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Sunlight House

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**

Overall summary

The last inspection of this home was carried out on 6 June 2015 when we found the provider was in breach of the regulations. This was because the provider did not always ensure medicines were managed properly and governance systems were operated effectively. This related specifically to the way staff recorded medicines they had handled on behalf of the people using the service and the provider's internal audits, which had failed to identify these medicines recording errors.

After the home's last unannounced comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to these breaches. We undertook an unannounced focused inspection on the 26 November 2015 to check the provider had followed their action plan and now met legal requirements.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Sunlight House' on our website at www.cqc.org.uk'

Sunlight House is a care home that provides accommodation and personal support for up to four people. The home specialises in supporting younger adults with a past or present experience of mental ill health or learning disabilities. The care home also caters for people with a visual impairment. There were four people living at the home when we visited.

The home is owned by an individual who is the registered provider. A registered provider is a person who has registered with the Care Quality Commission (CQC).

Summary of findings

Registered providers 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.

During our focused inspection, we found that the registered provider had followed their action plan, which they had said would be completed by August 2015. We saw legal requirements had been met because the provider now managed medicines safely and operated more effective governance systems. This meant staff kept accurate records of all medicines they had administered and the provider regularly checked the quality of the care and support people who lived at the home received.

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?

We found that appropriate action had been taken by the provider to improve safety.

The provider ensured medicines were properly managed. Specifically, staff kept accurate records of all medicines they had handled on behalf of the people living at the home. This meant people were given their prescribed medicines at times they needed them. The provider was now meeting legal requirements.

However, while improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice in relation to the safe management of medicines.

We will review our rating for safe at the next comprehensive inspection.

Requires improvement

Is the service well-led?

We found that appropriate action had been taken by the provider to ensure the home was well-led.

The provider operated effective governance systems to regularly assess, monitor and improve the quality and safety of the services people who lived at the home received. Feedback was also routinely sought from people using their service, their relatives and professional representatives, which the provider used to drive improvement.

However, while improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice in relation to the services quality monitoring arrangements.

We will review our rating for safe at the next comprehensive inspection.

Requires improvement

Sunlight House

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 checked 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 unannounced focused inspection was undertaken by a single inspector on 26 November 2015. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection in June 2015 had been made. We inspected the service against two of the five questions we ask about services: is the service safe? Is the service well-led?

Before our inspection we reviewed the information we held about the home, this included the provider's improvement plan we asked them to send us, which set out the action they would take to meet legal requirements.

During our inspection we visited the home and spoke with the registered provider and a care worker. We also looked at various records that related to the overall management of the service, including eight medicines administration record (MAR) sheets, numerous quality assurance audits and stakeholder satisfaction feedback forms.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of this service on 6 June 2015 we found the provider was in breach of the regulations because they had failed to ensure to proper and safe management of medicines. Specifically, staff had failed to always sign for medicines they had administered. This meant it was difficult to determine whether people had received their prescribed medicines at times they needed them.

At this focused inspection we found the provider had taken appropriate steps to follow their written action plan and address the staff record keeping issue we described above. We found the provider now managed medicines properly and safely.

People were supported by staff to take their prescribed medicines at times when they needed them. People had their own medicines administration record (MAR) sheets which staff appropriately signed each time people were supported to take their medicines. Where medicines had not been given the reasons for this were clearly documented. All the MAR sheets we looked at had been completed correctly. Our checks of stocks and balances of medicines confirmed these had been given as indicated on people's individual MAR sheets. Records showed staff had all received refresher training in September 2015 with regards the safe and proper management of medicines. This was confirmed by the provider and staff we spoke with. The provider also told us they would continue to check staffs' competency to handle medicines safely annually.

Although we saw some guidance for staff to follow in relation to the use of 'as required' medicines; we found these records did not always give staff enough detailed information about the triggers they needed to look out for when deciding whether or not to give this type of medication and who they must always contact to authorise its use. We discussed this issue with the provider who agreed to improve the guidance for the use of 'as required' medicines and ensure staff knew when and how to manage this type of medication safely.

Requires improvement

Is the service well-led?

Our findings

At our comprehensive inspection of this service on 6 June 2015 we found the provider was in breach of the regulations because they did not always operate effective governance systems to monitor the quality and safety of the service people received. Specifically, quality monitoring systems had not identified a number of recording errors on MAR sheets where staff had failed to sign for medicines they had administered.

At this focused inspection we found the provider had taken appropriate steps to follow their written action plan and improve their quality monitoring arrangements.

There was an open and transparent culture within the home because staff ensured people were given a say in how the service was ran and how it could be improved. Regular house meetings were held at the home where people were encouraged to contribute their ideas and suggestions. The provider also sought the views of people using the service, their relatives and their health and social care professional representatives through satisfaction questionnaires. People were encouraged to give their ideas and suggestions for how the service could be improved. We looked at a sample of completed questionnaires and these were positive about the care and support people received.

The provider carried out regular checks to assess and monitor standards within the home. They told us they were responsible for carrying out regular checks to ensure the expected standards had been met. Records indicated these covered key aspects of the service such as the accuracy of people's care plans, the management of medicines, cleanliness and hygiene in the home, the safety and quality of the physical environment, health and safety and staff training and support. These checks were all documented along with any actions taken by staff to remedy any shortfalls or issues they identified through these checks. Other records showed us a community based pharmacist had carried out an audit of the services medicines handling practices in November 2015 and were satisfied medicines were managed safely at Sunlight House. The provider told us they also had a contract for an external professional to carry out independent annual quality assurance reviews of the home starting early next year (2016).

Learning from incidents and events was used to drive improvements within the service. It was clear from records of team meetings and comments made by the provider that reason why so many medicines recording errors had happened in the past had now been analysed and appropriate action taken to minimise the risk of similar mistakes reoccurring. This included retraining staff to refresh their knowledge of safe handling of medicines, discussing lessons to be learnt at team meetings and undertaking regular audits of MAR sheets. Staff we spoke with confirmed medicines errors were discussed at their team meetings so that everyone was aware what happened and about the improvements that were needed. The provider staff told us the number of errors had significantly reduced as a result of the actions taken.