Cephas Care Limited

Sun Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Sun Court Nursing Home is a residential nursing home providing personal and nursing care to up to 29 people, in one adapted building. At the time of our inspection there were 25 people using the service, some of these people were living with dementia.

People's experience of using this service and what we found
People and staff told us they felt there were not enough staff to meet their needs. The provider was in the process of addressing this. This included work to reduce the times the registered manager was working 'on the floor' to enable them to undertake their registered manager duties. Staff told us morale was low and they did not always feel listened to. People's care plans and records were not person centred and did not provide guidance for staff on how people's specific needs were being met. We found breaches in Regulations 18 (staffing) and 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a comprehensive action plan in place which identified improvements required and actions being undertaken to address them, with timescales and regular monitoring of improvement by the provider management team. There were systems to assess and monitor the service provided and these were continuously being improved. However, at the time of our inspection, not all of these improvements had been fully implemented and embedded in practice.

The systems for keeping people safe were not robust, this included how risks were assessed and mitigated, this was in the process of being addressed. The service had systems to identify when people had not received their medicines when required and addressing it. Infection control processes were in place and issues were addressed when required. Systems were in place to recruit staff safely and learn lessons when things had gone wrong.

People told us the staff were kind and caring, which confirmed in our discussions with staff who were committed to provide good quality care to people.

There were systems in place to receive feedback from people using the service and their comments were being addressed.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service when registered under the previous provider was good (published 07 June 2018). Sun Court Nursing Home was registered with the current provider 30 September 2019, this is the first inspection of this service under the current provider.

Why we inspected
The service was due for a planned inspection based on the registration date of the current provider. In addition, we had received notifications from the service and information from members of the public which concerned us that people were not always being provided with safe care. As a result, a decision was made to undertake a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to staffing and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Sun Court Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

Due to the Covid 19 pandemic the first day of inspection was carried out by visiting the service. The following days were carried out remotely. This means we made telephone calls to staff and relatives away from the site and asked for documents to be sent to us by the service.

Inspection team
The inspection visit took place on 27 August 2020. It was undertaken by two inspectors and a pharmacy inspector. Another inspector reviewed records and spoke with people's relatives and staff remotely and provided feedback to the management team.

Service and service type
Sun Court Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We called the service to announce our inspection visit shortly before the inspectors arrived. This was to ensure we could ask the service for specific information regarding if there were any people using the service who had a positive test for Covid 19 and the provider's procedures for infection control and Covid 19 to

ensure we were working within these procedures.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since registration, including registration records. We sought feedback from the local authority. We used all of this information to plan our inspection.

During the inspection
We spoke with the registered manager and the provider's service director for adult and community services. During our visit we observed the care and support provided to people, including interactions between staff and people using the service.

We spoke with three people who used the service and two relatives of people using the service for their views of the service provided and received electronic feedback from two relatives. We spoke with seven staff members including the deputy manager, nursing staff, senior care staff and care staff.

We reviewed a range of records. This included the full care plans for two people and sections of other people's care records. We reviewed medicine records, including audits. A variety of records relating to the management of the service, including audits and quality assurance were reviewed.

We fed back our findings from the inspection to the nominated individual, registered manager, the provider's director for adults and community services, assistant director and the provider's head of older people's services in Norfolk. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection when the service was registered under the previous provider, this key question was rated as good. This is the first inspection under the current provider. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● People told us, although they felt the staff were caring there was not enough of them. One person said, "You can tell the staff are running about and in a 'panic' not always able to respond as quickly as I would like." Another person commented, "They do their best running around… Don't have to wait long for help but can see on their faces they are tired, they are very good and work so hard." We were told by staff and a person using the service that a lot of staff had left, which the person using the service said, "Comes back on us, not enough to do the job properly." We asked one person if they could ask for a shower or bath when they wanted one, they responded, "I won't ask for more, can't ask for the impossible."

● The minutes for a meeting attended by people using the service on 3 September 2020 discussed staffing and loss of staff, also identified there was no time for extras such as cutting nails and tidying up.

● All of the staff spoken with told us there were not enough staff. They did say they worked hard to ensure people's physical needs were being met, but they did not have time to spend with people, one stated, "It is like a conveyor belt." Another staff member said, "There is not enough hours in the day to do our job." Another commented, "It would be nice though, if we could spend more time talking to [people who used the service] and not be so rushed. Especially during this lockdown when they could not have visitors."

● The provider was in the process of addressing staffing issues in the service, one member of the management team told us this was, "A work in progress." This included using agency staff, increase in hours to provide activities, the extension of catering staff hours to support staff in the morning with breakfasts and ongoing recruitment of staff. The registered manager told us how new staff were starting to work in the service, with a nurse starting during our inspection.

We found no evidence that people had been harmed however, despite the provider having plans to improve the staffing levels, at the time of our inspection staffing levels or deployment were not sufficient to meet the needs of people. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had a dependency tool in place which they used to calculate the numbers of staff required. A meeting with the management team was held in July 2020 where the staffing numbers and how the rota was managed were discussed and agreed how staffing levels would be spread evenly throughout the day. A staff member confirmed they had been told the rota and hours were changing but not sure when this was to take place.

