

Hartwood Care (2) Limited

Sunnybank House

Inspection report

Botley Road
Fair Oak
Eastleigh
Hampshire
SO50 7AP

Tel: 02380603120

Website: www.cinnamoncc.com/care-homes/sunnybank-house/

Date of inspection visit:
29 June 2018
02 July 2018

Date of publication:
21 August 2018

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Sunnybank House is a care home. People in care homes receive accommodation and their care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection. Sunnybank House provides accommodation for up to 60 older people. The accommodation is arranged over three units. Rose unit is on the ground floor and provides residential care for people with less complex needs. Dahlia unit is on the first floor and cares for people living with dementia. Nemisia unit is on the upper floor and provides nursing care for people with more complex needs. At the time of the inspection there were 47 people using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (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 and associated Regulations about how the service is run.

Our last inspection had identified concerns regarding the safe and proper management of medicines. This inspection found that overall the required improvements had been made and the legal requirements were now being met.

We did however identify some new concerns.

There had been a failure to assess and mitigate risks to some people.

Improvements were needed to the management and governance arrangements in the service. There were instances where the safety and quality of the service had been compromised. Staff were not always following risk management plans and were not clear on their roles and responsibilities. Staff lacked understanding on the accountability for decision making.

Staff had not always been deployed in a safe manner and the high use of agency workers had impacted upon the continuity of care people received.

Some of the records relating to people's care and support could still be improved. For example, daily records did not consistently show that people's care was being delivered in line with their care plan.

The service were making improvements to ensure that staff were always acting in line with the Mental Capacity Act 2005 and relevant guidance.

Environmental risks were managed.

Recruitment practices were safe and relevant checks had been completed before staff worked in the service unsupervised.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect.

Each of the people we spoke with felt that the home was clean. Throughout our visit, we did not find any malodours and we observed that staff used appropriate personal protective equipment (PPE).

Improvements to the induction of new staff and with the supervision programme were being embedded. Staff had completed a range of training.

People were mostly positive about the food. A selection of hot and cold drinks was available throughout the day.

A range of healthcare professionals including GP's, community mental health nurses, occupational therapists and physiotherapists had been involved in planning people's support to ensure their health care needs were met.

Overall the design and layout of the premises met people's needs.

People were cared for by kind and compassionate staff. It was clear that the permanent staff and the longer-term agency staff had developed meaningful relationships with people.

People were encouraged and supported to make decisions about their care and support and staff tried to promote people's independence wherever possible.

People were treated with dignity and respect.

Care plans recorded people's individual preferences and the permanent staff and longer-term agency staff knew people well.

Improvements were being made to the activities programme provided.

Information about how to complain was readily available within the service and the provider maintained a record of the complaints that had been received and how these had been responded to.

The provider sought feedback from people, their relatives and from staff and used this to continually improve the service.

There was evidence that people had been supported by staff to have a comfortable and dignified death.

Staff were generally positive about the registered manager and most felt supported in their roles. They told us morale was improving.

The registered manager demonstrated an understanding of the performance of, and challenges within, the service and expressed a commitment to their role and to driving improvements within the service.

This is the second consecutive time the service has been rated 'Requires Improvement'. The service is not yet consistently providing good care. We will meet with the provider to discuss the findings of this report and continue to monitor the service to ensure that improvements are ongoing.

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.

There had been a failure to assess and mitigate all of the risks to people.

Environmental risks were managed.

Staff had not always been deployed in a safe manner and the high use of agency workers continued to impact upon the continuity of care people received.

Recruitment practices were safe and relevant checks had been completed before staff worked in the service unsupervised.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect.

The home was clean, we did not find any malodours and staff used appropriate personal protective equipment appropriately.

Is the service effective?

Good 

The service was effective.

Some of the records relating to people's care and support could still be improved. For example, daily records did not consistently show that people's care was being delivered in line with their care plan.

Improvements were being made to ensure that staff were always acting in line with the Mental Capacity Act 2005 and relevant guidance.

Improvements to the induction of new staff and with the supervision programme were being embedded. Staff had completed a range of training.

People were mostly positive about the food. A selection of hot and cold drinks was available throughout the day.

A range of healthcare professionals including GP's, community

mental health nurses, occupational therapists and physiotherapists had been involved in planning people's support to ensure their health care needs were met.

Overall the design and layout of the premises met people's needs.

Is the service caring?

Good ●

The service was caring.

People were cared for by kind and compassionate staff. It was clear that the permanent staff and the longer-term agency staff had developed meaningful relationships with people.

People were encouraged and supported to make decisions about their care and support and staff tried to promote people's independence wherever possible.

People were treated with dignity and respect.

Is the service responsive?

Good ●

The service was responsive.

Care plans recorded people's individual preferences and the permanent staff and longer-term agency staff knew people well.

Improvements were being made to the activities programme provided.

Information about how to complain was readily available within the service and the provider maintained a record of the complaints that had been received and how these had been responded to.

The provider sought feedback from people, their relatives and from staff and used this to continually improve the service

There was evidence that people had been supported by staff to have a comfortable and dignified death.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

Improvements were needed to the management and governance arrangements in the service. There were instances

where the safety and quality of the service had been compromised. Staff were not all following risk management plans and were not clear on their roles and responsibilities. Staff lacked understanding on the accountability for decision making.

Staff were generally positive about the registered manager and most felt supported in their roles. They told us morale was improving.

The registered manager demonstrated an understanding of the performance of, and challenges within, the service but expressed a commitment to their role and to driving improvements within the service.

Sunnybank House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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. We also checked to see if the improvements required following our last inspection had been made.

