Sunningdale Nursing Home Limited

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Inspection report

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Date of inspection visit:
23 November 2016

Date of publication:
09 January 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service in May 2016 when four breaches of legal requirements were found. We found a breach in regulation regarding the safe management of medicines, people's care not being planned effectively, a lack of arrangements to ensure staff were appropriately supported in their roles and responsibilities and systems in place to regularly assess and monitor the quality of the service were not effective.

We asked the provider to take action to address these concerns. After the comprehensive inspection, the provider wrote to us to tell us what they would do to meet legal requirements in relation to the breaches.

We undertook a focused inspection on 23 November 2016 to check that they had they now met legal requirements. This report only covers our findings in relation to the specific area / breach of regulation. This covered four questions we normally asked of services; whether they are 'safe', 'effective', 'responsive' and 'well led'. Was the service 'caring' was not assessed at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Sunningdale Nursing Home' on our website at www.cqc.org.uk.

We found the service had made improvements and all but one of the breaches we had previously found in May 2016, had now been met. Although medicines management had been improved overall, we still had some on-going concerns and medicines remains in breach of regulation.

Sunningdale Nursing Home caters for the nursing needs of older people. It can accommodate up to 32 people.

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.

At this inspection we reviewed the management of medicines. We found improvements overall but there were still areas of concern and therefore the service had not fully met this requirement. We found improvements were needed to record and monitor the application of creams and the thickening agents for fluids.

At our last inspection in May 2016 we found people's care planning lacked sufficient detail to help ensure their care needs were being effectively monitored and evaluated. In some instances people's care needs was not included or updated in the care planning.

We found people's care planning had improved. Care plans had sufficient detail to help ensure people's care

needs were being effectively monitored and evaluated.

At our last inspection in May 2016 we found staff were not fully supported in their roles and responsibilities.

We reviewed the training and support for staff to prepare and support them in their role. We found support was better planned and staff were up to date with their training needs being met. Staff told us there had been a lot of work completed to meet the breach of regulation and that they felt well support to carry out their work. They described a positive learning culture in the home.

At our last inspection in May 2016 we had concerns around the systems in place to monitor the service.

We found action had been taken to improve the management and governance of the service. There were clearer and more effective systems to monitor standards and to further develop the service.

We however made a recommendation that there were more rigorous auditing of medicines so as to improve the overall management of medicines in the home.

You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not wholly safe.

We reviewed the management of medicines; we found improvements overall but there were still areas for improvement. The service had not fully met this requirement.

We will review our rating for 'Safe' at the next comprehensive inspection.

Is the service effective?

Requires Improvement

The service was effective.

We reviewed the training and support for staff in the home to help ensure staff were supported in their role. We found improvement had been made and the service was now meeting essential standards.

While improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for 'Effective' at the next comprehensive inspection.

Is the service responsive?

Requires Improvement

The service was responsive

We found people's care planning had improved. Care plans had sufficient detail to help ensure people's care needs were being effectively monitored and evaluated. We found improvement had been made and the service was now meeting essential standards.

While improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for 'Responsive' at the next comprehensive inspection.

Is the service well-led?

Requires Improvement

The service was mostly well-led.

We found action had been taken to improve the management and governance of the home. The registered manager had developed clearer and more effective systems to monitor standards in the home.

Although improvements had been made we recommend there are more rigorous auditing of medicines so as to improve the overall management of medicines.

We will review our rating for 'Well-led' at the next comprehensive inspection.

Sunningdale Nursing Home Limited

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 focused inspection took place on 23 November 2016 and was unannounced. The inspection team consisted of two adult social care inspectors to check that improvements to meet legal requirements identified after our comprehensive inspection on 3 & 6 May 2016 had been made.

We inspected the service against four of the five questions we ask about services; is the service safe, is the service effective, is the service responsive and is the service well led. This is because the service was not meeting legal requirements in relation to these questions.

Prior to the inspection we looked at the notifications and other intelligence the Care Quality Commission [CQC] had received about the home. We contacted the commissioners of the service to see if they had any updates about the service.

At this inspection we looked at records in respect of the management of medicines [including medicine administration sheets], staff training and support, people's plan of care and quality assurance processes and systems [including service audits]. We spoke with two people who were living at the home, two registered nurses and three care staff. The registered manager was not on duty at the time of the inspection though we spoke with them following the inspection.

Requires Improvement

Is the service safe?

Our findings

We previously visited this home in May 2016 and found the provider to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found medicines were not being managed safely. We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet this breach.

On this inspection we checked to make sure requirements had been met and we found improvements in respect of medication management. There were still some specific areas of concern remaining; therefore this breach had not been fully met.

We checked five medicine administration records [MARs] and found staff had signed to say they had administered the majority of medicines. Records were clear and in most cases we were able to track whether people had had their medicines.

