Staffordshire Care Limited

Sunningdale Nursing Home

Inspection report

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Date of inspection visit: 10 February 2015
Date of publication: 11/05/2015

Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Good**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

We inspected Sunningdale on 10 February 2015 as an unannounced inspection. At our last inspection in October 2013 the service was meeting all of the legal requirements we looked at. The service provides residential and nursing care for up to 42 people. There were 37 people living in the home on the day of our inspection.

There was no registered manager in place as required for the service's registration with us. The manager had been working at the home for a year but had not completed the registration process. 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.

People we spoke with during the inspection told us they felt safe. Staff understood their responsibilities to protect people from harm and knew how to raise concerns if necessary. There were processes in place to ensure medicines were administered correctly.

Summary of findings

People's human rights were protected as staff understood the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were asked for their consent to the care they received.

Some people required specialist equipment to receive their nutrition. We saw this was not stored as required to keep the equipment clean. Some people were rushed to consider their food choices and staff did not always guide them when required.

Staff received training which was linked to people's needs. Staff told us they received supervision and they felt supported to fulfil their roles.

Some staff did not respond in a timely manner to meet people's personal needs. There was limited communication between staff and the people who used the service.

There were arrangements in place to involve people in hobbies and pastimes which interested them but some people told us they would like a more variety.

People and their relatives told us they would feel comfortable raising complaints or concerns with staff or the registered manager and felt they would be listened to.

There were arrangements in place to monitor the quality of the service provided to people.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe. People told us they felt safe. Staff understood how to safeguard people from harm. Medicines were managed and administered correctly. People's risk of avoidable harm was assessed and managed effectively. There were regular checks made to ensure the environment remained safe for people.

Good

Is the service effective?
The service was not consistently effective. People were not supported to enjoy a sociable mealtime experience. The equipment used for the delivery of specialist feeding equipment was not stored correctly. Staff were following the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Standards to support people, when appropriate, with decision making. People were supported to access healthcare professionals to maintain their health.

Requires Improvement

Is the service caring?
The service was not consistently caring. People told us they were happy with the care they received but we observed occasions when their dignity and privacy was not supported.

Requires Improvement

Is the service responsive?
The service was responsive. People's care plans reflected their preferences for care and support. The care plans were regularly reviewed to ensure they met people's current needs. People were supported by a member of staff to pursue their hobbies and interests.

Good

Is the service well-led?
The service was not consistently well-led. The manager had not registered with us as required. The provider did not receive our request to complete the Provider Information Return as the manager had not informed us of a change to their email address.

Requires Improvement

Sunningdale Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 February 2015 and was unannounced.

The inspection was carried out by 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 uses this type of service. The expert by experience on this inspection had a special interest in the care of older people.

We had asked the provider to complete a Provider Information Return (PIR). This is a document that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. The provider had changed their email address and because they had not informed us as required, they did not receive the email and complete the PIR. We considered this when we made our judgements.

We looked at the information we held about the service including information received from the local authority commissioners, who contract the service for people. We also looked at the statutory notifications the manager had sent us. A notification is a document the provider must send us about incidents which have occurred in the home.

During our inspection we spoke with ten people who lived in the home, three relatives, seven care staff, the manager and the operations manager.

We looked at care plans for six people, four staff recruitment files and documents associated with the management of the home.

Some people who used the service were unable to tell us about their care. We used our Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who are unable to tell us about their care.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at the home. One person said, "We're as safe as can be". A relative told us, "I have no concerns about safety here". The staff we spoke with told us that they were aware of their rights to raise concerns about a service by using the whistleblowing policy. One member of staff told us, "I've raised a concern in the past, it was treated seriously. I would do it again if necessary".

All of the staff we spoke with demonstrated they understood their responsibility to keep people safe and protect them from harm. Staff records we looked at showed that staff received training in safeguarding. Staff were able to explain the signs to look for which might indicate a person was at risk of harm. They told us there was a process in place to update them about safeguarding referrals which had been made by the home and the outcome of any investigation.