This was an unannounced inspection which took place over two days on 29 June and 2 July 2018. On the first day of our visit, the inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of service. On the second day, the team consisted of two inspectors.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification tells us about important issues and events which have happened at the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with 23 people who used the service and eight friends or family. We spoke with the registered manager, the nominated individual, the operations manager, the care and quality manager, two registered nurses, five care workers and two agency care workers. We also spoke with the chef and the maintenance manager. We reviewed the care records of nine people in detail. We also looked at the records for five staff and other records relating to the management of the service such as audits, incidents, policies and staff rotas.

Following the inspection, we sought feedback from eight health and social care professionals about the care provided at Sunnybank House. Four of these provided a response.

The last inspection of Sunnybank House was in March 2017 when the service was rated as requires improvement. This was because we found that the legal requirements regarding the safe and proper

management of medicines were not being met.

Is the service safe?

Our findings

People told us they felt safe living at Sunnybank House. One person told us, "I do feel well cared for and much safer than at home". This was reflected by their visitor who said, "I have come to visit my friend, she hasn't been here long and is still settling, but she feels much safer here". A relative told us about a recent accident their family member had had. They told us, "I can't fault the nurses and the carers who were on the spot immediately".

Whilst people told us they felt safe living at Sunnybank House, we found that some improvements were needed. One person's care records included an assessment from a speech and language therapist (SALT). This stated '[the person] must never eat and drink when on her own due to the risk of aspirating'. We observed that for a period of five minutes on the first day of our inspection, this person was alone in the dining room with food and drink in front of them. This placed the person at risk of harm. This person's nutrition plan stated that they should have a 'fork mashable' diet, but they were observed to be eating a ham and cheese sandwich. We discussed this with the senior nurse who told us the person was refusing a fork mashable diet and was losing weight. Despite there being some doubt about the person's capacity to make decisions regarding her care and treatment, there was no specific mental capacity assessment regarding the person's decision to not follow the SALT guidance or to check that the person understood that diverging from the recommended diet could place them at increased risk of choking. We found one other example, where a person was being offered foods that were not in keeping with their dietary needs, the registered manager has addressed this.

A second person's care records also contained a SALT assessment providing recommendations that the person follow a modified, in this case, soft diet due to their potential risk of choking. Staff were not following these guidelines. We brought this to the attention of the registered manager. They have ensured that the care plan is amended and that staff are following this. They have also requested an urgent SALT referral. The registered manager was unable to ascertain who had made the decision to diverge from the SALT guidelines. Whilst the person had not experienced any choking episodes, we were concerned that the failure to following the SALT guidelines, could have placed them at risk of harm.

Whilst there were systems in place to learn from safety incidents, these were not always effective. For example, one person's bed rail risk assessment stated that both of their bed rails should be up if the person was lying on their back. When we visited the person on two separate occasions, they were lying on their back, but only one of the bed rails was up. This is of concern as in June 2018, there had been an incident whereby a person fell from bed as two agency staff had not ensured their bed rails were raised.

Whilst there was evidence that people's weight was usually monitored. One person's care records stated that they should be weighed three times a week. This was not happening. This had been identified as a concern in April 2018 following a visit to the service by a team from Hampshire County Council Adult Services. No action had been taken to address this or to seek clarity about why this was required. Since our inspection, the registered manager has informed us that the GP has reviewed the person and changed the frequency with which they are to be weighed to weekly as there was no clear rationale in place for three

times weekly schedule. However, there had been a failure to monitor this person's weight in line with their care plan.

People were not, at all times, receiving safe care and treatment due to a failure to assess and mitigate risks. This is a breach of Regulation 12(1) and (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted improvements could be made to demonstrate that post falls huddles and observations were being completed in line with the provider's policies and procedures. We raised this with the registered manager who has provided assurances that the provider's policies and procedures have been reviewed in light of this feedback to ensure that staff are confident with their role and responsibilities following a fall, particularly where this may have resulted in a head injury.

Other risks were being more safely managed. For example, people had falls risk assessments. Chair alarms were being used to alert staff that people were standing so that they could attend and check their safety. Other risk assessments were in place in relation to areas such as mobility, skin integrity and malnutrition. Some people had choking risk assessments which provided guidance for staff on what to do should a person choke. Clear guidance was displayed discreetly regarding people's dietary needs along with information on how to prepare food and drinks to certain consistencies. The risks associated with people managing their own medicines had been assessed.

There were a range of systems and processes in place to identify and manage environmental risks. Maintenance staff completed a range of health and safety checks, for example, the lift was regularly serviced and checks were made of the safety of electrical and gas appliances, the call bell system and hoists and other equipment used for moving and handling. Regular checks were undertaken of fire safety within the service and there was evidence to show that faults identified were repaired as soon as possible. A business continuity plan was in place and set out the arrangements for ensuring the service was maintained in light of foreseeable emergencies. Regular checks were also made of the water safety both to prevent scalding but also to manage risks associated with legionella. We did note that whilst a legionella risk assessment had been completed in October 2017, regular sampling of the water was not currently taking place. We discussed this with the provider who was very responsive to the feedback and has made arrangements for legionella sampling to be implemented across all of the provider's homes.

