Woodean Limited

Sunhill 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 effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Sunhill Court Nursing Home is a residential care home providing personal and nursing care for up to 40 people, the majority of whom are living with dementia and/or mental health conditions. At the time of our inspection, 32 people were using the service.

People's experience of using this service and what we found
We had significant concerns about a person living at the home and made a safeguarding referral as a result. Some parts of the home were not cleaned or maintained to a good standard. The administration of medicines to people required improvement because eye drops were left on top of the trolley. Hand hygiene by the staff member was not undertaken between each person receiving their medicines. One person receiving their medicine in their dessert was not supervised to ensure they took all their medicine.

At lunchtime, several people had to wait a while before they received their meal; this caused anxiety for some. People's preferences with regard to menu planning were acknowledged and included. People were encouraged in a healthy lifestyle with their dietary needs, and healthcare professionals were involved in their care. The layout of the home was accessible and conducive to people living with dementia. People were supported by staff who knew them well.

Audits were not sufficiently robust to monitor the care delivered and the service overall. Environmental audits had not identified issues found at this inspection. Risk assessments were not always documented accurately with information and guidance for staff to follow. Notifications of abuse or alleged abuse had not always been sent to CQC in line with regulatory requirements.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were happy living at the home. One person said, "They look after me very well. I don't get too lonely as staff pop in, check on me and have a chat. There are enough staff. Sometimes they are a bit short, but generally, yes, there's enough, and some are very good." There were sufficient staff on duty to meet people's care and support needs promptly. Staff were recruited safely.

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 was good (published 7 April 2020).

Why we inspected
This inspection was prompted in part due to concerns received about safeguarding. As a result, we

undertook a focused inspection to review the key questions of safe, effective and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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 COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well led section of this report. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.
You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to the administration of medicines, risk management, monitoring of the service and auditing systems, protecting people from abuse or harm, and statutory notifications.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Sunhill 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by 2 inspectors.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, including concerns raised by members of the public. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people and a relative about their experience of the service. We spoke with the provider's compliance director, regional director, registered manager, deputy manager, clinical lead, chef, and 3 care staff.

We reviewed a range of records including 4 care plans and multiple medication records. We looked at 2 staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection, we received feedback about the home from 2 healthcare professionals.

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 our last inspection we rated this key requires improvement. The rating has for this key question remains 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.

Systems and processes to safeguard people from the risk of abuse

- Systems and processes were not always effective in preventing the risk of abuse or harm.
- Before we inspected, significant concerns were raised by a healthcare professional, and information was shared with us about a person living at the home. We are unable to provide detail of the specific concern as this would identify the person. We were not satisfied the person was protected from the risk of abuse or harm and we made a referral to the relevant safeguarding authority during the inspection.

The provider had failed to ensure systems and processes were sufficiently robust to protect people from harm. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We discussed our concerns with the registered manager. After the inspection they told us a multi-disciplinary meeting would be arranged to review the care and support this person required.
- A relative told us, "Staff are always kind and polite. I think he is very safe and well looked after here. The staff are always nice to me as well and go out of their way to make you feel welcome. I think it can be quite challenging sometimes, because of the level of confusion. Some people can get angry, but I have only seen staff react with kindness and gentleness."
- Staff completed safeguarding training, and demonstrated their understanding. A staff member said, "We would try and find out if there was truth in what people were saying, for example, if a service user disclosed staff had been unkind. I would report to the manager and they would need to investigate to make sure things are safe; staff would be removed as a precaution."

Using medicines safely

- Some aspects of medicines were not managed safely.
- We observed a nurse giving people their medicines at lunchtime. They did not sanitise their hands in between administering each person their medicines. This was an infection risk.
- Eye drops for 2 people were left out on top of the medicines trolley until they were needed. We observed the medicines trolley was left unattended and the eye drops were not stored securely, although the doors to the trolley were locked shut.
- One person was given a medicine in their dessert, which was their preference; the medicine was not given covertly. The nurse sprinkled a crushed tablet over the trifle, and the person proceeded to eat the pudding. However, the nurse did not wait to see that the person had finished their pudding and ensure they had consumed all the medicine. The nurse could not be assured the person had taken this particular medicine as prescribed.