Some of the people who used the service were at risk of increased risk of falls and we saw plans were in place to minimise their risk. Some people had sensors on their beds which activated to warn staff when they got up. Other people, who had been assessed to be very high risk, had a member of staff with them at all times. We saw from the care plans that people at risk were referred to specialist services for further support and assessment for example to prevent them from falling. One person who used the service told us, "They [the staff] keep me safe, they don't let me tumble". A relative told us, "My [the person who used the service] is always supported when they walk. I don't have any concerns about their safety".

Some of the people who used the service demonstrated behaviour which challenged their own safety and that of others. We saw there were management plans in the care plans so that staff had the information they needed to offer people consistent support. There was information for staff in place to document what might be a trigger for a person's behaviour and guidance on the best way to manage them safely and effectively. One entry read 'Staff to give reassurance to help calm them'. The staff we spoke with told us it was important to try and calm people when they became distressed as it protected their safety.

There were systems in place to monitor the upkeep of the home to ensure the environment was safe for people to live in. The records we looked at indicated there were regular tests of the fire alarm system and emergency lighting. We also saw, in the minutes of a meeting that relatives had been reminded of the importance of signing in and out of the home when they visited so that staff knew who was in the home should an emergency occur. A few days prior to our inspection the boiler providing heat to part of the home had broken. Additional heaters had been provided for the affected areas and their use had been risk assessed to ensure people were protected from harm. The boiler was being repaired when we arrived for our inspection.

There were plans in place to be used in an emergency. The personal emergency evacuation plans provided staff with information about people's mobility and how much support they would need in an emergency. The plans were reviewed regularly and changed to mirror any alteration in people's level of independence. Arrangements for emergency accommodation and local taxi firms were also listed which meant staff were provided with guidance to support them in unforeseen emergency situations.

There were eight members of care staff working on the day of our inspection including a trained nurse and two carers from an agency. The operations manager told us there were some staff vacancies but they usually managed to cover gaps in the rota with staff from their other homes to ensure continuity of care.

We looked at the recruitment records for four members of staff and saw there was a suitable recruitment process in place. Staff we spoke with told us that they had to provide previous employers for references and they waited for the return of their Disclosure and Barring (DBS) check before taking up their post. The DBS provides information on criminal records for potential staff. This meant that the provider checked that staff were suitable to work with people before allowing them to commence care.

We observed a member of staff administering medicines and saw this was completed in a safe manner. We saw staff remained with people until they were sure they had taken their medicine before recording it. The medicine administration records (MARs) we looked at provided clear information for staff on the time medicine was due by colour coding the entry on the chart. Staff we spoke with told us this made identifying which medicines were due at certain times of the day much clearer and reduced the risk of errors. People we spoke with told us they received their medicines regularly and at the time they expected them.

Requires Improvement

Is the service effective?

Our findings

People told us the staff looked after them well. A relative said, "I was worried before they came here that the staff might not know how to look after them but it's been fine". We looked at six care plans and saw that people's care needs were assessed prior to admission to ensure the home would be able to meet their individual requirements.

Staff we spoke with told us they received training which provided them with the skills they needed to care for people. Staff told us the training was delivered in different formats, for example, either electronically via the computer or face to face from external trainers which meant the staff's different learning styles were recognised and catered for. One member of staff told us they had enjoyed the training provided for care of people living with dementia. Following the training the member of staff recognised people would benefit from using different coloured cups and plates and arranged for these to be provided. Coloured crockery aids people with dementia as it stands out against a white tablecloth. This demonstrated the member of staff used the information they gained at the training to improve the life of a person living with dementia.

Staff told us they were supported in their role and received regular supervision from the manager during which they could discuss their performance or anything they were worried about. A member of staff told us, "When I have supervision I feel that I'm being encouraged. If there's criticism it's said positively so you learn from it". There were arrangements in place for new staff to receive induction support. One member of staff told us, "I worked at another home in the group but still received another induction and support when I came here".