When looking at the staffing arrangements within the service, we identified some concerns with the numbers of staff deployed, but also with the continuity of care provided. During the inspection, our observations on Rose and Dahlia Units, indicated that there were suitable numbers of staff deployed to meet people's needs in a timely manner. There were agency staff on duty both days and although we observed that they needed to seek guidance and information from the permanent staff, they were attentive and engaged with people in a person-centred manner. However, we did have some concerns about the numbers of staff deployed on the Nemisia unit. The usual staffing levels on this unit were currently one registered nurse and two care workers. The unit was currently caring for nine people and all but one of whom needed two staff to manage their moving and handling needs. This meant that if the two care workers were supporting a person, there might be times when staff would not be able to answer other call bells or ensure that the communal area was supervised. During our inspection, we observed one such occasion when five people sitting in the Nemisia lounge were left for a period of five minutes without either a care worker or a nurse being present. The nurse had left the floor and the two care workers were attending to another person. One staff member told us that on one occasion, they had had to put a person to bed to keep them safe as they were at high risk of falling and so could not be left unsupervised in the lounge whilst they were attending to other people. They told us, "There aren't enough staff here... My concern is this floor

[Nemesia]... If a person needs two carers, we have to leave other people in the lounge... There is one person who smokes, she has to be taken down twice a day. That leaves one carer up here. When someone rings their bell you have to leave people in the lounge to see what it is. The nurses help. If you call them they will come. If they are doing medications they can't leave that. It needs three carers up here". A second staff member told us, we are short staffed constantly. We've been cut down to two carers on Nemesia in the afternoon. Three in the morning. We have nine residents on this floor. They [the management team] said they couldn't justify the carer to resident ratio. They said we didn't have enough residents to warrant having three carers. It does get quite stressful, some days it's OK if you are working with staff who know the residents. But if you are working with someone who doesn't know the floor very well it's difficult". We discussed this feedback with the registered manager who told us that the staffing levels on this floor will be reviewed.

Staff on the other units gave us mixed feedback about the staffing levels. One staff member said, "Staffing levels are decided by managers... We can approach the manager if the needs of the residents have changed. If we feel that their needs have become nursing needs and its challenging on the floor. We can ask the manager to give us extra staff. It might not be for the whole shift, it might be in the morning or at lunch, during the busy times of the day". Another staff member said, "There is not always [enough staff] ... the agency can be brilliant, but recently there have been a lot of new ones". The staff member told us that people's essential care was delivered, but that they often felt stretched and were unable to provide the person-centred care they would like to. This was echoed by a third staff member who told us one of the challenges of their job was, "Not having enough staff, we are more rushed, they [people using the service] still get the care, but it takes a long time.

The majority of people we asked, felt that there could be improvements to the time taken for their call bells to be answered. For example, one person said, "The bell never gets answered quickly... its better at night, but in the day, I can wait ages before someone comes" and another said, "I ring my bell and no-one comes... sometimes I am waiting for a long time... there is not enough staff on duty at times". The call bell logs viewed during the inspection indicated that call bells were usually responded to promptly. These continue to be monitored by the registered manager and they have assured us that action will be taken to investigate any response times that are unacceptably long.

Many people and relatives also expressed concern about the high use of agency workers. A relative told us, "Overall this is a good care home, but it's the small things that sometimes go wrong, such as the number of agency staff that are used..... they don't always know what to do for my wife". Another relative told us, "This is not a complaint about the agency staff as most of them are capable carers, but there are only a few that are regular and there are far too many "new faces" which [family member] and others find unsettling".

People and their relatives acknowledged that the agency workers were needed to ensure that gaps in the rota were safely covered and they told us that the agency workers were kind, caring and supportive, but just not always effective. For example, one relative told us an agency worker had not been aware of interventions that could be successfully used to manage their family members anxiety. Some relatives expressed a lack of confidence that the management team and provider were addressing their concerns about staffing adequately.

We reviewed the rotas to assess the extent with which agency staff were being used. These confirmed that agency staff were required on each floor daily and each night. Sometimes, two or three of the five care staff on Rose and Dahlia units might be agency workers. Wherever possible the same agency staff were used and some of these had been working at the service for a number of years, but recently there had been an influx of a new agency workers, due to changes at the agency used, which the registered manager acknowledged

had impacted upon the consistency of care provided. The high use of agency staff had been a concern noted at our last inspection. The manager in post at the time, told us that recruitment remained a priority for the provider but this had been hampered by the high turnover of staff. This continued to be a challenge for the provider with records showing that 59 staff had left the service between March 2017 and March 2018.

There was evidence that the provider was acting to reduce the impact of the staff vacancies on people using the service. For example, they had taken the decision to no longer admit people with nursing needs to Nemesia unit until they had a more permanent team of registered nurses. The provider was also working hard to try and recruit and reduce the reliance on agency staff. Records showed that the number of agency staff required had fallen during each of the last three months and during our inspection, four new health care assistants and one registered nurse had started their induction. A second registered nurse was due to start the following week which would mean that the home was fully recruited in term of nurses. However, there remained vacancies for 11 health care assistants. Initiatives such as staff being offered rewards for introducing new staff were being offered. A recruitment manager had been employed to oversee the provider's target of recruiting two new staff each month and to help ensure new staff were suitably inducted and felt valued and thereby support the retention of staff. The success of these initiatives will be key to reducing the ongoing risk of there being periods when the staff available do not have the right mix of skills, knowledge and experience to support people.

In most cases, relevant checks had been completed before staff worked in the service unsupervised. These included identity checks, obtaining full employment histories and Disclosure and Barring Service checks. Checks were also made to ensure that the registered nurses were registered with the body responsible for the regulation of health care professionals. In one of the records viewed, the references in place were not from the prospective staff members most recent employer despite this being in a health and social care setting. The registered manager assured us that moving forward, this requirement would always be acted upon.

Our last inspection found that the provider had failed to ensure that there was an effective system in place to manage people's medicines. This was a breach of Regulation 12 (2)(g) of the Health and Social Care Act. This inspection found that improvements had been made and the legal requirements were being met. There were appropriate facilities for the storage of medicines. Each floor had their own medicines room where the medicines trolleys were kept securely. Medicines requiring refrigeration were stored in a lockable fridge. The medicines rooms were climate controlled and the temperature of the fridge was monitored daily. We looked at the medicines administration records (MARs) for each person living at the home. All MARs contained a front sheet with a recent photograph for identification purposes, along with relevant information, such as whether the person suffered from allergies.

