Woodean Limited

Sunhill Court Nursing Home

Inspection report

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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

Overall summary

The inspection took place on 30 June 2015 and was unannounced.

Sunhill Court Nursing Home provides nursing care for up to 40 older people with dementia care needs and/or mental health needs. At the time of our inspection, there were 39 people living at the home. Sunhill Court Nursing Home is a large Edwardian building on the outskirts of Worthing which overlooks the South Downs. There are several communal areas – a large lounge, dining area and conservatory on the ground floor and a smaller lounge on the first floor. People have their own rooms and have access to a large garden at the rear of the property.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks to people were not identified or assessed adequately to prevent them from harm. Carpeting which had lifted away from the floor in one area posed a trip hazard to people. There was a lack of ventilation in the conservatory during the hot weather. Care staff were

Summary of findings

observed drag lifting one person rather than using a hoist. Staff were not fully conversant with the requirements of local safeguarding procedures and requirements. Accidents and incidents were not used to update people's care plans. Monitoring of one person's pressure ulcers was inadequate. There was a lack of suitable staff to keep people safe at all times and meet their needs. People did not always have access to their call bells when they wanted to summon help. Medication Administration Record (MAR) charts showed a large number of omissions where staff had not signed to say people had received their medicines. Medicines were not stored, audited or managed safely. However, people told us they felt safe.

Staff did not receive adequate supervision or appraisals and were not asked for their feedback. Not all staff had received the training they needed to meet people's needs effectively. The majority of staff did not have English as a first language and workbooks were supplied in English. There were no systems in place to identify specific training needs to ensure that staff were able to meet people's needs overall. Staff had no understanding of person-centred care. Consent to care and treatment was not always sought in line with legislation and staff had a limited understanding of the requirements of the Mental Capacity Act 2005 and associated legislation under the Deprivation of Liberty Safeguards. People were not assessed on their capacity to make decisions. People were not always supported to have sufficient to eat and drink and to maintain a healthy diet. People did have access to healthcare services and professionals when needed. The physical environment of the home was not always conducive to people who lived with dementia.

Some care staff treated people with kindness and understanding, whilst other staff were more task orientated. People were not always treated with dignity and respect and there was a lack of empathy from some staff. People and relatives thought staff were kind and caring and that they were looked after well.

Care plans did not record people's life histories, their hobbies or interests. There was a lack of activities organised that reflected people's preferences. Mental stimulation was limited and some people were sitting idly or distressed. People were not always responded to or supported in a positive manner by care staff. Complaints were logged, but were poorly managed, with no recorded evidence to show how they had been responded to.

Quality assurance and governance systems were not fit for purpose. The provider had failed to identify areas of concern such as gaps in medication records. There was no robust system in place to drive continuous improvement and a lack of good management and leadership. Staff were unsure of what was expected of them. Residents' meetings were held monthly and relatives were asked for their views about the home.

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

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve;
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Risks to people were not managed to protect them from harm.

Staffing levels were insufficient to meet people's needs at all times.

Medicines were not managed safely.

Inadequate

Is the service effective?
The service was not effective.

Not all staff had received sufficient training and supervision; appraisals were not fit for purpose.

Staff had a limited understanding of legislation associated with mental capacity and people's consent was not always sought when they received care.

People were not always supported to have sufficient to eat and drink.

People had access to healthcare professionals and services.

Inadequate

Is the service caring?
Some aspects of the service were not caring.

Some care staff treated people with kindness and understanding, whilst others were more direct in their approach. People were not always treated with dignity and respect.

People and their relatives felt that staff were caring and kind.

Requires improvement

Is the service responsive?
The service was not responsive.

Care plans were not personalised and there was a lack of information about people's life histories and their preferences. No account was taken of people's interests when activities were organised.

Staff did not always know how to respond appropriately to people who lived with dementia.

Complaints were not managed effectively.

Inadequate

Is the service well-led?
The service was not well led.

There was a lack of effective systems in place to measure the quality of care provided. Audits were not undertaken to identify any shortfalls or any action that needed to be taken.

Inadequate

Summary of findings

The service did not demonstrate good management and leadership.

People and their relatives were asked for their views about the service, but the service did not evidence how their views were acted upon to drive improvement.

Sunhill Court Nursing 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.

The inspection took place on 30 June 2015 and was an unannounced inspection.