The exception to this was regarding the application for topical preparations [creams]. We found the systems in place for recording these applications was not robust. For example, we looked at the MAR for one person who was clearly prescribed a cream to be applied 'four times daily'. This was also written on the recording chart in the person's room. The chart, however, only recorded sporadic application. The nurse in charge told us the cream was applied 'when they [person] asks for it'; we were also told the person had 'some' confusion. This approach was not clear and needed to be reviewed to ensure consistency.

Another person had a cream recording chart in their room which listed two separate creams to be applied with different instructions recorded. A cream had been recorded on the morning of the inspection but it was not clear which cream; there were dates when no creams had been recoded. We discussed the need for two separate charts [one for each individual cream] and clearer, consistent recording by care staff.

In both examples the charts had been poorly photocopied [from an original template] and it was difficult to see signatures and dates [similarly] with a third person we reviewed.

A further anomaly was the need for better recording around the consistency of thickening agents added to drinks. Thickening agents are added to people's drinks if they have been assessed as having difficulties with swallowing; for example following a stroke. Failure to manage this area of care may result in a person being placed at risk from choking. For one person we were told by a staff member, 'They [person] have three scoops in a large glass'. There were no specific instructions recorded on the person's fluid chart and the tin of 'think and easy' stored in the person's rooms just said 'as prescribed'. When the person was given drinks the amount of thickener was not recorded on the fluid chart. The person's MAR, however, stated 'Stage two thickened fluids – one and a half scoops per 100mls'. This was confusing. We spoke with the nurse in charge about the importance of accurate recording of thickened fluids to ensure the right consistency was being administered.

Poor recording of administration of medicines can make it difficult to evaluate the effectiveness of the

medication in question.

This remains a breach of Regulation 12 (2) (g) HSCA 2008 (Regulated Activities) Regulations 2014.

We spoke briefly with two people who were sat in the lounge. They told us they felt the home was good and that their medicines were managed well. People told us they received their medicines on time and could request tablets, such as painkillers, should they have a headache.

We found improvements had been made in specific areas. A medication policy was in place; this had been reviewed and was now inclusive of guidelines for covert administration of medicines. We looked at one person whose medication was being administered covertly; i.e. without their knowledge and in their best interest. We found this had been managed well with a robust care plan in place which clearly identified the risks involved and consideration of the consent issues involved. We found there had been appropriate liaison with health care professionals including the person's GP and family. A capacity assessment had been carried out to meet requirements under the Mental Capacity Act 2005.

We found medicines to be stored safely when not in use. Some medicines need to be stored under certain conditions, such as in a medicine fridge, which ensures their quality is maintained. If not stored at the correct temperature they may not work correctly. The provider's action plan told us: 'I will ensure that the temperature of the medication fridge is recorded daily, always by the registered nurse on duty. This is for the quality and safety of the medications to be maintained'. We saw the temperature of the drug fridge was recorded daily.

Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation. We saw controlled drugs were stored appropriately and records showed they were checked and administered by two staff members. We checked a number of medicines, including a controlled medicine and found the stock balances to be correct.

People had a plan of care which set out their support needs for their medicines, including 'as required' [PRN] medicines.

Requires Improvement

Is the service effective?

Our findings

We previously visited this home in May 2016 and found the provider to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found a lack of staff training and support. We asked the provider to take action to address these concerns.

The provider submitted a provider action report which told us the improvements they had made to meet this breach. On this inspection we checked to make sure requirements had been met and we found improvements had been made. This breach had been met.

People living at the home told us staff had the skills and approach needed to ensure they were receiving the right care with respect to maintaining their health. We looked at the training and support in place for staff.

The provider's action plan told us: 'The training programme used at the home covers many areas of necessary staff training and has been carried / implemented quite successfully. On checking the training carried out so far it has become apparent that some staff members require additional help/assistance. I will ensure that they receive this support from the registered nurse who is allocated to monitor them'.

Staff we spoke with told us there had been a lot of work to update all staff. Training courses had been organised, both through DVD training and also 'face to face' training in the home. We saw a training matrix on display in the staff room and this was up to date and comprehensive in the areas of training covered including moving and handling and infection control. A staff member told us "The manager has worked really hard to make sure we have the necessary training." Another staff commented, "It's brilliant; I feel well supported in my role."

The staff files we saw clearly recorded training to date and were up to date and well maintained records.

We spoke with a fairly new member of staff who told us they had had a 'thorough' induction and the registered manager had supervised this. We were not sure of the content of this induction and whether it met the standards in the 'Care Certificate' which is the government's recommended blue print for staff induction.

Following the inspection the registered manager sent us an update which stated: 'At Sunningdale Nursing Home, at this present time, I ask employees who have no previous experience and are new to care to achieve a Care certificate by working through a hand book and knowledge book. The Care Certificate is achieved by completing the hand book, after having read through the detailed knowledge book. The knowledge book provides the information necessary to complete their handbooks, which are monitored and assessed. Upon completion of the handbook, the certificate found at the back of the book can then be signed off by the assessor'.

Following the inspection the registered manager confirmed that care staff had qualifications in care such as QCF [Qualifications Credits Framework]. We saw evidence that 63% of care staff had completed these

courses and attained a qualification.