We checked a number of the individual medicine balance records for medicines stored in their original containers rather than in pre-dispensed blister packs. All but one was correct. This could indicate that the person had not received their medicines as prescribed. An investigation by the service was not able to establish where or when the error occurred. This had been a concern at our last inspection also and indicates that the systems in place need to be embedded further to ensure that they are fully effective. To address this staff are liaising with the GP to see if an alternative medicine can be prescribed that can be supplied in a blister pack and are reviewing their arrangements for recording the daily counts of boxed medicines.

We observed staff administering people's medicines and this was managed in a person-centred manner. Staff did not leave the medicines trolley unlocked when unsupervised and signed MAR charts only when the person had taken their medicine. The topical medicines administration records (TMAR's) viewed were now

being more fully completed and those medicines viewed included a date of opening. We did note that a number of the TMARs did not contain comprehensive instructions about the frequency, and site, the medicine was to be applied to. The registered manager is seeking advice from local health care professionals about how this might be resolved.

Protocols were in place for PRN or 'as required medicines'. The protocols outlined how, when and why the medicine should be taken. Staff received additional training to assist with the safe monitoring of therapeutic drugs such as insulin to ensure concentrations of the drug in the person were safely maintained. Where people were receiving their medicines covertly (that is, without them knowing,) there was evidence that the correct legal processes had been followed.

Controlled drugs were stored and administered safely. Controlled drugs (CD's) are medicines which are controlled under the Misuse of Drugs Act 1971 and which require special storage, recording and administration procedures. Staff administering medicines had received training and had their competency to administer medicines safely, assessed on an annual basis. Homely remedies were available within the service. Homely remedies are medicines the public can buy over the counter to treat minor illnesses like headaches and colds. The use of these medicines had been agreed with the GP on an individual basis.

Robust medicines audits were undertaken and action plans produced as a result. Where medicines errors or omissions had occurred, these were investigated and remedial actions taken which included the staff member completing a reflective account of their learning from the incident.

On a monthly basis, the registered manager completed an analysis of incident and accidents to identify any trends or patterns so that remedial action could be taken which might reduce the risk of similar incidents happening again. We did note that some of the incidents relating to medicines errors, or to incidents of unexplained bruising, had not been escalated to the local authority. We were concerned that two other incidents, which, although they did not result in harm to a person, would also have benefitted from being shared with the local authority to establish whether they might meet the threshold for a safeguarding investigation. This is important to ensure that the local authority have oversight of potential risks within the service. Since the inspection, the registered manager has liaised with the local authority to develop a clear protocol on how such incidents should be escalated moving forward. We have also reported in the 'well led' section of this report, the additional actions the provider was already putting in place to improve how staff report upon and learn from safety events.

The permanent staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. The provider had appropriate policies and procedures which made explicit links to the local authority's multi-agency safeguarding procedures. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Staff had a positive attitude to reporting concerns and were confident that concerns would be acted upon by the registered manager to ensure people's safety. Most staff were aware of what was meant by 'whistle-blowing', the reporting of poor practice, and knew where the whistleblowing helpline number was displayed.

Each of the people we spoke with felt that the home was kept clean. Throughout our visit, we did not find any malodours and we observed that staff used appropriate personal protective equipment (PPE). Suitable cleaning schedules were in place and followed in practice. The kitchen was clean and the catering team were completing appropriate food hygiene records.

Is the service effective?

Our findings

Overall people were positive about the care they received and this was confirmed by the majority of the relatives with spoke with also. Relatives comments included, "The home is very good at letting us know if anything pops up, we like that as it makes us feel they are doing their job...we like this home and we feel [family member] is safe and well cared for, it's the right place for her" and "[family member] has been well cared for both mentally and physically... The staff are caring and committed and I have no concerns whatsoever regarding my [family members] care. I am a frequent visitor and have personal knowledge of the home environment".

During our inspection, we observed staff delivering effective care. For example, we saw staff effectively supporting one person, who could display behaviours which others might find challenging, to eat. They tried a number of different methods to calm and encourage the person, including changing the staff member and offering a range of different foods. We saw staff undertaking moving and handling interventions appropriately. The staff explained what they were doing and guided the person throughout.

Before a person came to stay at the service, an assessment of their care needs was carried out to gather information from the person, and where appropriate, from their relatives and any professionals involved in their care. This helped to ensure that appropriate decisions were made about whether the service would be able to meet the person's needs. These initial assessments were used as the basis for a wider set of care plans which described the person's needs in a range of areas such as personal care, eating and drinking, mobility, medicines management and mental health. People also had oral hygiene, sleeping and activities plans in place. Our last inspection had noted that some people's care plans did not reflect their current needs and were not always suitably detailed. During this inspection, we found that overall people's care plans were suitably detailed, however, we did find that some of the daily records could still be improved. For example, daily records did not consistently show that people were having regular pad changes or being supported to reposition to maintain their skin integrity. We discussed this with the registered manager, they felt this was a recording issue as they were no systemic concerns about the care of people's skin. Similar concerns about the daily records had been noted at a visit by Hampshire County Council Adult Services and in the provider's own pressure area audits in April 2018 and so this remains an area where further improvements are needed.

Prior to our inspection, the provider had already been developing plans to implement an electronic care planning system within the home. They have now confirmed that this system will be rolled out as part of a phased approach with the nursing floor being the first to have the system put in place. The system enables staff to have flexible and timely access to people's care plans and associated records, such as food and fluid and repositioning charts, using hand held mobile devices. The system will also alert staff if essential care has not been provided and a record of this maintained. This new system will take some time to embed, but the provider is confident that it will help to reduce omissions in care documentation and evidence that people are receiving care as planned.