We saw that people's nutritional needs were assessed and their weight was monitored regularly to ensure they were receiving sufficient food and drink. If people had lost weight the reasons why this had occurred were investigated and arrangements were put in place, where appropriate, for them to receive supplements to their diet. Some people who used the service were unable to swallow and were receiving their nutrition directly, through a tube, into their stomach. There was a risk assessment and management plan provided by a health care professional which provided detailed information about the way the equipment should be stored when not in use. We saw the equipment was left on a table between use when, according to the management plan, it should have been stored in a clean, lidded box. The syringe was not labelled with the date it was first used as required to ensure it was replaced regularly. This meant the equipment was not stored correctly to ensure it remained clean and reduce the risk of contamination.

Whilst people were waiting for their lunch we saw they were asked what they would like for tea that day or for lunch the following day. We saw some people struggled to make a decision and we saw the member of staff get impatient with them and rush them into making a decision which meant people were not supported to make choices in a way that reflected their needs. At teatime we saw one person who had struggled to make a decision was provided with sandwiches which they were unable to eat. A relative visiting them asked the staff to provide a softer option. The relative told us, "The staff have replaced the sandwiches with soup but I don't know what would have happened if I hadn't been visiting".

We reviewed how the provider obtained consent from people for care, treatment and support and saw people were asked, wherever possible, to sign their consent in the care plans. Where people lacked the capacity to make decisions for themselves we saw the provider followed the principles of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). People may lose the capacity to make some decisions through illness or disability. In these circumstances other people can be authorised to make decisions on their behalf, as long as they are in the person's best interests. Staff we spoke with understood the requirements of the MCA and told us they were booked for training the following week. The manager told us nobody living in the home was being deprived of their liberty or had a DoLS in place at the time of our inspection. Applications were being made for two people, one of whom had tried to leave the home but lacked the capacity to understand risks to their safety.

We saw that people had access to health care professionals to support their mental, physical and social health needs. Care plans included referrals to a range of external services including, the optician, podiatrists, dieticians, the speech and language service and their GP. A visiting health care professional told us, "The staff listen to us and take action

Requires Improvement

Is the service effective?

on our recommendations". Staff we spoke with told us that, if people had hospital appointments or an emergency admission to hospital and a relative wasn't available, they would always be accompanied by a member of staff.

Requires Improvement

Is the service caring?

Our findings

During lunch we saw some people required support to eat or cut up their meals. We observed staff standing over people whilst they were eating rather than sitting with them and chatting to provide them with a sociable meal experience. Conversation during lunch was stilted and staff were not observed encouraging people to eat their meals. Most of the interaction we observed was task related, for example the offer of a drink or when attending to people's personal needs. During the afternoon several people were sitting in the main lounge. There was a member of staff present who at times was watching the television but there was no interaction with people who used the service to encourage conversation. We saw that other members of staff were sitting together chatting in the conservatory or having a cigarette break. This demonstrated that socialising with people was not a priority.

We saw that some people were not supported to maintain their dignity. One person asked for support with their personal care but the member of staff said, "I'm going on my break but someone else will come to you". We observed the person showing signs of increasing discomfort and at our request, a member of staff came to support them. During lunchtime we saw some people had spilt food but we did not see staff support them to wipe their mouths or change their clothing. We observed one member of staff calling for assistance from a colleague and they said in a loud voice' "Can you give me a hand [Name] wants to go to the toilet". This did not support the person to maintain their privacy.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The volume of the call bells was high and people we spoke with commented that they disliked the noise and were disturbed by them. One person said, "It's going off again", when the call bell was activated meaning the home did not provide a quiet and calm environment for people. There was a radio playing pop music loudly during lunch until the manager turned the volume down. There were televisions on in both the lounge and the conservatory but we did not see staff consulting people about what they would like to view.

Everyone we spoke with told us they were happy living at the home and we saw people were treated with kindness by staff. One person said, "Staff do their best". A relative told us, "My [relative] has settled in really well. The family are happy with the care here". As some people were unable to tell us about their experience of living in the home we observed experience of care in the communal areas.

People told us their relatives and friends could visit at any time. We saw relatives visiting throughout the day. The relatives we spoke with confirmed they were able to call in whenever they wanted which meant people were supported to keep in touch with friends and family.

Staff told us no one currently living in the home required the service of an advocate but they were aware how to arrange for this if it became necessary. An advocate works independently to help people make decisions about their health and social support if they are unable to do so for themselves.

