on the changes in management at the home. They told us, "I think the managers have changed two or three times", and, "They've had an enormous number of changes in management."

When we arrived for the inspection we were surprised to find the home manager had taken 27 days' annual leave and a senior care worker was acting manager of the home. Under the Care Quality Commission (Registration) Regulations 2009 registered managers must inform CQC about periods of absence of 28 days or more. As the home manager was currently not registered with CQC and the annual leave taken was 27 days, a statutory notification was not required. However, an informal notification or discussion with CQC around the arrangements in place at the home in the home manager's absence would have been beneficial.

We discussed the decision-making process for covering this extended period of leave with the area manager. They told us various options had been discussed, including bringing in a peripatetic manager. However it was decided the senior care worker had the appropriate skills and experience to manage with support from them and a peripatetic manager. The acting manager described shadowing the home manager for eight days prior to their annual leave and said the area manager and other staff working for the provider often popped in as provider's head office was in a building next to the home. They told us, "I do feel confident and head office are just six steps away." Despite our initial concerns about the acting manager's lack of managerial experience, we found them to be professional and capable and well respected by the other staff.

At the last inspection in July 2015 a system of audit had just been implemented; lack of audit and monitoring had been an issue at the home at the inspection prior to this. At this inspection we asked to see the audits which had been undertaken since the current home manager started in March 2016. We found no audits had been completed in August or July 2016. A medicines audit was done in June 2016, but this was the only documented audit at the home that month. In May 2016 the only documented audits were a complaints audit and an infection control audit. In April 2016 there was a medicines audit and an action plan for people found to be losing weight but no other audits were undertaken that month. This meant monitoring of care plans, pressure ulcers, health and safety, weight loss, accidents and incidents and other aspects of the service was not being done by the home manager. The home manager was therefore not monitoring the home for safety and quality on a regular basis. The home's previous area manager showed

us a new computer system which displayed accident and incident information which could be used to highlight any trends; however, there was no evidence this had been done by either the current or previous area manager or the home manager.

During the inspection we saw records of 'daily walkarounds' by senior care workers which started at the home in the middle of March 2016 and were completed on a largely daily basis until they stopped on 11 May 2016. Senior care workers had been asked to check for and log any health and safety or infection control issues that needed to be addressed. The acting manager told us the records stopped because the home manager had intended the checks to become part of standard practice and not require documentation.

The area manager provided a list of the recurring tasks the home manager was expected to complete. We saw this included oversight of weekly care plan audits, monthly pressure area audits, monthly infection prevention and control audits, monthly weight audits, monthly medicines audits and monthly analysis of safeguarding incidents and other accidents and incidents. Provider visits undertaken by area managers in April and June 2016 noted the lack of audit at the home. The area manager for the home said they intended to address the lack of audit with the home manager when they returned from annual leave; however, we noted the area manager's visit had taken place nearly six weeks prior the home manager going on leave so there was ample opportunity for this to happen before the home manager went on holiday. This meant the provider was aware audits had not been undertaken at the home but had not acted to address the issue. The acting manager told us the home manager had not mentioned audit during their period of shadowing and they had assumed the audits had been done prior to the home manager's annual leave.

The lack of audit at the home constituted a breach of Regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and their relatives if they attended residents' and relatives' meetings at the home or if they were given surveys to provide feedback. People we spoke with could not recall receiving surveys, but one person said residents' meetings were held, "Every so often." One relative we spoke with said they had never been asked to attend a residents' and relatives' meeting and had not received a survey. A second relative said of surveys, "They used to send them periodically. I've not had one for a while", and of meetings, "They used to be two to three a year. The last one was well over 12 months I think." Records at the home showed a survey last went out in July 2015. No records of residents' or relatives' meetings could be located during the inspection. The provider visit in April 2016 found there was no evidence of residents' meetings or of surveys undertaken. The record of the provider visit in June 2016 stated 'residents meeting to be booked'; at the time of our inspection this had yet to be done.

Feedback was not obtained from people and their relatives in order to improve the service. This constituted a breach of Regulation 17 (1) and (2) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the feedback session for this inspection with the acting manager, area manager and nominated individual we shared concerns regarding the inspection history and quality of service provided at the home. A nominated individual is a person appointed by the provider to supervise the management of the carrying on of the regulated activity. An inspection in March 2015 rated the home as inadequate in the domains of Safe, Responsive and Well-led, and therefore as inadequate overall. An inspection in July 2015 rated the home as inadequate in Effective and as requires improvement overall. This inspection has rated the home as inadequate in Effective and Well-led and as inadequate overall. Several issues identified at this inspection were also identified as concerns or breaches of regulation at the last two inspections. These include problems with adequate staffing, concerns over people's nutrition, the lack of meaningful activities, a lack of

audit and monitoring and the failure to seek feedback to drive improvement. These persistent issues demonstrated a consistent lack of oversight on the part of the nominated individual. The situation has been further exacerbated by the lack of registered manager at the home.