The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with people, their relatives and staff. We observed care to help us understand the experience of people who could not talk with us. We spent time looking at records including 20 care records, four staff files, six staff supervision and appraisal records, in excess of 20 medication administration record (MAR) sheets, the staff training plan, quality audits, complaints and other records relating to the management of the service.

On the day of our inspection, we spoke with seven people using the service, two relatives, the provider, the registered manager and five members of care staff.

This service was last inspected on 16 July 2013 and there were no concerns.

Inadequate

Is the service safe?

Our findings

Risks to individuals and the service were not managed safely to ensure they were protected from harm. Premises were not managed to keep people safe. On the first floor of the home, the carpeting was extremely stained and dirty. Outside one person's bedroom, the carpet had lifted up and was a trip hazard to this person who had mobility issues. In the next door bathroom, the carpet had also lifted causing a trip hazard. During our tour of the home in the morning, the registered manager informed us that carpet tape was usually stuck over the loose carpet to mitigate the risk, but this was not in place on the day of our inspection, nor was the issue resolved later on in the day when we checked. After the inspection, the provider informed us that the defective carpeting had been replaced with new laminate flooring.

A door leading to staff living quarters on the second floor was operated through a key coding system. We were informed by management that this door should be closed at all times, as the stairs beyond were a trip hazard to some people living at the home. On the day of our inspection, we observed that the door was left open twice; this posed a risk to one person who was observed walking in this area of the home. A ramp leading from the home into the garden was uneven posing a trip hazard.

The day of our visit was one of the hottest of the summer with temperatures nearing 30 degrees Celsius. The Met office issued alerts to advise the public that the heat could affect the health and well being of vulnerable groups including older people and those with long-term illnesses. During the inspection, we observed the majority of people spent the day in a communal conservatory/sun lounge attached to the rear of the premises and this area was extremely hot on the day we visited. There were two cooling systems in place and one system was switched on and in use at one end of the conservatory. The cooling systems were remote controlled and staff demonstrated their knowledge of the systems. The other cooling system was not in use and the registered manager stated that people often did not like it on as they would complain it was too cold. Windows were opened in an attempt to ventilate the area, however, there was no assessment of risk and actions to be taken to protect people from the heat.

Although some staff had received training in manual handling, health and safety and falls awareness, the competencies of staff in this area varied greatly. We observed one person in their room who had slipped right down their chair and was at risk of falling to the floor. The person could not reach their call bell, so we summoned staff to assist. Two care staff came promptly and told us that this happened frequently with this person. They then manually lifted this person taking their full weight to standing by drag lifting them under the arms and tugging them back into the chair. There was no verbal communication during this procedure and no reassurance was given to the person. About 20 minutes later, we observed that the same person had slipped down their chair again. This time, two different care staff responded and a hoist was procured. When we asked the care staff whether this person should be hoisted, they said that they did not know. The hoist was not used and the person was moved by staff who used an underarm lift. One member of staff then said to the other, "Leave the hoist there and when my other colleague gets here, we'll put her in bed". Both people and staff were placed at risk because staff demonstrated a lack of understanding of safe moving and handling processes.

Arrangements were not in place to review safeguarding concerns, accidents and incidents. Although safeguarding training was a mandatory training topic, staff questioned appeared to have only a superficial understanding of safeguarding and this lack of knowledge could put people at risk. Care staff were unaware of the local authority's multi-agency safeguarding policy and what action to take if they suspected abuse was taking place. Staff knew some of the different types of abuse that might occur, but were unable to identify what might constitute a safeguarding concern when presented with a mock scenario.

The registered manager told us that care plans were generally reviewed monthly or if people's needs changed. Three people had been involved in three different, recent incidents. Following review of the incidents, these people were assessed as requiring 15 minute observations. There was no review of the care plan following these incidents. When the care plan was reviewed for these three people, the review stated, 'No change'. When we asked staff why 15 minute observations were in place for these people, two members of staff said they did not know. Therefore risks associated with people's care had not been assessed or planned for when their needs changed.

Inadequate

Is the service safe?