The provider had failed to ensure the safe management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014.

● We discussed our observations of the medicines round with the registered manager. They told us they would address the concerns with the staff member and arrange for them to undertake refresher training in the administration of medicines. Only staff who completed training in medicines were allowed to do so; they were registered nurses and nurse assistants.
● People told us they received their medicines as prescribed. One person told us, "Staff are all very kind to me. I get my medication when I need it. I have no complaints."
● Medicines were ordered, stored, and disposed of safely.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. In 2 rooms we found food debris on the floor and in 1, liquid splashes on the walls. There was an open drain in a bathroom from which emanated an unpleasant smell. During the inspection, cleaning was undertaken in the problem areas, and the open drain was provided with a cover.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

The home was open to visitors, and hand sanitisers were available for anyone to use.

Assessing risk, safety monitoring and management
● Risks to people were identified, assessed and managed safely. At the last inspection, there were concerns relating to modified diets and the way a person's risks were managed.
● We observed staff supported a person to sit up in their reclining chair in order that they could eat their meal safely; this was in line with guidance received from a speech and language therapist (SaLT). Another person was observed being transferred from their wheelchair to a chair. Staff used an overhead hoist to assist with this manoeuvre, and provided the person with reassurance throughout.
● Risks were documented within people's care plans. For example, 1 person's risk of malnourishment had been assessed and measures put in place to mitigate the risk. Their nutrition and hydration care plan noted staff should encourage the person to eat their meals. As a result the person had increased their weight which was now within normal limits.
● We observed two bathrooms where the flooring posed a trip hazard to people. The registered manager told us there were plans to undertake refurbishment of the premises in August. During the inspection, the flooring was repaired, resolving the trip hazard.

Staffing and recruitment
● There were sufficient trained staff on duty to meet people's needs. Staffing levels were assessed using a dependency tool. This was used to calculate the number of staff required according to people's care and support needs.
One person said, "The staff are pretty good and know what they are doing. They come quickly if I ring the

bell, but I don't often need to."
● Staff felt they had time to spend with people and did not feel rushed. One staff member said, "There's plenty of staff. This is the most staff we've ever had."
● Staff were recruited safely. Checks were completed to show new staff were suitable to work in a care setting, including Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong
● Lessons were learned if things went wrong.
● Incidents and accidents were documented, and actions taken as a result were recorded. If a person sustained a head injury, staff would always call for an ambulance. If paramedics assessed the person did not need to be admitted to hospital, staff would undertake hourly checks of the person to monitor their wellbeing.
● Departmental meetings were organised. The registered manager explained that staff had felt there was a lack of communication and told us of a particular safeguarding incident. The registered manager added, "We discuss high risk residents and we come up with a plan, behaviours that challenge, what we need to improve communication, housekeeping, kitchen issues, clinical issues, complaints, compliments, and feedback from the previous week. We ask each head of department what they learned from particular incidents."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. The rating for this key question has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to maintain a balanced diet and a healthy lifestyle. One person said, "The food is nice, not bad. I used to be a chef, so I am a bit fussy, you get a choice. I would like to have a bit more fresh fruit."
- We observed people having their lunchtime meal in the dining room and conservatory. One person became a little agitated and was looking at what other people were eating. They asked staff where their meal was and waited an hour before it was served. Nine people waited at least 30 minutes before they received their meal, and this caused distress and anxiety for some. We discussed this issue with the management team who said they would review the way meals were served, as we saw many people had to wait a while.
- The chef understood how to modify food to meet people's assessed needs. For example, 1 person had the meat portion of their meal pureed as they had an episode of choking on meat in the past. A referral was made to a speech and language therapist for advice.
- Menus were planned by the chef, and people were asked for their food likes and dislikes, so these could be incorporated. The chef said, "We have a main meal choice, then we have an alternative. There's pasta, sandwiches, jacket potatoes, omelettes. We have 1 person who really likes ham and mashed potatoes, so we do that a lot."
- Food surveys were completed by people to find out what was liked on the menu and whether there should be any changes.
- Drinks were freely available to people throughout the day.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before being admitted to the home. Referrals for placement came from local authorities and families also contacted the home direct.
- The registered manager usually completed assessments for potential new admissions, and obtained advice from the clinical lead for people with medical needs. Information derived from assessments formed the basis of a care plan.
- Families were involved in the care planning process.