We looked at how the service was implementing the Mental Capacity Act (MCA) 2005. Where there was doubt

about a person's capacity to make decisions regarding their care and treatment, staff had, in some circumstances completed mental capacity assessments and undertaken consultations to reach a shared decision about what was in the person's best interests. For example, we saw people had mental capacity assessments in relation to the use of alarm mats and bed rails. The 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.

We did, however, see a number of examples where consent to care documentation had been signed by a representative of the person who did not have the legal authority to do so. This included care plan documentation, flu jab forms and consent forms for having photographs taken. We also noted that decisions about people's health and wellbeing was sometimes being directed by family members, but there were no records in place to confirm that the family either held a lasting power of attorney (LPA) for health and welfare, or that a best interest's consultation had been undertaken with relevant people and professionals. The provider told us that they had already identified that this was an area where further work was needed and since the inspection, the registered manager has been working with external healthcare professionals to seek evidence as to whether best interest's consultations have taken place and to ensure documentation is available within the service to support this. They told us that where this is found not to be the case, new best interest's consultations will be organised. The registered manager also advised that a tracking record is to be implemented to more clearly monitor which people have appointed a legal representative to act on their behalf and what this covers. New consent documentation is also being introduced and the provider is exploring more detailed training for staff in relation to consent. A solicitor has also been engaged to hold an event for families to advise about consent and LPA's.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Relevant applications had been submitted by the home and had either been approved or were awaiting assessment by the local authority.

Induction records prior to the current manager starting in January 2018, were sporadic and did not evidence that new staff had always completed an induction when they first started working within the service. This was confirmed by some of the staff we spoke with. Records showed that action was being taken to address, retrospectively, the shortfalls in the induction of existing staff. Since the appointment of the current registered manager, induction records have been more robust and evidence that staff have received a site-specific induction and completed a number of 'shadow shifts' during which they were able to shadow more experienced staff and learn about their role and responsibilities. Agency staff also undergo a brief induction to the home at the beginning of their first shift which includes fire procedures and key information about the people using the service.

It was the provider's policy that all employees joining Sunnybank House in a care role were required to complete the Care Certificate in the first 12 weeks of their employment. The registered manager confirmed however that none of the staff who had started in the last 12 months had, as yet, successfully completed this. To address this, we were advised that an external consultant has been asked to provide support to the management team with driving improvements with completion rates of the care certificate. Although the staff concerned had not completed the Care Certificate, they had undertaken other training linked to some of the 15 standards within the Care Certificate such as training on equality and diversity, fluids and nutrition, safeguarding adults, basic life support, health and safety and infection prevention and control.

Staff had completed a range of training and in most cases, this was up to date. This included subjects such as moving and handling, health and safety, fire training, infection control, safeguarding, food hygiene and first aid. The provider supported the registered nurses with their revalidation and provided opportunities for additional training in a range of clinical skills. Revalidation is the way in which nurses demonstrate to their professional body they continue to practice safely and effectively and can therefore remain on the nursing register.

The provider had recently undertaken a review of its training to ensure this would equip staff with the skills and knowledge they needed to meet people's needs. Plans had been made to add additional training to the list of core, or mandatory training, that staff were expected to complete such as end of life care, falls awareness and equality and diversity. The home had an infection control champion who attended training on this subject provided by the local clinical commissioning group. Staff were positive about the training provided, for example, one care worker said, "We have mandatory training... It gives staff the knowledge to provide appropriate care. If we feel we need further training, i.e. diabetes, Parkinson's, falls awareness. We can suggest it to the deputy manager or manager".

It was the provider's policy that staff 'receive ongoing and periodic supervision', although it did not specify a specific frequency. Supervision and appraisals are processes by which an organisation provides guidance and support to staff and assesses their learning and development needs. The provider did not currently have a system that would allow us to easily view the supervision that had been delivered for all staff over the last 12 months and therefore we looked at the records for a random sample of ten staff. Most of these staff had received regular supervision. Staff told us they felt able to seek guidance and support from the management team when this was needed. One staff member told us, "Every three months I get individual supervision with either my manager or deputy manager. We sit down and talk about how we are getting on, if we have any issues with other carers or safety of residents. They discuss training needs".

People were mostly positive about the food. One person said, "I am a vegetarian and they make sure I get the right food" and another told us, "I go to the lounge for my food, it's not bad, we like to moan but it's ok". A third person told us, "I can't manage two meals a day, so I asked the carers to bring me something cold at teatime, a sandwich or something and I keep that to eat later in the evening, they are very good like that". We met with the chef and spoke with them about the menus. They had not been in post long but were knowledgeable about people's specialist diets. They explained that they were continually adapting the menu to try and meet people's preferences and requests. For example, at the request of people, lamb's liver had been changed to pig's liver. They told us, "We have a vegetarian, [chef] sat down with her and created a vegetarian menu, she gets what she has identified herself". During the inspection, a meeting was being held with a new butcher to see if this might improve the quality of the meat. People were given the opportunity to influence the menus through food forums. People who required pureed diets were offered the same menu as everybody else unless the meal was not suitable for pureeing in which case they were offered an alternative.

A selection of hot and cold drinks was available throughout the day and each person we visited had water or juice in their rooms. People also had access to fresh fruit and we observed people being supported to eat this during the inspection. Due to the hot weather, people were also being offered ice lollies and jellies throughout the day. We saw staff encouraging people to drink, for example, we saw one care worker say to a person, "It is very hot today, so do please drink this up... I'll pop back and top it up for you later".