These incidents related to people attempting to leave the home unaccompanied. There was no evidence to show that learning had taken place as a result of these incidents. In one person's care plan, it was logged that they were aggressive with staff and that they said, "I want to go home". They had tried to leave the home three weeks later. Another person had been logged as, 'restless, wandering around, disturbing other residents' and had tried to leave the home through a fire door. A care plan review undertaken in June 2015 showed that no changes had been made to this person's care plan, despite the above incident. No action was taken to find activities to provide mental stimulation to these people, no changes had been made to people's routines, just a coping strategy in place to 'contain' people. Risks were not managed proactively to ensure people's safety and well-being.

On the morning of our inspection, we asked care staff why ten people were still in bed. Three staff members were unsure and one staff member said it was because they were at risk of falls.

Arrangements were not in place to monitor and report pressure ulcers to make sure necessary action was taken. One person had five pressure ulcers ranging from grade 1 to grade 4. Any ulcer of grade 2 or above should be investigated using a tool such as Root Cause Analysis. This is a tool for management of pressure ulcers. Any ulcer of grade 3 or above should be considered as possible neglect and reported or notified as a safeguarding concern to the local authority and directly to CQC as required in CQC regulations. The registered manager did not take this necessary action. In addition to the above, people with pressure ulcers of grade 3 or above should have a detailed assessment of the ulcer which is recorded. The assessment should be supplemented with photography and/or tracings. The ulcer should be reassessed at least weekly. There was a wound record in place for this person which showed that their ulcers were checked every two to three days and their dressings were changed. Although there was routine wound care given, there was no clear wound monitoring in place to check whether they were improving or deteriorating. If a pressure ulcer fails to respond to effective wound management or is deteriorating, then a referral should be made to a tissue viability nurse, either directly or through a GP. The registered manager could not evidence that this had been done.

People's medicines were not managed so that they received them safely. In excess of 20 Medication Administration Record (MAR) charts were checked. Out of 20 MAR charts, there were 87 gaps in recording from 1 – 30 June, where the registered nurse had not signed to confirm whether people had received their prescribed medicines. Drugs prescribed for conditions such as depression, schizophrenia, bi-polar disorder and insomnia may have been administered, but MAR charts did not confirm this on 87 occasions. One person had refused their medicine to treat a thyroid condition so that they had not taken their prescribed medicine between 16 and 30 June, with two additional gaps to recording within the month. There was no evidence to prove that any action had been taken by the provider to address this, for example, that the person's GP had been consulted or that the medicine could be administered in an alternative way. This put their health at risk.

Another person was prescribed medicine daily for their dementia. The MAR chart showed that on 11 June, there were 14 tablets in stock for this person. There were eight tablets left in the packet on 30 June, but based on the prescription, this medicine should have been used up by 24 June. This meant that the person was not being given their prescribed medicine.

A dedicated refrigerator was in use to store medicines that were required to be kept within a certain temperature range to maintain their effectiveness. An opened bottle of eye drops, which should have been disposed of after 28 days, had not been removed from the fridge. There was a bottle of an antipsychotic medicine for one person which was marked as 'spare' in the fridge. The MAR chart for this person showed that the medicine was no longer needed and had not been prescribed, but the medicine had not been disposed of. There was a fridge temperature chart, but no temperatures had been recorded for June and the sheet was blank. A policy on the fridge stated that any temperature outside 2 – 8 deg C range must be reported to the registered manager. On the day of our inspection, the fridge showed a temperature of 0.7 deg C; this had not been recorded on the temperature record and had not been reported to the registered manager. This could have an impact on the effectiveness of the medicines if they were not stored at appropriate temperatures.

At the provider's operational managers' meeting, minutes dated 7 May 2015 stated, 'All staff administering medication

must sign the MAR sheets immediately. Medication, including controlled drugs, should be audited monthly by the manager and six monthly by the pharmacist and a record of these kept'. The managing pharmacy had undertaken an advisory visit in February 2015 and no issues were identified at that time. The registered manager told us that they had undertaken monthly audits and that one was planned on the day of our inspection. However, there was no evidence to show that any medicines audit had taken place since the pharmacy audit four months ago.