● Times of responses to call bells were not being monitored to ensure people received their requests for assistance in a timely way. During feedback we were told the system did not allow this, however, this would

be looked into.
● Staff recruitment was done safely, this included making appropriate checks to reduce the risks of people being cared for and supported by staff who were not suitable for working in this type of service.

Systems and processes to safeguard people from the risk of abuse
● During our inspection visit we identified two incidents which had not been reported to the local authority safeguarding team, who are responsible for investigating abuse, and we had not been notified. Once this was pointed out, appropriate action was taken by management.
● We had been told about other incidents, as had the local authority. However, due to the incidents which had not been reported we could not be assured the provider's system for reducing the risks of people being abused were robust enough.
● Staff had been trained in safeguarding and told us they would have no hesitation in reporting concerns.
● People told us they felt safe.

Assessing risk, safety monitoring and management
● The provider had identified areas in the service which required improvement to reduce the risks to people. Some work had started on these improvements, but they were not yet fully implemented and embedded in practice.
● Care records were not kept up to date, there were risk assessments in place but limited control measures. For example, the records for one person who was identified as at risk of choking, their care plan said to monitor and report to the nurse on duty if there were any swallowing problems. There was no information about signs and indicators of choking and any immediate actions staff should take and what immediate actions could be taken whilst calling for assistance from a nurse. The provider had identified that care records needed reviewing and this was in progress but not yet fully implemented.
● The records for monitoring people's food and fluid intake, where people were at risk of malnutrition and/or dehydration were not robust. For example, there were no targets for what people should have to drink each day, therefore we could not be assured staff were aware of when they should seek support from other professionals. In addition, the food records varied in quality, some stated the actual amount people had to eat, others did not. The provider was aware of this and was in the process of addressing this, but it was not fully implemented.
● We reviewed personal emergency evacuation plans for three people who used the service. These were all worded the same and did not identify any specific needs relating to the individual, such as any sensory loss, specific mobility needs and any behavioural issues which would affect the person being supported to evacuate the building. These were identified as requiring improvement by the provider, but not yet completed.
● There were no risk assessments on the two sets of stairs in the service. Once we pointed this out, this was addressed. There were other environmental risk assessments in place to reduce the risks to people living in the service and others.
● Regular checks on equipment and systems reduced the risks to people. For example, checks on moving and handling equipment, fire safety, electrical items and bed rails. Where shortfalls were identified these were reported and addressed.

Using medicines safely
● The service carried out regular audits of people's medicines, however, it had identified occasions when people had not received their medicines as prescribed.
● During the inspection we identified further gaps on people's medicine charts that were unexplained, including for medicines prescribed for topical application such as creams and emollients.
● The service had systems in place to improve in this area and this was ongoing.

● Staff responsible for administering medicines had been trained to do so and their competency was checked annually.
● The people we spoke with told us they got their medicines when they needed them. One person said, "Medicines given on time, I have [condition] so it is important." Another person commented, "They are very good with medication, some nurses left when they changed [provider] but the ones here very good."

Preventing and controlling infection
● The service had a risk assessment for Covid 19 in place and had included it in their contingency plan. There had been no cases of Covid 19 in the service and they had managed well during the pandemic.
● The registered manager explained their infection control processes and regular auditing was undertaken in this area. Records confirmed what we had been told.
● Personal protective equipment was worn by staff and made available for staff by the provider. However, there was hand sanitiser available in a dispenser by the front door, we saw other sanitisers which were empty with a note on them saying it was on order. We spoke with the registered manager who confirmed it was on order but not yet delivered, and staff were hand washing effectively to reduce risks.
● There were some areas in the service which we had noted during our visit, such as a freezer in the service which was marked inside the door, limescale on taps and linen being left in the bathroom, this was fed back to the management team who told us it would be looked into.

Learning lessons when things go wrong
● Records showed where actions had been taken to learn lessons, these included safety checks on beds and bed rails, following previous incidents. As a result, several new beds and mattresses had been purchased to reduce future risks.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection when the service was registered under the previous provider, this key question was rated as good. This is the first inspection under the current provider. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was a management structure in the service, however, the registered manager was working shifts including night nurse shifts and long days, in addition, they were covering in the kitchen when needed, as well as undertaking their registered manager responsibilities, including implementing improvements on the action plan. Actions were being taken to address this, including the recruitment of staff, administration support and allocating some tasks to other staff, this was not yet fully implemented.
- Staff spoken with had varying views about how the service was led. All talked about how the registered manager worked on the floor and worked long hours. Some staff told us the registered manager was available to listen to their concerns, others told us they had been told the registered manager was too busy to discuss any issues they had.
- Staff told us morale was low. They felt communication with the provider was poor, if they raised issues, they were not provided feedback about actions being taken and did not feel listened to. One staff member told us they had one to one supervision but no team meetings where they could discuss any issues as a team. When they needed guidance, they were often told to do different things by different staff and felt there were no changes when they raised concerns.
- People's care plans were not person centred and did not provide guidance for staff to meet people's specific needs. Where people's care needs had changed, the ways this was recorded was in different places and difficult to see which the current needs of people were. For example, some updated information was written onto the care plan and some in the review records. The improvements needed in care records had been recognised by the provider and actions were being taken to address this. However, at the time of the inspection this had not yet been implemented.
- Daily records completed by staff to show how people's care needs were met, varied in quality, some had the actual times when people had been supported, some did not. We fed this back to the provider who was aware and the completion of the new records they had introduced were in the process of being improved.