Staff support: induction, training, skills and experience

- Staff completed a range of training which the provider considered was necessary to undertake their roles and responsibilities. There were opportunities for staff to undertake vocational qualifications in health and social care.

● Training included dementia awareness, falls management, moving and handling, positive behaviour support, and safeguarding. Other training modules were available for staff to complete. A staff member said, "We have training on challenging behaviour … we don't restrain people, but we know how to redirect them, and have had specific training on how to do this safely."
● New staff, who did not have English as their first language, could access support to improve their communication skills.
● Staff received supervision from their line managers. A staff member said, "I have supervision with the manager to make sure I am okay. A lot of training is done face to face, but some is online. Every year we renew the training."
● In addition to supervision meetings, staff attended weekly catch-up meetings to share information. Daily handover meetings to discuss people's care and support needs were attended by staff.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People received support from a range of health and social care professionals.
● GPs called the home weekly and at weekends. Face to face visits were undertaken every fortnight. People who became unwell were responded to promptly by healthcare professionals.
● Where there was a cause for concern with people's welfare, referrals were made to speech and language therapists, dieticians, and others who provided advice and guidance on any health issues, including mental health and dementia.
● A healthcare professional told us, "I have always found the staff and the manager at Sunhill Court very engaging and open to my input. The staff don't hesitate to request input or to ask advice with care needs for their residents."

Adapting service, design, decoration to meet people's needs
● The premises had been adapted to meet people's needs. There were plans to undertake further refurbishment and redecoration within the next few months. The lower ground floor bedrooms had been re-equipped and redecorated. A staff member said, "The décor needs sorting, and the reception area, but there are plans for improvements."
● Some parts of the home were fitted with overhead hoist tracks to enable moving and handling.
● An accessible lift meant people and staff could move freely between floors.
● Signage around the home helped orient people living with dementia.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (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 MCA 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.

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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions

relating to those authorisations were being met.

● Consent to care and treatment was gained lawfully. We observed staff routinely checking with people and gaining their permission before providing care and support.
● Before the inspection, we were made aware of concerns relating to people's consent being recorded within Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms. People's wishes and preferences were recorded with regard to how they wanted to be supported in a medical emergency.
● People's capacity to make specific decisions was assessed and documented.
● Staff completed MCA training. One staff member explained their understanding and said, "The MCA is always assume they have capacity, although capacity can fluctuate due to illness or another reason. We mustn't be too restrictive. Just because a person makes an unwise decision, doesn't mean they don't have capacity. With regard to DoLS, almost everyone living here has one. There are key codes in many parts of the home."
● DoLS were authorised by the local authority.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems for monitoring the service and identifying areas for improvement were not always effective.
- The risk of abuse or harm had not been recognised (see the Safe section of this report).
- Medicines were not always administered in a safe way.
- Some parts of the home required cleaning and cleaning schedules did not recognise the need that some rooms needed more frequent cleaning. Environmental audits had failed to identify the flooring in 2 bathrooms had lifted and posed a trip hazard, and in 1 bathroom, that an open drain needed attending to.
- A choking risk identified on the front of 1 person's care plan noted they received a normal diet with pureed meats and normal fluids. This was contradicted by a choking risk assessment with a score of zero, indicating there was no risk. However, further information was confusing, stating they were at risk of choking if eating in bed.
- There was no alcohol risk assessment for 1 person regarding their consumption of alcohol. Staff told us the person was restricted in how much they were allowed to drink, whilst other staff said there were no restrictions, and the person could ask for more if they wanted. Specific guidance for staff on the management of this issue was not recorded.
- The way risks were assessed and documented within the electronic care planning system was not reliable or accurate. The management team assured us this would be addressed with the manufacturer of the system so updates could be carried out.