The above evidence demonstrates that the issues above are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were insufficient numbers of suitably qualified staff to keep people safe and meet their needs at all times. The home relied heavily on agency staff to provide care to people and this resulted in a lack of continuity of care. The registered manager told us that they needed to recruit registered nurses to cover some day and night shifts. At the time of our inspection, registered nurses were supplied from an agency. Many care staff worked a twelve hour shift, which was their preference. People did not always have their call bells within reach when they needed to summon assistance from care staff. One person was heard calling repeatedly for a member of staff and said, "Help me, help me. Open the door, help me, I need help, I'm locked in". After 15 minutes, with no staff present on this floor, we alerted care staff using the person's call bell. Staff responded promptly and a cup of tea was offered. The member of care staff said, "They [staff] will bring you downstairs, you don't have to call, we are here for you. I look after all these people like you". The care staff then put the television on, left the room and closed the door. We heard this member of staff say, "I have to see to everybody, I'm here for all the residents, I can't stay here all day".

Care staff told us that there was little opportunity to take people out because of a lack of staff, especially at weekends.

We observed another person leaning right out over their chair in an attempt to get a straw into their beaker of juice. They could not reach their call bell. We observed this went on for at least 20 minutes and there were no care staff on this floor. There were not always enough staff available at certain times of the day. For example, at meal times, in addition to care staff, a member of cleaning staff supported people to eat their meals. Staff did not appear to have time to offer people enough emotional support and stimulation. At 4.30 pm on the day of our inspection, we saw that four staff were having a cigarette break outside the front of the property. We observed that during this time, there were no care staff available in the main communal areas. People were unable to ask staff for assistance and were heard calling out.

Throughout our inspection we observed several examples of both nurses and care staff providing care and treatment which was not safe and placed people at risk of harm. This demonstrated that staff were not entirely skilled or competent to carry out their roles safely.

The above demonstrates that there were insufficient numbers of suitably skilled and competent persons deployed in order to ensure people's safety. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe, free from harm and would speak with staff if they were worried or unhappy about anything. One person said, "I've not been here long and 'yes' I suppose I feel safe. If something was really bothering me I would definitely speak up, especially if I was getting anxious about it". Another person told us, "I'm very safe, no question and would discuss it", meaning they would talk to staff if they did not feel safe.

People said their medicines were administered on time and that supplies did not run out. One person referred to staff and said, "They sort my tablets and everything out, 'yes' it's always fine. I get them when I should and nothing has ever run out as far as I know". We observed medicines being administered to people by a registered nurse at lunchtime. The medicines trolley was kept locked when the nurse left to give people their medicines. The nurse communicated well with people, asking their permission before administering medicines and explaining what the medicines were for.

When asked if people felt there were sufficient numbers of staff on duty to meet their needs, one person said, "They can be a bit tight on staff sometimes, but they have a lot to deal with".

The service followed safe recruitment practice. Staff files showed that all necessary checks had been undertaken to ensure that new staff were safe to work with people at risk.

Inadequate

Is the service safe?

Following our inspection, we raised a safeguarding alert in relation to the concerns we found at this inspection.

Inadequate

Is the service effective?

Our findings

People did not always receive effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Six staff supervision and appraisal records were checked. The appraisal records had a tick box system divided between professional attributes, personal attributes and practical skills of staff. There was a feedback box for the registered manager's comments and the member of staff. In all records, the report was completed by the registered manager, but there were no comments or feedback from staff. Comments from the registered manager were largely critical in nature and were based on work performance of staff with no agreed plan of action to address the perceived weakness. Supervision records were similar in design and content, with no input from the member of staff concerned and no issues to be actioned. When questioned, three care staff did not understand what supervision was. We had difficulty in ascertaining the value of these systems and how they were used to improve the quality of care delivery.

A training plan showed that staff received training in the following topics: death and bereavement, dementia, diabetes, diet and nutrition, health and safety, infection control, mental capacity, pressure sore prevention, record keeping, risk assessment, equality and diversity, falls awareness, fire safety, first aid, administration of medicines, coping with aggression and substances hazardous to health. Based on the information supplied in the training plan, not all staff had completed their mandatory training and there were no systems in place to monitor when training had been completed. Training was delivered by an external agency and staff completed workbooks supplied by the agency on work related tasks. The majority of the care staff did not have English as a first language and the use of workbooks written in English appears to have had an adverse effect on their understanding. The training plan showed that one member of staff had completed infection control training, but when we checked this with the member of staff concerned, she said that she had not completed the training.

In the Provider Information Return, it stated that fourteen staff had a National Vocational Qualification Level 2 in Health and Social Care, although this was not evidenced in the records we looked at.