We found no evidence that people had been harmed however, despite the provider having plans in place to improve at the time of our inspection, systems were either not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were concerned there was no clinical support in the organisation to ensure the clinical aspect of the service was overseen and the registered manager received appropriate clinical supervision. A member of the management team told us they were recruiting to a new post and interviews were being held. Following our feedback, we were advised a clinical lead had been employed and were due to start in October 2020. The registered manager told us about a new nurse who had started who may be able to assist with the clinical supervision.
● There were areas in the environment which required attention, such as redecoration of corridors. This had been identified by the provider, and a programme of redecoration had commenced. This was not yet fully completed, work in this area had reduced during the Covid 19 pandemic but was now being actioned.
● Without exception, people told us the staff treated them with kindness and respect, which was confirmed by relative feedback. One person said, "Staff are caring and respectful." One relative commented, "[Family member] adores them and they adore [family member]."

Continuous learning and improving care
● The provider had employed the services of an external organisation who had completed an overall audit on the service. An action plan had been developed, with timescales for completion. A member of the management team told us they were ensuring improvements were embedded in practice before they were signed off fully. The majority of the shortfalls we had identified during our inspection had been picked up by the provider's action plan, but not all, including the lack of risk assessment for the stairs and incidents not being reported appropriately.
● Since the provider had taken over the service, they told us about improvements which had been made, including training and guidance for staff regarding safeguarding, the introduction of accountability daily records, a new IT system, the implementation of 'rep board meetings', how incidents and accidents were recorded and reported, new hoists and beds, redecoration of vacant bedrooms and the communal lounge and ceasing the use of communal items, such as shower caps.
● A programme of audits were undertaken and action plans in place. There were monitored by the provider's representative and identified where actions were needed these were returned to the auditor to ensure they were done, for example updating care plans and referrals to health care professionals.
● Staff told us they felt they had the training they needed, which was confirmed in records. Training had been delivered on line during the Covid 19 pandemic and the service were now moving to provide more training in different ways, such as recent syringe driver training for nurses on a video conferencing system.
● Records and discussions with staff identified some people using the service required support with behaviours others may find challenging. We found training for staff had not been provided in this area. The registered manager told us they had spoken with the training staff member and this was going to be provided.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There had been the introduction of recent 'rep board meetings' and staff told us they could raise issues with their representative. Minutes were not being made available and when they asked the representatives for feedback, they had said they were told in the meeting this could not be discussed. A member of the management team told us they would make clear in the meetings what could be fed back to the staff team.
● The minutes for a 'rep board meeting' held in July 2020 were attended by members of the senior management team to suggest and discuss ideas for improvement. We did see action had been taken, this included changing the providers of their meat orders after concerns being raised. There was also a meeting planned to discuss staffing. The minutes showed the current staffing hours were discussed and new suggested staffing going forward.
● We did see the minutes from a 'sisters meeting' for nursing staff held in June 2020. Where they were kept

updated with the expectations of their role.
● Despite concerns staff had about staffing levels and leadership, staff told us they were committed to providing good quality care to people and they spoke about people in a caring and compassionate way. The provider management team told us they were working to make improvements in the service.
● Meetings for people using the service had not been held during the Covid 19 pandemic, but these were starting again. One had been held on 3 September 2020, people said they could see improvement in the dining experience, which had been identified as an issue in quality assurance surveys, showing actions had been taken as a result of people's comments. In addition, people had brought up the issue of not liking the toilet rolls which were provided at the meeting and the order had been immediately changed to address this.
● One person told us how issues had been brought up during meetings and these had been addressed, "When they took over the first thing was cheaper stuff we are sorting that as we complained bitterly."
● People's relatives told us they felt they were kept updated about their family member's wellbeing. One person's relative said, "I receive regular updates from nurses and they are always available/willing to discuss and elaborate." Another relative commented, "I love the fact they will phone me about how I am feeling about [family member] and any suggestions, what they can do to help [family member]. We work together as a family and staff."

Working in partnership with others
● The service worked with other professionals involved in people's care. This included referrals made to GPs, occupational therapists and dieticians, where required.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The service had a duty of candour policy in place and records reviewed showed actions were taken in line with their policy when an incident had happened, including offering an apology.
● This was confirmed by a person's relative who told us how they were informed of an incident and they were kept updated with what had happened as a result.

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	Regulation 17 HSCA RA Regulations 2014 Good governance At the time of our inspection, systems were either not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing At the time of our inspection staffing levels or deployment were not sufficient to meet the needs of people. Regulation 18 (1)