# Care UK Community Partnerships Ltd

# Sunningdale

## Inspection report

Birkdale Way
New Bridge Road
Hull
Humberside
HU9 2BH

Tel: 01482587924
Website: www.sunningdalecourthull.co.uk

Date of inspection visit:
12 February 2016

Date of publication:
03 March 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Inspected but not rated |
| Is the service safe? | **Requires Improvement** |

# Summary of findings

## Overall summary

We carried out an unannounced comprehensive inspection of this service on 7 and 8 October 2015. A breach of legal requirements was found regarding the management of medicines; we issued a warning notice and the registered provider had to be compliant with this by 20 November 2015. We undertook this focused inspection on 12 February 2016 to check the registered provider had made improvements and to confirm they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sunningdale on our website at www.cqc.org.uk.

The findings from this inspection did not affect the overall rating of the service, which was 'Requires Improvement'; it also did not affect the rating of the specific question 'Is the service Safe' which was also 'Requires Improvement' at the last inspection. This is because we want to make sure improvements are sustained over a period of time and we will check this out again at the next full comprehensive inspection. Just prior to the inspection we were notified by the local safeguarding team that they had received information of concern about pressure area care for three people who used the service and a bed rail issue for another person. A safeguarding officer accompanied us on the inspection to check this out.

Sunningdale is situated to the east of the city of Hull, near to public transport facilities and there are local shops within walking distance. The service is registered to provide accommodation and personal care for a maximum of 49 people some of whom may be living with dementia. All the rooms are for single occupancy. There are sufficient communal areas, bathrooms and toilets on both floors. There is an accessible garden and car parking at the front and rear of the building.

The service has a registered manager. 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.

We found there were improvements in the management of medicines. People who used the service received their medicines as prescribed. We found medicines were obtained in a timely way, they were stored securely and stock control was managed effectively. The recording of medicines had also improved. We observed medicines were signed for when they were received into the service and when they were administered to people.

The safeguarding officer found the records of one person who used the service did not indicate pressure relief had been carried out during the night. Staff had recorded the person was asleep and comfortable. However, the district nursing team had requested two hourly turns day and night for the person to help in the treatment of a sore area. The registered manager is to meet with the district nursing team to discuss options for the person. The safeguarding officer found there were no concerns with the three other people mentioned in the initial alert and appropriate action had been taken to meet their needs.

## 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**

We found that action had been taken to improve the safety of the service.

People received their medicines as prescribed and staff obtained them in a timely manner to ensure they were always available when needed. The recording of medicines had also improved. We found medicines were stored securely. This meant the registered provider was now meeting legal requirements.

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 safe at the next comprehensive inspection.

# Sunningdale

**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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an unannounced focused inspection of Sunningdale on 12 February 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 7 and 8 October 2015 had been made. We inspected the service against one of the five questions we ask about services: is the service SAFE. This is because the service was not meeting some legal requirements.

The inspection was undertaken by one adult social care inspector and we were accompanied by a local authority safeguarding officer.

We spoke with a regional director, the registered manager and a senior care worker. We looked at the medication administration records of all the people who used the service and we checked to see how controlled drugs were managed and recorded. We also looked at audits of medicines management to make sure staff identified any shortfalls to be addressed. We checked the two treatment rooms to make sure medicines were stored appropriately.

The safeguarding officer looked at the records of four people who used the service as part of their investigation.

Requires Improvement

# Is the service safe?

## Our findings

At our comprehensive inspection of Sunningdale on 7 and 8 October 2015 we found people did not always receive their medicines as prescribed. This was a beach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this focused inspection on 12 February 2016 we found the registered provider had made significant improvements in the management of medicines to meet shortfalls in relation to the requirements of Regulation 12 described above.

The medication administration records (MARs) showed people now received their medicines as prescribed. We found medicines were signed on the MARs when they were received into the service, when they were administered to people and when items were carried forward from the previous MAR. When medicines were omitted, the correct codes were used to describe the reasons why this had occurred; this could be that the person had declined to take them as they were not required or they had been admitted to hospital.

There had been improvements in the general recording of medicines. When medicines were delivered mid-cycle or when changes were made to the doses, staff had to hand-write the instructions on the MARs. We found these were written accurately and counter-signed to verify the changes. When people were prescribed a variable dose of medicine, staff had identified how much had been administered on each occasion. This made sure staff were aware of how much medicine each person had been administered. When people who used the service were prescribed medicines that interacted with other medication, staff had recorded the specific times they were required to be administered. This made sure they were given at the correct times. When medicines were prescribed to be taken 'when required', for example pain relief, these were recorded on the reverse of the MAR and the reason why. When creams, ointments or lotions were prescribed, staff recorded when these were applied on a separate MAR for topical products. We found these were recorded in line with people's prescriptions. There was a system of recording when medicines were returned home with people who were admitted for respite care or when they were collected to be destroyed.

We checked the controlled medicines register and found improvements in the way pain relief patches had been recorded when applied to people. These had been applied in a timely manner and line with people's prescriptions.

We found the ordering of medicines was managed more effectively to make sure people did not run out of them and also to ensure an overstock did not occur.

We found medicines were stored appropriately. There was a treatment room on both the ground and first floors; these rooms were locked when not in use. Medicines for daily use were stored in trolleys which were secured to the walls. Those medicines that required cold storage were held securely in lockable refrigerators. Staff monitored the temperature of the treatment rooms and the refrigerators to ensure appropriate storage conditions. The treatment rooms were clean and tidy.

We found audits of medicines management had been completed in-house to ensure good practice continued. There had also been external audits completed by a medicines management support team and the local supplying pharmacy. We saw any recommendations were actioned straight away.

The registered manager told us there had been challenges to overcome with the ordering of medicines. This was because the people who used the service gained their prescriptions from six GP practices, some of which had differing ordering systems in place. There had also been a difficulty with the local pharmacy ordering cycle which had now been resolved by reordering the next month's medicines when the current month was delivered. The service had been allocated a link person at the local pharmacy to improve communication and to raise any issues about medicines ordering or delivery.

The local safeguarding officer investigated a concern about pressure area care. They told us there was no record that one person had received pressure relief at night as staff had recorded the person was comfortable and asleep. The district nursing team had requested the person received pressure relief every two hours. The registered manager is to discuss this with staff and has arranged to have a meeting with the district nurse to discuss treatment options for the person. The local safeguarding officer found records of pressure relief could be improved. One some occasions these were completed very well and on others there were some gaps. This was mentioned to the registered manager to discuss with staff and to monitor more effectively.

The local safeguarding officer checked out a concern regarding the absence of a bedrail for one person. The person had rolled out of bed so the registered manager had ensured the bed height was lowered and a 'crash mat' placed on the floor in case the incident was repeated. The registered manager completed a risk assessment for a bedrail and installed one, however this was three days after the incident. The registered manager told us a bed rail was not fitted straight away as, in the past, there was a concern the bed rails would pose a risk for the person. The bedrail was now considered safe for the person and staff were monitoring this.

We will check out the management of pressure area care and the timeliness of risk assessments at the next full comprehensive inspection.