Good

Is the service responsive?

Our findings

Staff told us they sat with people when they first came to live in the home so they could understand what people particularly liked or disliked and their preferences for individual care. We looked at six people's care plans and saw they included people's preference for their morning and night time routine. One member of staff told us, "We don't wake people; we let them get up when they're ready. It's the same at bed time; we wait for people to tell us when they want to go to bed". We saw and people told us that they got up and had their breakfast at a time that suited them rather than being rushed to eat at a set time. People told us they could stay in bed if they preferred and we saw that several people had chosen to do so because of the lack of central heating. This demonstrated that staff respected people's choices.

The care plans we looked at also included a 'life map' which provided information about people's past life. Staff we spoke with were knowledgeable about people and could tell us about their previous lives and the effect that had on them. For example, one person had previously worked in a job in which they had spent most of their working day walking. Staff told us the person still liked to keep on the move and would walk around the home. During our inspection we observed the person walking constantly.

We saw that some people had 'short term' care plans in place. The short term plans were used when there was a temporary change in a person's care needs. For example, we saw one person had some damage to their skin and staff had implemented changes to their care whilst it was being treated. This demonstrated that staff recognised and responded to changes in people's needs.

There was a member of staff employed solely to support people with participating in hobbies and pastimes which interested them. The member of staff told us their first job of the day was to speak with people who chose to stay in their rooms and if appropriate, help them with any letters they received. During the course of the inspection we observed the member of staff helping people on an individual basis, for example, they helped one person make a greeting card for a special occasion in their life. We did not see people encouraged to join in and interact together as a group. The member of staff told us they had planned a game of bingo but didn't provide it because of the problem with the heating earlier in the day meant several people had stayed in their rooms. One person told us, "There not much to do and it seems to be the same all the time". Another person said, "I'd like there to be a bit more variety". This meant the support was not meeting everyone's needs and preferences.

Information about making a complaint or a suggestion was displayed prominently in the home so that people could make any comments or complaints about the service. There was a complaints process in place and we saw that when concerns had been raised there had been an investigation and timely response sent. The people we spoke with said they would tell the staff if they were unhappy or had concerns. One relative told us, "I'd go to the manager if I was unhappy". This demonstrated people felt able to raise their concerns when necessary.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager although the manager had been working at the home for over a year. The manager told us they had started the registration process with us some time ago but had completed the application incorrectly which was delaying their registration. We noted that the manager was described as 'registered' on a questionnaire which had been issued to people, their relatives and healthcare professional who visited the home which was incorrect. We had not received a PIR from the service because the email address we had on record was incorrect and we had not been notified, as required.

The manager had sent us notifications about events and incidents which had occurred in the home. We saw that, when appropriate, information had been shared with the local authorities and investigations had been undertaken.

People, relatives and staff had been given the opportunity to feedback their opinions of the service in a satisfaction survey. The manager told us they provided people with this opportunity on an annual basis. We reviewed the most recent survey which had been analysed by the manager. Information on compliments and concerns was recorded and the action the manager intended to take in response to people's comments. People also had meetings provided for them and their relatives to discuss the home and receive updates about future plans.

The manager told us they liked to work with staff so they could observe the way in which care was delivered. During the course of our inspection we saw the manager speaking with people. People and relatives we spoke with were aware who the manager was and were happy with the management arrangements. Staff told us the arrangements for communication within the home were good. Staff we spoke with told us the manager was approachable and supportive to them.

The manager had arrangements in place to record the quality of the service being provided to people. The manager completed audits for several aspects of care, including the quality of staff recording in care plans and medication administration. When actions for staff were identified there was a process in place to ensure these were completed. The manager showed us how they analysed the information from audits to identify if there were any trends, for example, if the risk of people falling was more common at certain times of the day. The operations manager for the provider explained that they also had an audit programme in place. This was used to ensure appropriate actions were completed at a local level, for example, people were being supported to comply with their dietary requirements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person was not ensuring that the care and treatment of service users met their needs.**

This section is primarily information for the provider

Enforcement actions

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