There did not appear to be any systems in place to identify specific training needs of staff based on what was happening in the home and no follow-up to aid understanding. For example, no training was offered on person-centred care. Staff had no concept of person-centred care when asked. Up to nine people living at the home had mental health needs, but there was no training in mental health awareness. When asked how many people at the home were receiving end of life care, two staff said, "No-one", one staff member thought it was, "Five or six" and another staff member said, "Twenty-nine". Therefore staff were not suitably knowledgeable or skilled in meeting the needs of the people who lived at the home.

The issues above are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Consent to care and treatment was not always sought in line with legislation and guidance. Staff did not understand the relevant requirements of the Mental Capacity Act (MCA) 2005. In the Provider Information Return (PIR) which the registered manager had submitted, it stated that 11 care staff had received training on the MCA and Deprivation of Liberty Safeguards (DoLS). However, when we asked care staff about their knowledge of these areas, they appeared unsure. There was no information within the care records to show how people were asked for their consent to care and treatment. There were no assessments within care records to show whether people's capacity to make decisions had been evaluated.

Some people living at the service were subject to DoLS and the registered manager was in the process of applying for authorisation of these from the local authority. DoLS protects the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. However, without a clear assessment of the person's mental capacity, an application for DoLS authorisation would not be appropriate. Therefore people's rights to consent may have been infringed upon because the provider had not followed relevant legislation and guidance.

The issues above are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

People were not always supported to have sufficient to eat, drink and maintain a balanced diet. The Provider Information Return completed by the registered manager stated that 14 people were at risk of dehydration and malnutrition. These people could not be easily identified from the information in their care plans and staff, when asked, did not know who they were. Fluid charts had been completed by staff for some people living at the home and we checked seven fluid charts. Staff had recorded the amount of fluids consumed by people, however, we observed that some people had not touched their drinks over a particular time period. We were informed that drinks had been replaced within this time frame. Whilst fluid recording charts identified the quantity of fluids that people had been given, it was not clear whether people had actually consumed these amounts. We observed that people's drinks were taken away by staff before they had been finished. In one instance, a member of care staff asked a person if they had finished their drink, but before the person could respond, the drink had been taken away. Another person informed a member of care staff that their tea had gone cold, but was ignored. This may have placed people at risk of dehydration

One person in the foyer area had hardly touched their lunch. A member of staff asked them, "Do you want your quiche?". The person said, "No", but was not offered an alternative. A second dessert was offered to one person and accepted, but the dessert never arrived and another member of staff cleared the person's table away. Staff often used directive language such as, "Open your mouth please", "Have a drink" and "Have more now". One person was asleep in their room and we observed two full beakers of tea/juice which remained untouched the entire morning. People were not supported to eat and drink in sufficient quantities.

The issues above are a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Seasonal menu choices were planned over a four week period, with two main food choices, although alternatives were available. People's individual dietary needs were taken into account, for example, people with diabetes or food allergies. Meals were prepared according to people's needs and some people needed a soft diet or for their food to be liquidised. The chef knew people's dietary needs well and gave examples of people's individual food needs and preferences. Snacks were available to people at any time of the day. People were asked for their menu choices the day before, which is not best practice for people living with dementia, who may forget what they had chosen or wanted to change their minds. Comments from people included, "I do get a choice and I can have my meals brought to me if I want to", "The food's ok, it could do with a bit more flavour and spices" and "I'm diabetic and the food's taken care of for that".

At lunchtime, tables were laid up in the dining area with tablecloths, condiments and serviettes. There was a large whiteboard with the day's menu displayed on it. People who ate their meals in the conservatory at smaller tables also had tablecloths provided. Staff were talking with people and one said, "[Named person] are you sleeping?" (This was said gently so as not to alarm the person.) "I have your lunch for you. Can you reach the table?" Another member of staff said, "[Named person] I have your lunch for you darling". Where people needed support to eat their lunch, this was provided by care staff who sat next to people. However, we observed on two occasions that care staff were standing over people or crouched down next to them, when assisting people to eat.

People had access to healthcare services and received ongoing healthcare support. GPs did not routinely visit the home, but the registered manager or nurse would call a GP if needed. People said that they felt that medical attention would be sought if required. One person told us, "I had a fall and I saw the doctor". People spoke of having their hair done, being seen by a chiropodist and optician and having manicures. One person said, "I recently had some new glasses, but I don't think I need a hearing test". Another person told us, "They supply everything here, chiropody, eyes, diabetes stuff, all of it". One person received dental attention privately in their room. However we have referenced an example in the Safe domain where the registered manager was unable to evidence whether advice from the Tissue Viability Nurse had been sought in relation to a person with several pressure sores.