We observed people having their lunch on the first day of our inspection. The meals were presented attractively and looked appetising. Condiments, such as tartare sauce, were served on an individual basis allowing people to make their own choice about whether they would like these. Where people needed

support to eat and drink, this was mostly provided in a way that was safe, dignified and respectful of the individual. We did see that one person was eating their meal with their knife for some time, before staff noticed this and intervened to offer support. Staff readily chatted with people, offering encouragement to eat and clearly explaining to people what the meal was. The provider undertook meal time audits. The last audit undertaken in June 2018 on the Nemisia unit had noted a number of areas where the mealtime experience could have been better. These were being shared with staff to drive improvements.

A range of healthcare professionals including GP's and community nurses had been involved in planning people's support to ensure their health care needs were met. There was evidence that staff recognised if people were unwell and sought medical advice. The frequency with which people developed chest or urine infections was monitored in order that remedial actions might be taken. One person told us, "They're good here if you're poorly, they move quick to help, they've been brilliant with my legs, can't fault them". This view was shared by a health care professional who told us, "They do not delay in contacting us if they have a query or concern regarding one of their residents". Each week, a GP attended a routine visit to the home, during which they were able to review people about whom staff had concerns or who were presenting as being unwell. Staff documented visits by GP's or other healthcare professionals so that a record was maintained of changes to treatment pathways.

There was evidence that care and treatment was being delivered in line with a range of evidence based guidance and clinical pathways. For example, pathways were used for the treatment of wounds. The provider had developed a set of quality standards for the care of people living with dementia and planned to use this to assess and develop the quality of dementia care provided. Our observations during the inspection indicated that some of the quality standards were already evident in the practice of the care team, for example, we saw staff offering people comforting touches, smiles, eye contact and hugs. To support the implementation of the quality standards, an external consultant had been engaged by the provider to deliver a 12-month support programme aimed at developing the person-centred care and enhancing the experience of people living on the Dahlia unit. A dementia team leader had also been appointed to mentor staff and act as a good practice role model. The registered manager had implemented a read and sign file for each floor which contained information about best practice guidance for staff on areas such as recognising and preventing delirium. They were also embedding the use of the 'Herbert Protocol'. This is a national scheme being introduced locally and involves care plans being compiled which contain useful information which could be used in the event of a vulnerable person going missing.

Overall the design and layout of the premises met people's needs. The home was a purpose-built care home. All rooms were spacious and had ensuite facilities and were individually furnished with the person's own possessions. There were a range of areas where people could have some privacy with their visitors. There were pleasant gardens which were accessible from the Rose Unit although people on the Dahlia and Nemisia units would need support to access these. Some homely touches had been introduced. Bread makers were located on each floor and were used to prepare the bread for lunch and on Dahlia unit we saw that there were tomatoes and fresh herbs growing on the windowsills.

A range of equipment and adapted bathrooms were available to support people's care. Dahlia Unit was primarily for people living with dementia. To support this, toilets were all clearly signed and the doors were all painted yellow. There was a variety of reminiscence items for people to engage with. Other improvements had taken place included the redecoration and reconfiguration of one of the lounges on Dahlia so that smaller, more intimate spaces were created and the fitting of a second small kitchenette area that people, and their visitors, could access to make drinks and to socialise. To further enhance the environment for people living with dementia, a number of additional actions were planned. These included placing memory boxes outside people's rooms and introducing individualised door knockers related to

each person's life story. There were plans for the bathrooms to be made homelier with pictures and murals on the walls.

Is the service caring?

Our findings

People told us they were cared for by kind and compassionate staff. One person said, "I like it here, the carers are lovely. ... I feel like they care for me". Staff were confident that all of their colleagues were kind and caring and were clear that if this was felt not to be the case, they would raise their concerns and this would be addressed.

Staff spoke fondly about the people they supported and it was clear that the permanent staff and longer-term agency staff had developed meaningful relationships with people. For example, one staff member said, "Every day is different. I like that I get to know the residents and create a bond with them". Where people were anxious or in need of comfort staff interacted with them in a compassionate way. We observed care workers using touch to convey their care and concern for people. For example, when one person was a little unsettled, the staff member sat with them and stroked their back to soothe them. The interaction was positive and the person responded well. One of the health care professionals we spoke with told us staff were caring and said, "I feel the residents are treated with dignity and respect, the carers seem to know the residents well, even down to how they like to take their tea or coffee. I like that the domestic staff know the resident's name and always ask how they are".

The lounge areas were welcoming and we saw people enjoying spending time in these areas with staff during our visit. We saw a number of warm and friendly exchanges between staff and people. For example, we saw that staff bent down to speak with people at their level and spoke in a calm and reassuring manner. Staff used humour to interact with some people and in turn people seemed relaxed with the staff caring for them and there was lots of smiling and laughter throughout the day. For example, at lunchtime, we heard staff telling people the soup 'would make their hair curl'.

People were encouraged and supported to make decisions about their care and support. For example, we saw that at lunchtime, people were shown 'show plates' of each of the menu items to assist them in making their choice. We saw an agency worker supporting one person to make a choice about what they would like to eat. They did not rush the person and adapted their approach to see if this might encourage the person to make a choice. Where able, people had signed consent forms in relation to their care plans and a number of people told us they had been involved in drafting their care plans and reviewing these on a regular basis. For example, one person said, "I know I have a care plan and they [staff] ask me when they review it". Another person told us, "The carers use my care plan and I can see it if I want to".

Staff ensured that special events were celebrated such as birthdays and anniversaries. A family member had commented on this in an email saying, 'Please could you pass on our thanks to all staff for making mums birthday special, she said she feels like the queen, I am so happy to see mum walking better and in such a lovely mood'. Another family member had commented, 'We were a bit worried at mum feeling 'lost' when we all disappeared so were really pleased when a team member immediately sat to chat to mum'. Staff spoke with enthusiasm about providing a family environment where people felt safe, valued and cared for and their relatives welcome. The welcoming attitude of staff was commented on by one relative who said, "I come in to visit very often and the carers are very welcoming and I couldn't fault those I know". A health care

professional also told us, "I found [Sunnybank House] to be welcoming from reception to the care staff and manager".