The provider failed to implement effective governance systems to monitor the quality and safety of the service provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During and after the inspection, cleaning was undertaken in the rooms which had been identified previously. Bathroom flooring was repaired or replaced, and the open drain was covered.
- After the inspection, a risk assessment for 1 person's alcohol intake was drawn-up. Training was to be organised with staff regarding the need to include detailed information within each risk assessment so this could be followed.
- Reviews on a website recorded positive comments from relatives. One review stated, 'Mum lives with dementia and she settled in straight away. This was a huge relief as she had become increasingly unhappy and withdrawn before. Sunhill endeavours to recognise the individual needs of each resident, and we feel that we are welcomed and listened to.'

● Incidents which were identified as abuse or alleged abuse were notified to the local safeguarding authority, but not always notified to CQC. The registered manager had not understood that all incidents of abuse or alleged abuse must be notified to CQC. They had thought any incident was only notifiable if the local authority accepted it as a safeguarding referral with further action needed.

The provider had failed to ensure notifications relating to abuse were always notified to CQC. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People received personalised care and we observed positive interactions between people and staff. For example, we observed an altercation between 2 people. A member of staff quickly intervened and was skilful in defusing the situation, using distraction techniques. One person was encouraged to go into the main dining room for lunch.

● Although we did not see any planned activities on the day of our inspection, we were told an activities co-ordinator supported people to engage in various pastimes such as flower arranging, games, and pampering sessions. We saw a person become upset and tearful, and a staff member came over, rearranged their knee blanket, and talked gently with the person. The staff member sang quietly to the person, and they smiled, made eye contact, and joined in with the singing.

● People appeared happy and comfortable in their surroundings. One person said, "I know the manager I can talk to her about anything if I'm worried. She knows me quite well and pops in for a chat. I do think it is well managed; I'm pretty happy here really."

● People's diverse needs were catered for. For example, 1 person's religion was important to them, and staff acknowledged this. People with sensory impairments were supported with glasses for their sight, or hearing aids to address their communication needs.

● People's feedback about the home was sought. For example, people's preferences contributed towards menu planning.

● Staff felt supported in their roles. One staff member said, "I like it here. There's never a dull moment, everyone is nice. People can be challenging, but they are all lovely."

● Departmental meetings and staff meetings were regularly organised. Staff had three monthly supervision meetings with their line managers. A staff member said, "We do have meetings with staff and talk about any problems, and things that are going well."

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 registered manager explained their role and responsibilities under duty of candour. They told us, "I have to be honest with my residents, and it's my responsibility to report anything such as safeguarding the residents, or if they have got anything really concerning. My residents have to know what is happening, what will happen next, and I work well with professionals."

Working in partnership with others

● The home worked with a range of health and social care professionals.

● Two healthcare professionals provided their feedback about the home. One stated, 'Staff are able to provide high quality care for people who have often been discharged from mental health units and therefore have significant physical and psychological needs.'

● The registered manager talked about their professional relationships with funding bodies, commissioning and others. Multi-disciplinary meetings were organised to ensure people received holistic care and support.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure notifications relating to abuse were always notified to CQC. Regulation 18 (1) (2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure all aspects of medicines were managed safely. Regulation 12 (1) (2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems and processes were sufficiently robust to protect people from harm. Regulation 13 (1) (2) (3) (4)(c)(d) (6)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to implement effective governance systems to monitor the quality and safety of the service provided.

Regulation 17 (1) (2)(a)(b)(c)(f)