Sunnycroft Care Home Limited

Sunnycroft Care 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?	**Inadequate**

Summary of findings

Overall summary

About the service
Sunnycroft Care Home is a residential care home that can provide accommodation and personal care to up to 59 people. Care is provided over two floors, each having their own separate communal areas for people to access. At the time of the inspection, 33 people were residing in the home, most of whom were living with dementia.

People's experience of using this service and what we found
The provider's governance systems had failed to robustly monitor the quality of care provided to people. Risks to people's safety had not always been adequately assessed and managed and the systems in place to protect people from the risk of abuse were not effective.

There were enough staff working in the service to keep them safe but not to provide them with adequate stimulation to enhance their wellbeing. The provider had recognised this prior to our inspection, and plans were in place to improve this area.

Relatives were happy with the care provided to their family members. They felt the culture was open and that the management team and provider was approachable. However, not all staff felt this way with some telling us they did not feel confident to raise concerns for fear of reprisals. Furthermore, external organisations such as the local authority and CQC had not been notified of incidents when they should have been, to enable them to have adequate oversight of the care people received. This did not demonstrate a truly open and transparent culture.

Most of the required checks had been completed to ensure staff working in the service were safe to do so. People received their medicines when they needed them, and the service and equipment people used was clean. There were good systems in place to prevent the spread of infection including COVID-19.

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

Rating at last inspection and update
The last rating for the service was Requires Improvement (published 16 May 2019) and there were two breaches of regulation. The provider completed an improvement plan to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service remains rated Requires Improvement. This service has been rated Requires Improvement for the last four consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding people from the risk of abuse and the culture within the service. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained as 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.

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 assessing and managing risks to people's safety, protecting people from the risk of abuse, monitoring the quality of care provided and for not notifying CQC of certain incidents as is required by law.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will 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?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Sunnycroft Care 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 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 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 care service.

Service and service type
Sunnycroft 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
This inspection was unannounced.

What we did before the inspection
We reviewed the information we held about the service. This included feedback we had received since the last inspection and notifications the provider had sent us regarding the care provided. 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 used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service briefly and eight relatives about their experience of the care provided. We spoke with seven staff and received written feedback from five staff. This included care, kitchen and domestic staff. We also spoke with the registered manager, the provider's quality manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included four people's care records and multiple medicine records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess risks relating to the health and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014. Not enough improvement had been made and the provider is still in breach of regulation 12.

- Risks to people's safety had not always been adequately assessed or managed, placing them at risk of harm.
- One person had lost a significant amount of weight in a short period of time and had been assessed as being at high risk of malnutrition. Reasonable actions to mitigate this risk had not been taken such as alerting the person's GP.
- The risks posed to people living in the service such as experiencing physical or verbal abuse had not been re-assessed following incidents of another person's distressed behaviour. Concerns had not been raised with healthcare professionals for support when it would have been appropriate to do so.
- The garden area was unsafe for people to use. Patio stones were raised creating a trip hazard and a broken greenhouse was present with exposed panes of glass. These risks had not been identified.
- The registered manager told us the exit door to the garden was sometimes left unlocked so people could access it freely. We found this to be the case however, the garden area was not secure. There were missing fence panels next to a neighbouring property and three low gates that led to a busy main road. The registered manager told us there were people living in the service who were mobile and who would be unsafe within this area. These risks had not been identified.

The above evidence demonstrates a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider responded immediately during the inspection. They completed a full audit of the garden area and told us they had taken steps to reduce any risks to people's safety.

Systems and processes to safeguard people from the risk of abuse

- The provider's systems were not effective at reducing the risk of people experiencing abuse.
- Safeguarding concerns had not always been investigated in a timely manner. Staff had raised one allegation to a senior staff member on 3 April 2021, but this had not been investigated until 12 April 2021. This delay left people exposed to the risk of abuse.

●Not all allegations of abuse had been reported to the relevant authorities such as the local authority or the CQC. This did not enable independent oversight and monitoring to ensure people were safe from abuse.
●Restrictive measures had been put in place without due consideration for the principles of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards. This had resulted in one person who the registered manager told us lacked capacity to consent to these restrictions, being unlawfully deprived of their liberty.

The above evidence demonstrates a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing and recruitment
●There were enough staff to keep people safe but not to provide them with adequate stimulation to improve their wellbeing. This required improvement.
●Six relatives told us they felt there were enough staff to keep their family members safe. One relative said, "My relative is safe. The staff are in and out all the time." Two said their family members had told them that on occasions, they had to wait for their call bell to be answered. Three said they did not feel there was adequate stimulation for their family member such as a lack of social interaction, which was important to them. One relative told us they felt this had contributed to a decline in their family member's mental health.
●Staff gave us mixed views although all said they could keep people safe and provide them with the care they required to reduce risks to their safety, such as providing regular drinks and re-positioning. However, most staff said they did not have adequate time to engage meaningfully with people. Our observations confirmed this. We saw staff could meet people's care needs but had little time to spend with them.
●The registered manager had recognised staff were busy and during the inspection, they increased the number of staff working during the day. They told us they were actively recruiting a new member of staff to work in their wellbeing team. This was because the staff who had responsibilities in this area needed to support with COVID-19 testing. This had reduced their ability to spend time with people.
●Most checks required on new staff to ensure they were appropriate to work within the service had been made before they were employed. However, for one of the three staff members records we viewed, the reasons for them leaving their previous roles in care had not always been adequately explored and a full employment history had not been requested. The provider' policy did not include requesting a full employment history as is required. They immediately changed this to reflect the legal requirements.