The home was bright and colourful with lots of pictures on display depicting different eras. However, contrasting colours could have been used more effectively to help people living with dementia to navigate around the home. Signage on people's doors gave their name and a room number, but there were no visual prompts or colours used which might have helped them to recognise their room

Inadequate

Is the service effective?

from the outside. There was a 'reminiscence room', but it was not clear how people used this room as staff also used the area as an office. A box containing items of interest could not easily be accessed as a laptop was on top of it. A person living with dementia wanting to access items from the box could have become confused by a sign (relating to the laptop) which stated that it should not be moved or shut. A day/date board in a communal area had the previous day's information on it, although by lunchtime this had been updated. The information on the board was not presented in an accessible way for people to understand easily.

Some people's rooms were personalised and contained items that were special to them such as photographs and other memorabilia. However, many rooms were decorated similarly and bed linen was all the same. People told us they were happy and comfortable in their rooms.

We recommend that the provider utilises best practice guidance to ensure that the design and adaptation of the service supports the orientation of people living with dementia.

Requires improvement

Is the service caring?

Our findings

Our observations of staff interactions with people were mixed and did not always provide consistently caring and respectful exchanges. Some members of care staff had a good understanding and empathy with people and positive, caring relationships had been developed. Generally, people looked to be comfortable and at ease with staff. Some staff were engaging and smiled at people, whilst others appeared to be more task orientated. When we asked some care staff how they communicated with one person who had limited communication, they stated that people, "Don't communicate because they have dementia". People were not always asked for their views and sometimes had little control or say in how they were looked after. One person said they were not involved in decisions about their care or on the décor of their room. They told us, "I do not care about the room colour, but I would never have chosen the bedding". Some staff had a limited understanding of how to provide person-centred care.

People were not always treated with dignity and respect. We observed two members of staff hoisting a person from their wheelchair to a chair in the conservatory. The language used was very directive: "[Named person] hold this", then "[Named person] you need to hold this". Staff did not check with the person to see if they were happy to be moved and there was no reassurance, encouragement or explanation of what was happening. The person then grabbed the member of care staff, who responded, "Stop, you're hurting me". The person's grasp was loosened and they were lowered back into the wheelchair. The member of staff then said, "You want to stay in the wheelchair – why did you grab me?". With no emotional support or reassurance provided by staff, the person was wheeled back to their room.

One person asked to go to the toilet at lunchtime, but they were confused as to where the toilet was situated. A member of care staff informed the person where to go, put their hand on the person's shoulder and moved them forward. This staff member then left to take plates to the kitchen. The person still appeared confused and continued to say they needed the toilet. A member of the cleaning staff then intervened and offered reassurance to the person. This member of staff then guided the person to the toilet, explained when they were there, reassured them that they were safe and waited for them outside the door.

We observed one person trying to get the attention of a member of care staff. The person was initially ignored, but eventually a member of staff came over. The person asked if they could go to hospital because they felt unwell. Instead of the member of staff talking with the person to find out why they thought they were unwell, they said, "I'll get someone for you" and walked off. The person then called another member of staff over and insisted they needed a doctor and to go to hospital. The person went to stand up, but the member of staff placed their hand on the person's shoulder and motioned them back into their seat saying, "Don't worry, we have a nurse", then left. Again the person called out and a member of staff said, "The doctor will be out later". The person was clearly very anxious, shaking and then started shouting. No staff came to reassure them. When we checked with care staff to see whether a doctor was coming or if the nurse had been summoned, we were told, "No". This person had not been reassured and no account was taken of how upset she had become.

The above evidence demonstrates that staff did not consistently treat people with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we observed examples where staff did not treat people with dignity and respect, the majority of people and their relatives said that staff were caring and that they felt looked after. One person said, "It does feel caring here, the staff are kind". Another person told us, "I can't fault them, it's superb. I would recommend it here to anyone". A further comment was, "They are respectful and like to know what I've done in my life. It's a question of age".

