Review of compliance

Mr & Mrs A Wood Sunnyside Residential Home	
Region:	North West
Location address:	37 Ullet Road Sefton Park Liverpool Merseyside L17 3AS
Type of service:	Care home service without nursing
Date of Publication:	October 2012
Overview of the service:	Based in a residential area of Liverpool, Sunnyside Residential Home provides support for up to twenty two people. Accommodation is provided in single bedrooms, twenty of which have en-suite facilities.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Sunnyside Residential Home was not meeting one or more essential standards. Action is needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 20 September 2012, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

During our visit we spoke with ten of the people living at Sunnyside Residential Home and with four members of staff. We examined a sample of records and spent time observing the support provided by staff.
One person told us that in their opinion, "it's like being at home only you get waited on" and another, "I like it here". Several people commented that the building was kept clean and tidy and had no unpleasant odours.

The people living there told us that staff had regularly asked them their opinion of the service they had received with one person explaining, "It's good, if you ask for anything they try to get it". They told us that staff had listened to them and acted on their wishes. People also told us that they had received the support they need with their health and personal care and that they had confidence in the staff team. They said they had felt safe living at Sunnyside Residential Home and had felt confident to raise any concerns they had had with staff. One person explained, "I'm safe here, you don't' have to worry".

What we found about the standards we reviewed and how well Sunnyside Residential Home was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

The provider was meeting this standard. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider was meeting this standard. People experienced care, treatment and support that met their needs and supported their rights.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The provider was meeting this standard. People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse occurring.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. People who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

The provider was meeting this standard. People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.
The provider did not have arrangements in place to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard. The provider did not ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by the means of appropriate maintenance of an accurate record and the management of the regulated activity.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
The people living at Sunnyside Residential Home told us that they had been supported by staff to make their own decisions. Their comments included, "I decide", "I choose" "it's up to me, they don't stipulate" and "if I say no they listen". They told us that they made their own decisions around personal and health care, times they wanted to go to bed and get up and where they spent their time.
One person explained that they had met with staff from the home and had been invited to visit, have a meal and meet the other people living there, before deciding to move in.

Other evidence
During our discussions with staff they displayed a good understanding of how to support people to maintain their independence and they gave us examples of the ways in which peoples views had been obtained and supported. Staff had a good knowledge of the decisions people had made around their care and were clear that people had the right to refuse care and treatment if they choose to do so. We observed throughout our visit that staff spoke respectfully to people and that they gained permission before entering bedrooms, respecting people's views if they refused.

Care records contained information about people's representatives and where applicable, their advanced wishes in the event they became unwell. Discussions with

staff evidenced that they were aware of this information.

Our judgement
The provider was meeting this standard. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People told us that they had received the help and support from staff that they had needed. Their comments included, "if you are not well they understand", I can have a bath anytime I want" and "they are always here to help". People confirmed that staff had always helped them with their personal care. They also told us that when they had been unwell staff had arranged medical appointments and attended with them if needed.
A visiting therapist was at the home during our visit providing Indian Head massage for the people living there. People told us that this therapist had visited regularly and in addition they had had regular visits from an entertainer and Tai Chi lessons. They also told us that staff regularly arranged activities including skittles and games, all of which they had enjoyed.

Other evidence
We asked staff to tell us about the needs of some of the people living at the home. Staff gave responses which indicated that they knew people well and had provided support based on the person's individual needs and choices.
In meeting the people living there it was evident that they had received the support they needed to meet their personal care needs.
Individual care records were in place for all of the people living at Sunnyside Residential Home. The provider may find it useful to note that not all of these records were up to date. For example we saw a risk assessment that had not been formally reviewed since 2007. We also noted that care plans were not in place for the support one person had received regarding their weight or risk of falls. Discussions with staff and the person

evidenced that this support had been provided.

Our judgement
The provider was meeting this standard. People experienced care, treatment and support that met their needs and supported their rights.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We asked the people living at Sunnyside Residential Home if they had felt safe living there and they told us that they had. One person told us that they felt, "very safe" and another "I'm safe here, you don't' have to worry". People told us that if they had had any concerns they would have felt confident raising them with staff. One person explained," Anything you want to talk about they listen and another, "I can talk to any of them".

Other evidence
In discussion staff demonstrated that they had an awareness of safeguarding adults including signs and symptoms that may indicate a safeguarding incident had occurred. They told us they had received training in this area and that they would not hesitate to report any safeguarding issues. Records confirmed that staff had received training in this area, with further training booked to take place shortly.
Our records evidenced that staff had appropriately reported potential safeguarding adult's incidences to the relevant authorities. Records at Sunnyside Residential Home confirmed that senior staff had co-operated with investigations and supplied information required to the appropriate authorities.

Our judgement
The provider was meeting this standard. People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse occurring.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

The provider is non-compliant with Outcome 10: Safety and suitability of premises. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
Several of the people living at the home commented that the building was always clean and tidy. One person told us that they liked it because there were no unpleasant odours.

Other evidence
Everybody living at the home had their own bedroom and we noted that people had been able to personalise these with their belongings. All areas of the home were clean, bright and odour free. Shared space for the people living there included a lounge, dining room and sun room. A passenger lift provided access to the upper floors. In addition the sun room had been fitted with a wheelchair platform lift for people who could not navigate the small set of steps leading to the seating area.