Staff told us how they tried to promote people's independence wherever possible. We observed a staff member clearly talking a person through the process of standing from a seated position. The care worker gave clear instructions, did not rush the person and then praised them for successfully completed the task. One member of staff told us, "We encourage people to do as much as possible for themselves, even if it's washing their face. If they can eat on their own we encourage them. We don't want to take everything away from them. We try to promote their independence as much as they can".

People told us they were treated with dignity and respect and when staff spoke with us, they referred to people in a respectful and dignified way. Staff told us they knocked on people's doors before entering and made sure people were fully covered when being supported with personal hygiene. Our observations indicated that care was provided in a discreet manner and that staff were mindful of people's privacy and dignity when providing care.

The provider had recently introduced training in equality and diversity. Information regarding people's religious and cultural needs was gathered prior to admission. At the current time, the registered manager told us everyone living at the home had a similar ethnic background and religious beliefs. A variety of religious services were held each month and each of the units had an information folder with details of different religious requirements. At Christmas one lounge was kept 'Christmas free' for those that did not celebrate this Christian feast.

Is the service responsive?

Our findings

Overall people's care plans contained sufficient detail about their individual preferences. This supported staff to deliver responsive care. For example, we saw that one person liked to have porridge or scrambled eggs for breakfast and preferred tea to coffee. It was noted that another person preferred to wear trousers to skirts. Plans described how people preferred to take their medicines for example. Some of the care plans, although not all, included information about the person's life before coming to live at the home and about how they liked to spend their time which enabled staff to understand the person and the things that were important to them.

Some of the permanent staff told us they had never read any of the care plans and relied upon the verbal and written handovers to learn about people's needs and find out about changes to these. Despite this there was evidence that the permanent staff and longer-term agency staff did know people well and were aware of how they liked their care to be performed. This was also commented on by one of the healthcare professionals who had regular contact with the home. They said, "I feel they are (for the majority of the time) responsive to the resident's needs, and appear to know them thoroughly".

We noted that agency staff were not currently attending the daily handovers. This was because the handover took place at 7.45am and their shift started at 8am. Whilst we were told that agency staff were all given a handover sheet which gave a summary of the key needs of each person on the unit, the registered manager acknowledged this was not always fully up to date. Handovers provide information about changes in people's needs and the support that has been given. We discussed this with the registered manager. They advised that further checks have been instigated to ensure the daily handover sheet is accurate and contains robust information. They advised that there was always a permanent team member on each shift who would be able to provide further information to agency staff if this was required.

In addition to the handovers, a 'heads of department stand-up meeting' was held each day. We attended one of these meetings during which the senior staff discussed any people that were unwell, any incidents or accidents that had occurred and anyone experiencing weight loss and the action being taken in response. There was evidence that communication with people's relatives was maintained and documented on relative contact sheets. Most relatives told us they were kept fully informed about their family member's wellbeing and promptly told about falls and the outcome of health appointments. Newsletters were also used to keep people and family up to date with news and events happening within the home.

We looked at the activities provision within the home. The registered manager told us that the activities had over the last six months been on an ad hoc basis as and when care staff were able to provide these as there had been no activities staff in post. This had at times, impacted upon people taking part in meaningful activities. For example, we saw that in April 2018, a healthcare professional had recommended that one person be supported to have reminiscence therapy. This had still not yet started to take place. In the absence of the activities staff, external entertainers had continued to be provided and an existing staff member had been assigned on a full-time basis to ensure stimulation was provided to people. In addition to this, staff were offered overtime specifically to facilitate activities. Two new activities leads had now been

appointed and were settling into their new role providing 60 hours of activities across the week. For example, during the first week of our inspection, the planned activities included, interactive games, baking, fitness classes, gardening and a visit from an animal therapy group. The provider owned a mini bus for shared use by three of its local homes and a relative was being trained to drive this so that trips could be arranged to local places of interest. On the first day of our inspection, there were entertainers visiting the Dahlia unit. They were singing with people and using sensory aids such as feathers to interact with people. We observed that they visited each person on an individual basis. People appeared to be engaging with the entertainers and enjoying the session. Other activities taking place included a knit and natter group and a visit from a local children's nursery.

People were generally positive about the activities provided. One person told us, "Yes I get a list of what's going on.... I believe we've got a new minibus so that should be good". Another person said, "I like knitting, sewing and reading...there is a good library here in the home". A relative did express concern that many of the organised activities took place on the ground floor and felt that a more balanced approach across all of the floors was needed.

We looked at how the service was meeting the accessible information standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The registered manager told us that where necessary information would be provided in a format according to people's needs, by, for example, using large print or signs and symbols. Staff were supported to understand their responsibilities in relation to the AIS at team meetings and posters informing them and people about what this might mean for them were displayed throughout the service.

Information about how to complain was available within the service and the provider maintained a record of the complaints that had been received and how these had been responded to. There were also systems in place to monitor complaints to look for themes or trends over time. Most of the people we asked felt confident raising concerns and felt that wherever possible action was taken to address these. For example, one person said, "Oh I don't mind complaining and generally they listen and do something to help". Another person said, "I know I can complain, but I've got nothing to complain about!" Two relatives expressed concerns about the manner in which the registered manager and provider had responded to their concerns. They did not feel that their complaints had been resolved to their satisfaction. We have asked the registered manager and provider to consider whether there might be ways in which they might facilitate further mediation with those concerned, to provide reassurances that people who raise concerns will not be disadvantaged and their concerns will be dealt with in an open and transparent way.