Learning lessons when things go wrong
●Incidents had been reported to management when they occurred, but robust investigation and analysis had not always taken place to learn lessons. This needed improvement.
●Staff understood the need to report any incidents that occurred with regards to people's safety. Records showed in the main, this had taken place.
●The registered manager advised the deputy manager would review any incidents that occurred. However, records did not show this had always happened and therefore, it was not clear what action if any had been taken to learn lessons. This included incidents of alleged abuse.

Using medicines safely
●Medicines were managed safely.
●The relatives we spoke with raised no concerns in this area. One relative told us, "The staff do the medication and I am not aware of any errors."
●Records showed people had received their medicines when they needed them. They were stored securely for the safety of people living in the service.
●Staff had received training in how to give people their medicines correctly and their competence had been assessed in line with best practice, to ensure they did this safely.

Preventing and controlling infection

●Adequate systems were in place to prevent the spread of infections.

●We were assured that the provider was preventing visitors from catching and spreading infections and was meeting shielding and social distancing rules.

●We were assured the provider was admitting people safely to the service. However, although staff knew one person was isolating, there was nothing to warn visitors of this to ensure they took appropriate precautions should they need to enter their room. The registered manager agreed to review their processes in relation to this.

● We were assured that the provider was using PPE effectively and safely and that they were accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises and was making sure infection outbreaks could be effectively managed.

● We were assured that the provider's infection prevention and control policy was up to date and that they were facilitating visits for people living in the service in accordance with current guidance.

Inadequate

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 this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider had failed to ensure there were robust governance systems in place to monitor the quality of care provided. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014. Not enough improvement had been made and the provider is still in breach of regulation 17.

- Governance systems were not robust at monitoring or improving the quality of care. This placed people at risk of harm.
- The registered manager had been absent from the service from the end of December 2020 to 12 April 2021. The provider told us they monitored the quality of care through a monthly report that was sent to them by their managers. However, this had not continued despite the provider's quality manager leading the service in the registered manager's absence. This monthly report had not resumed on the return of the registered manager. Therefore, the provider did not have adequate oversight of the quality of care being provided.
- The registered manager demonstrated some shortfalls in their knowledge with respect to safeguarding and the application of the Mental Capacity Act 2005. The provider's quality manager had not reported an incident of actual abuse to the appropriate organisations when they were running the service. The provider had failed to identify this through their governance systems to ensure people were being effectively protected from the risk of abuse.
- Recent health and safety audits that had been conducted by the provider's quality manager had failed to identify the concerns we found with the safety and security of the garden area. We also found an unlocked room that was being refurbished. This contained hazardous items such as exposed wiring and a saw. The registered manager said this should have been identified on the daily manager's walkaround, but it had not been.
- When asked, the provider was not able to tell us what their governance structure was to ensure there was robust monitoring of the quality of care provided. Safeguarding incidents and complaints were not analysed for patterns to ensure any associated risks were being managed appropriately.
- The provider failed to ensure the fundamental standards of care were being met. This is the fourth consecutive inspection where breaches of regulation were found. This did not demonstrate a drive for improvement.

The above evidence demonstrates a continued breach of regulation 17 (Good Governance) of the Health

and Social Care Act 2008 (Regulated Activities) 2014.

●CQC had not been notified of several incidents as required by law. This included an incident of actual abuse, allegations of abuse and a serious injury experienced by a person following a fall.

This was 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; Working in partnership with others

●The staff we spoke with gave mixed views about the culture within the service. Some said they found the registered manager, deputy manager and provider approachable but others said they did not. Some said either they felt hesitant to raise concerns particularly if they witnessed poor staff practice for fear of losing their jobs or were aware of staff who felt this way. Furthermore, the provider had not ensured external organisations such as CQC had been contacted when it was necessary to do so. This did not demonstrate an open culture.

●Seven of the thirteen staff we gathered feedback from said they did not feel valued with some saying their morale was low. We spoke with the registered manager and provider about this feedback. They told us they were aware staff had been working hard and the service had experienced a difficult time during the COVID-19 pandemic. The provider had put provision in place to support staff following an outbreak at the beginning of the year. They had recognised further work was required and were looking to improve staff engagement and their presence around the service to support staff.

●There was no formal mechanism in place to gather feedback from people regarding the care they received. The registered manager said this was difficult as people would require increased support to do this adequately. They had plans however, to improve this with people's views being sought on a regular basis to help drive improvement within the service.

●Relatives told us they were happy with the quality of care provided. One relative said, "The care given to my relative is excellent and [Family member] is quite happy and likes the carers. The staff are kind and do a good job."

●Relatives said they found the registered provider and manager approachable and were confident any concerns they raised would be managed 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;

●Relatives we spoke with told us communication was good and they had been told if their relative had been involved in any incidents. Records we saw confirmed this.