Baby safety gates had been fitted to the top and bottom of several flights of stairs. A senior member of staff advised us that this was to lessen the risk of people falling. They also explained that they had considered the needs of the people living there and these gates did not prevent people moving around the home as they could use the lift. Although these gates had been referred to within the fire risk assessment this did not include an assessment of any risk posed in the event of evacuation due to fire being needed.

No general risk assessment of the use of these baby gates on stairs had been carried out and we saw no evidence of reference to building regulations which state the minimum height of gates leading to a drop such as stairs. We also saw no evidence of advice having been obtained from relevant professionals. In addition individual risk

assessments for the people living at the home where not in place to assess any risk of accidents to them that these gates may pose.

Our judgement
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. People who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

Outcome 14:
Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
The people living at Sunnyside Residential Home told us that they had had confidence in the staff team. One person explained, "they are always there, can't do enough for you" and another, "I like them". People told us that in their opinion staff knew how to support them safely and well, with one person explaining, "They are trained".

Other evidence
Staff told us that they had undertaken a variety of training relevant to their role. They also explained that refresher training had been booked to take place in a few weeks time. All of the staff we spoke with explained that they had had formal supervision sessions with senior staff in the past, and their manager had told them further supervision sessions would be arranged soon. We looked at a sample of records which confirmed this. Staff explained that formal staff meetings did not take place within the home, although they had regularly discussed any issues that had arisen. They told us that they had felt supported by senior staff and that their views had been listened to and acted upon. The provider may find it useful to note that documented staff meetings would provide a formal way to discuss, document and review any issues that arose.
We looked at a sample of training records and these evidenced that staff had received training in basic areas of care with refresher training booked to take place in October 2012. In addition to basic training in areas such as moving and handling people, food hygiene and fire awareness furthur training had been planned in more specialist areas including end of life care, diversity and swallowing difficulties.
The training provided and planned helped to equip staff with the skills and knowledge to meet people's care and welfare needs safely.

Our judgement
The provider was meeting this standard. People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
The people living at Sunnyside Residential Home told us that staff had regulalry asked them for feedback and their opinion of the service they had received. One person told us "they do ask you what you think" and another "they ask a lot". A third person explained, "It's good, if you ask for anything they try to get it". One person living at the home explained that the home were in the process of setting up a committee with representatives from relatives and the people living there.

Other evidence
In discussion with staff they provided examples of the way in which people living there had been consulted. For example prior to meals being changed a taster day had been arranged and people's opinions about the food obtained, this was confirmed during our discussions with people living there.

We saw no evidence that internal systems for monitoring the quality of the service provided at Sunnyside Residential Home had been in place. No system was in place to formally monitor the care that had been provided to people. Similarly we saw no evidence of management systems to monitor the environment, medication practices or incidents and accidents. The lack of effective monitoring systems by senior staff may lead to risks of inappropriate or unsafe care and treatment not being identifed and therefore acted upon.

Our judgement

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.
The provider did not have arrangements in place to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is non-compliant with Outcome 21: Records. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke to people using this service but their feedback did not relate to this standard.

Other evidence
We looked at a sample of records at Sunnyside Residential Home and found that not all of these were up to date or accurate. For example fire records recorded that the last fire test had taken place on 13th August 2012, staff advised that a test had taken place the previous week but not been recorded.

The complaints procedure contained information about the previous regulatory authorities name and address and had not been updated with information about the Care Quality Commission's details. This could lead to people using the service and their relatives lacking the contact details they would need in the event they wished to raise concerns about the service provided.

The statement of purpose read, "We provide a service to service users of different ages category provided they have old age needs as with accordance of the Care Quality Commission rules and regulations". This is not accurate as the Care Quality Commission do not set age limits or categories for people living in care services.

The care records we examined were not detailed enough to provide a written audit trail of the support provided for people. For example one care plan recorded the person had

lost weight, although staff were able to provide verbal information no written information or care plan was available. Another care plan had last been updated in June 2012 and stated that a specialist nurse visit was being arranged, the plan had not been updated since the visit had taken place. Elsewhere in the person's records it recorded the visit had taken place, however it was unclear from the records whether the nurse's instructions had been carried out. We noted a risk assessment for one person had not been reviewed since 2007, although this did not appear to have impacted upon the person's health, the lack of reviewing could lead to changes to their support needs not being formally noted and therefore acted upon. We also noted that an assessment for another person identified they were at risk of falling over and had a low weight. No plan of care had been put into place to minimise these risks and support staff and the person. Discussions with the person and with staff evidenced that support in these areas had been provided but there was a failure to record the care.
The lack of written guidance and information in care plans could lead to people not getting the support they need with their care and welfare.

The provider may find it useful to note that information was not readily accessible within individual care records. For example risk assessments were stored in the same folder as records of eye tests.

Our judgement
The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard. The provider did not ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by the means of appropriate maintenance of an accurate record and the management of the regulated activity.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. People who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard. The provider did not have arrangements in place to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity.	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met:	

	The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard. The provider did not ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by the means of appropriate maintenance of an accurate record and the management of the regulated activity.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 7 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
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