The provider sought feedback from people, their relatives and from staff and used this to continually improve the service. 'Residents and relative's meetings' were held. These meetings gave people and their relatives the opportunity to hear about, and comment upon, developments and changes within the service. The provider also undertook annual surveys with people, relatives and staff. The resident and staff surveys had only just been sent out, but we were able to see the results of the recent 'friends and family' survey. Thirty-four replies had been received. 91% of those that replied said the service was 'good' or better. However, there were clear themes in the feedback provided which indicated that friends and family felt improvements were required in areas such as the consistency of staff, activities and communication. An action plan had been developed in response to the feedback and progress was being achieved with many of the objectives.

There was evidence that people had been supported by staff to have a comfortable and dignified death. Nursing staff ensured appropriate medicines were available to people nearing the end of their life to

manage their pain. Some people had advanced care plans which recorded information about the care the person should and should not, receive at the end of their lives, including under what circumstances they should be admitted to hospital and whether they should be resuscitated.

Is the service well-led?

Our findings

People told us that they felt the home was generally well run and well led. Their comments included, "I've been here three years and I wouldn't be here if I wasn't happy" and "I recently been given a form to fill in about my care at the home, a satisfaction thing I think, I've no complaints, I've got all I need". This was echoed by the majority of visitors we spoke with. Their comments included, "My relative came here about the same time as the new manager started...she's on the ball...if I complain, I know she'll get something done" and "Things here have vastly improved recently...the new manager is making good progress we think". A third relative noted, 'The home is modern, well run and with its current management is moving forward and making great advances in all areas'. A health care professional commented, "The manager took time to come and introduce herself and speak to me and appeared approachable and supportive of the staff".

Whilst the majority of people and relatives told us they were beginning to feel more positive about the service, this inspection identified that people were not always receiving safe care and treatment. This was a breach of Regulation 12 (1) and (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Where the inspection identifies a breach of any Regulation, we cannot normally rate the 'well led' domain any better than 'requires improvement'. We also found that improvements were still needed to how some aspects of the service were managed and to the governance arrangements of the service. Whilst a range of audits were undertaken on a regular basis, this inspection found a number of examples where the safety and quality of the service had been compromised. We found evidence that some staff were diverging from risk management plans which has led us to be concerned that they did not always understand their role and responsibilities and where accountability for decision making laid.

Our discussions with the registered manager and provider did provide some reassurances that they understood the importance of good quality assurance and they had already identified that further improvements were needed. For example, the provider had identified that further development of risk management systems was required to promote the safety of people using the service and to support those with responsibilities in the organisation to manage and mitigate risks and share learning from events. We have been advised that the revised quality strategy includes changes to how accident and events are reported and to the monitoring processes currently in place. For example, there were plans to increase the monthly reporting of incident and accidents to weekly, allowing senior management within the company to monitor that remedial actions had been taken in a timely fashion and to ensure risks to people's safety had been reduced. Audits of the safety and effectiveness of medicines, care documentation, health and safety management, nutrition and infection control will also continue to take place to feed into the service development plan which is detailed and demonstrates a commitment by the registered manager and provider to drive ongoing improvements within the service.

At our last inspection in March 2017, people, relatives and staff told us that the frequent changes of manager within the service had had a negative effect on the quality of care and on the running of the home. Since then there had been further changes within the management team and although the current manager had been in post for six months, staff remained fearful that the instability could continue. They were however,

generally positive about the new registered manager and most felt supported in their roles. One staff member said, "[registered manager] is lovely, she is trying to look after staff". Another staff member told us, "The manager is quite supportive.... She is trying her best to make the home better for residents and staff. I find her very approachable. She attends the monthly team meetings on each floor".

Staff told us morale was improving but could still be affected by working or managing shifts with large numbers of agency staff. However, they felt that despite the challenges, they generally worked well as a team to meet people's needs. Staff meetings were being held on a regular basis and staff told us they felt encouraged to contribute their ideas for developments. One staff member said, "They [the management team] are pretty good, all our ideas are welcome". Monthly team briefings were sent to staff ensuring that they were kept up to date with staffing changes for example.

The registered manager and provider had systems in place to celebrate best practice and to demonstrate their appreciation of the staff team for going above and beyond in how they provided care and support to people. For example, staff could be nominated for the 'making a difference award' and every Friday cakes or doughnuts were brought in as recognition and thanks for the care they provided. Some of the senior care staff were being supported to take part in leadership courses to develop their career and management skills. A benefits scheme had been introduced for staff offering low cost medical insurance, for example, and other incentive schemes were in place to reward staff financially for picking up additional shifts, helping to reduce the need for agency staff and enabling better continuity of care for people.

The registered manager kept up to date with best practice in the health and care sector and undertook continuing professional development in order to maintain their professional registration as a nurse. They were open and transparent during our conversations with them and were keen to tap into sources of support to help drive improvements within the service wherever these were offered. The registered manager felt well supported by their deputy and provider who visited the service on a regular basis. The registered manager demonstrated an understanding of the ongoing challenges within the service and expressed a commitment to their role and to driving improvements within the service. They told us that their priority was to maintain the momentum with recruitment and retaining staff, but also with improving and maintaining staff morale and team spirit. They also acknowledged that there was more to do to ensure that records relating to people's care and support were always suitably detailed and accurately reflected the care delivered. They spoke knowledgeably about the people living at the home and of the staff team that provided people's care. They and their deputy undertook daily walkarounds of the home and spent time interacting with people and staff in order to maintain an understanding of the issues affecting them. They were confident that despite the areas where improvements could be made, the care was given with affection by staff who genuinely cared about the people they supported which would be in keeping with our observations.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>People were not always receiving safe care and treatment and there had been a failure to assess and mitigate risks to some people's safety and wellbeing. This is a breach of Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>