There were some positive interactions between people and staff with a gentle and kind approach. Some staff were observed supporting people to walk, holding their hands and reassuring them in a calm manner. One person had mislaid their glasses and a member of care staff said, "Shall I get your other glasses for you?". The person then asked if they could go to her room together, to which the member of care staff replied, "Of course I'll come with you. We can go together, no problem".

Inadequate

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs. Care plans, which were kept electronically, did not reflect how people liked to receive their care, treatment and support. In 20 care records, pre-admission information was collated either by the person or their family and this provided the basis for the care plan. People's physical needs were assessed and plans gave detailed information of care delivery. The care plans had a section, a one page profile, which asked three questions: 'What is important to [named person]?, What people like and admire about me, How best to support [named person]?' In all records this section was blank and there was no evidence that people's personal histories or profiles had influenced care plans. Care plans were led by directions on people's physical needs. With no evidence of people's backgrounds and the lives they led prior to entering the home, there was no indication of how they liked to spend their leisure time. There was a section in the care plan entitled 'daily life', with an aim, 'to prevent isolation and promote social interaction', but there was no accompanying plan of action in place to address this need.

There were people living at the home with behaviours which challenged such as people trying to leave the home unattended. For people living with dementia, having opportunities for activities, social interaction and hobbies of interest can help to reduce social isolation, low mood and behaviours which may challenge. Progress notes showed no evidence that people were engaged in any meaningful activity or were given opportunities to access the community, unless their relatives or friends took them out. The weather was warm and sunny on the day of our inspection, but no people were supported to use the garden. There were no activities on offer that equated to people's choices or interests. This could lead to people becoming bored and/or frustrated through a lack of stimulation. Staff appeared to have little understanding of their role in a way that encouraged people to exercise choice, independence and control. The care plans had a task-led approach and were not personalised. Staff relied heavily on handover meetings to obtain information about people as the care plans did not reflect this detail.

There were no organised outings for people and staff told us that, "These would not work for people with challenging behaviour". An outside theatre company did visit occasionally. People could go to the pantomime at Christmas and a summer BBQ had been arranged for the beginning of August.

There was little in the way of activity and provision of stimulation until just before lunch on the day of our inspection. Some care staff sat in the conservatory and had a short time of one to one with a few people. This included drawing, looking at magazines, music playing and word searches. We were unable to ascertain whether activities were organised that reflected people's personal interests and hobbies. One person said, "I'd like to be friends with people, but they just all go to sleep". Another person told us, "I'd quite like to be out in that garden much more". A third person said, "There are a few things to do, but not enough. I quite like the exercises, but I'd love to do poetry and a few more meetings to get to know people. I like getting to know people". After lunch, one person sat down and was playing the piano, but no-one else had engaged with this activity, except the nurse on duty, who was singing along.

We had been told at the start of our inspection about one person who could be unpleasant. However, that was not our experience when we spoke with her, as she was chatty, engaging and friendly. She said, "I loathe it here. I don't want to die at [stated age] with nothing to do". She went on to say, "I've always loved animals and was very sporty. I would just love to be able to get out into the sunshine. I'm just nothing now. It plays on your mind". (This person was alone in their room on an upper floor.)

One person was taken to the conservatory by care staff and sat down next to another person. Shortly afterwards, the person who had been sitting there all along, became verbally aggressive, so that the person who had just sat down, got up and left. No staff were around to support the person. A little while later, the same person was brought back again by care staff and this time was sat down opposite the person who had shouted at them. Care staff did not ask the person they were supporting where they wanted to sit. Again, the person who had just sat down was verbally abused by the same person as before. The person got up and left the conservatory. Later on, this person was walking around and looked unsettled. They said to us, "Can you please take me somewhere quiet?" We sought out a member of staff and a member of staff from the office said to the person, "There aren't many places here that are

quiet". This member of staff did, however, take the person to a corridor which was quieter. Staff had not consulted the person in this situation and failed to respond to their distress.

The issues above are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a system of recording complaints. There had been no complaints recorded since January 2015. Five complaints had been logged prior to this date, but there was no evidence to show that they were handled within a reasonable timeframe or that the complaint was resolved to the satisfaction of the complainant. Details of the initial complaint and the response from the home were unavailable. Concerns, complaints and any feedback gained were poorly managed in that there was no evidence to show that they influenced any aspect of people's care plans in the way their care, treatment and support was delivered.