Staff we spoke with at the inspection reported they were asked their opinions and felt the registered manager listened and acted on feedback they gave. All of the staff we spoke with told us they had regular supervision sessions with the registered manager and this provided good support. We saw records in staff files to confirm this as well as set dates for supervision sessions displayed on the staff notice board.

Requires Improvement

Is the service responsive?

Our findings

We previously visited this home in May 2016 and found the provider to be in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found people's plan of care was not always planned effectively to meet their individual need. We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet this breach.

On this inspection we checked to make sure requirements had been met and we found improvements had been made to meet necessary. This breach had been met.

The provider's action plan told us: 'The personal care plans for each person will be amended to include much more detail specifically with regards to medications and PRN medications, nutrition and mental health needs. The plans of care will set out the support and care required for each person at the home'.

At this inspection we looked at four plans of care for people to ensure their care was planned effectively. A nursing care plan provides direction on the type of care an individual may need following their needs assessment. Care planning is important to ensure people get the care they need when they are at care home. The care files we viewed provided good information in respect of people's care and support. Care plans covered areas such as, mobility, personal hygiene, falls prevention, diet and nutrition, personal hygiene, skin care, social care and care plans for medical conditions that require clinical intervention. For example, an indwelling catheter, pressure ulcer, or tube for enteral feeding. Enteral feeding refers to the delivery of a nutritionally balanced feed via a percutaneous endoscopic gastrostomy tube (PEG). The PEG is passed into a patient's stomach to provide a means of feeding when their oral intake is not adequate. At the previous inspection we found gaps around recording nutritional support. At this inspection people's nutritional and hydration requirements had been recorded within their care files. This included the provision of PEG requirements, meal supplements and thickening agents. Thickening agents were added to drinks to support people who had assessed as having difficulty swallowing. We saw that the risks of malnutrition or dehydration had been appropriately assessed and referrals to other agencies, such as dieticians, had been made in a timely manner.

We looked at care monitoring documents which were used to record people's diet and fluids. We found staff were unsure on how best to record the use of thickening agents which had been assessed as needed for a number of people. We discussed ways or providing a more robust record to evidence the quantity of thickening agent used. The registered manager said they would implement this.

At the previous inspection there had also been concerned around the lack of documentation to support people with memory loss who may be living with dementia. At this inspection we saw people had a plan of care to support them with problems associated with cognitive impairment.

Staff told us the care plans now provided good information for them to follow and that the information was updated in accordance with people's individual needs. At this inspection we saw care documents were

reviewed regularly to reflect any change in care or treatment.

A person who was living at the home told us they were very happy with the care provision and the staff were attentive and supportive towards them.

Requires Improvement

Is the service well-led?

Our findings

We previously visited this home in May 2016 and found the provider to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found in light of the breaches we identified, the service's systems and processes were not robust to assure the service provision. We asked the provider to take action to address these concerns.

The provider submitted a provider action report which told us the improvements they had made to meet this breach. This included, 'I am going to improve and expand upon the existing audits in place to create a more robust system of monitoring the quality of the service'.

On this inspection we checked to make sure requirements had been met and we found improvements had been made. However, we discussed with the registered manager the need to improve the standard of medicine audit undertaken by the staff. This should include more rigorous checks for the management of topical preparations and thickening agents in light of our findings at this inspection. The service's current medicine audits which we viewed had not picked up on the shortfalls we identified in this area of practice at this inspection.

We recommend the provider carries out more rigorous auditing of medicines so as to improve the overall management of medicines.

At this inspection we also looked at other quality assurance systems and processes to monitor how the service was operating and to drive forward improvements. A range of audits and checks were undertaken to help assure the service; these were completed by the registered manager and staff. Areas included infection control and general cleaning of the home, health and safety checks of equipment [including checks of hot water and window restrictors] and the environment, accident and incident reporting [including falls], care file audits and audits of staff training. We saw that where improvements were needed, action was identified and timescales for completion recorded.

Environmental checks included general maintenance and contracts for services such as, gas, electric, fire prevention and Legionella compliance. The audits, checks and service contracts were up to date and provided a good over view of how the service was operating effectively and safely.

We checked our records before the inspection and saw that incidents that the Care Quality Commission [CQC] needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by the management to ensure people were kept safe.

Discussions with staff were positive regarding the improvements with the service over the last five months. A staff member said, "We have worked hard to make the necessary changes and we are all working as a team to make sure everything is right for the residents." Staff were complimentary regarding the registered manager's management and leadership of the home. A staff member told us, "It's a lovely home to work in."

From April 2015 health and care providers need to make arrangements to prominently display their CQC rating. The inspection report for Sunningdale Nursing Home was displayed in the main hallway and this showed the service's rating to help people and their families who use care services to make more informed choices about their care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We 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 12 HSCA RA Regulations 2014 Safe care and treatment We reviewed the management of medicines; we found improvements overall but there were still areas for improvement. The service had not fully met this requirement.