The issues above are a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative told us that they had written to the registered manager and said, "There was a lack of supervision after lunch. Since then I've noticed it's much better and I had an immediate response and a letter regretting it and it shouldn't have been like it. Things had slipped a bit".

Inadequate

Is the service well-led?

Our findings

The service did not have a robust quality assurance or governance system in place to drive continuous improvement. Medication audits had not been undertaken in line with the provider's policy. Lessons were not learned from accidents or incidents that had occurred. There was no system in place to identify trends or patterns as to how risks were assessed or managed. An audit of complaints received was unavailable. A management peer group, including managers from the provider's other services, held quality assurance meetings from time to time. One meeting was held in 2015 and had an agenda of items such as service users, health and safety, medication, quality assurance, policies and procedures, activities and any other business. There was no consistency to the organisation of these meetings and no evidence to show that audits covering all aspects of the service delivered had taken place. Shortfalls which we identified during the course of this inspection had not been picked up in the provider's audits. The management did not use information from investigations to drive quality across the service. The service did not measure and review the delivery of care, treatment and support against current guidance.

Residents' meetings were held on a monthly basis, but according to the minutes of meetings from January to May 2015, only a few people attended. Agenda items for each meeting were standard and included: 'food', 'activities' and 'health and safety'. The minutes of the residents' meetings were not shared with people, but were kept in the office. Questionnaires had been sent to people's families to ask for their views about the service. Nineteen completed questionnaires had been received which gave suggestions on a range of issues, for example, staffing levels in the lounge after lunch and a request for better communication in the form of a newsletter. When we asked the registered manager if she had collated the responses into a review summary, with an action plan to share with respondents to ensure they felt listened to, she said she had. However, when we asked for a copy of a collation of people's responses, it could not be located. After the inspection, the registered manager said that she was waiting for the last few responses before the results could be collated. When we asked for a copy of last year's summary, the registered manager said this had been lost in the computer system. Therefore the provider was unable to evidence how the views of people and relatives had been used and shared to improve the quality of the service.

The service was unable to demonstrate good management and leadership. Staff team meetings were held monthly, but these were poorly attended. There was no evidence to show that staff views had been taken account of or that action was taken on issues raised. Staff did not know and understand what was expected of them. The home suffered from a lack of clear leadership and staff were directed by task completion. The home did not have a cohesive culture and there was considerable variation in our observation of staff practice. Staff were largely led by care tasks rather than a focus on person-centred care and treatment.

The issues above are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they felt Sunhill Court Nursing Home was a well run home. However, One said, "I usually see the manager every week for a chat, she pops in to see me". Relatives said they were always made to feel welcome when they visited. We observed a visitor arrive at the home and that staff were very welcoming and immediately got the relative a chair so they could sit with the person they were visiting. Relatives' comments about the home were varied. Positive comments included, "[Named person] seems happy enough here, it's well maintained and they feed her well. We looked at lots and this was the best. As far as they go it's good, it is a commercial project. Myself and my family are happy with [named person] here". Another comment: "The staff are pretty good, they treat [named person] well and make a fuss. I think she's happy as she could be". Other relatives told us, "There's not a lot for her to do, but she can't do anything much anymore" and "This isn't like where [named person] was before. That was like a real family, but she is getting the care she needs".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: The registered person did not ensure that care and treatment of service users was provided with the consent of the relevant person. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The registered person did not ensure that care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9 (1) (a)(b)(c) (2) (3)(a)(b)(c)(d)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints How the regulation was not being met: The registered person did not ensure that any complaint received was investigated and proportionate action taken in response. Regulation 16 (1)(2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered person did not ensure that care and treatment was provided in a safe way for people. Regulation 12 (1) (2)(a)(b)(c)(d)(f)(g)

The enforcement action we took:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the registration was not being met: The registered person did not ensure that the nutritional and hydration needs of people were met. Regulation 14 (1) (2)(a)(b) (4)(a)

The enforcement action we took:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person did not have systems or processes established that operated effectively to ensure compliance with this regulation. Regulation 17 (1) (2)(a)(b)(c)(e)(f)

The enforcement action we took:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Enforcement actions

How the regulation was not being met: Service users were not treated with dignity and respect. Regulation 10 (1)

The enforcement action we took:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The registered person did not have sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet this regulation. Regulation 18 (1) (2)(a)

The enforcement action we took: