Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Sunnymede

4 Vandyck Avenue, Keynsham, Bristol, BS31 2UH

Tel: 01179863157

Date of Inspection: 18 October 2012

Date of Publication: November 2012

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✔ Met this standard
Safety and suitability of premises	✖ Action needed
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed
Notification of other incidents	✔ Met this standard

Details about this location

Registered Provider	Woodland Healthcare Limited
Registered Manager	Mrs. Bernice Currey
Overview of the service	Sunnymede Nursing Home is registered with the Care Quality Commission to provide accommodation for people who require nursing andpersonal care.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 18 October 2012, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

People we spoke with told us that they were happy with the care and support provided by the home. People told us that they were assess before they came to live at Sunnymede. They said they were involved with developing their care and support plan and that staff treated them kindly and politely. For example one person said "I feel safe here there is nothing to worry about. I have no complaints. Another person said if I am not happy I will let staff know but I am ok".

We saw that the provider had a policy on safeguarding people from abuse and that staff had attended training to ensure that people who live in the home were protected from the risk of abuse.
We saw that the provider had an effective system in place to regularly monitor the quality of service that people received.

We found from speaking to the people living in the home, staff and looking at the staff rota that that there were insufficient numbers of suitably qualified, skilled and experienced staff at all times to meet the needs of the people who used services.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 14 December 2012, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our

decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People did not always experience care, treatment and support that met their needs and protected their rights. The provider was not meeting this standard. We judged this to have a moderate impact on the people using the service and action was needed for this standard.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People we spoke with told us that they were happy with the care and support provided by the home. We spoke with thirteen people in the home. Some told us they were happy living at Sunnymede One person said "I couldn't' think of a better place".

Care and treatment was not always planned in a way that was intended to ensure people's safety and welfare.
People told us that they were assessed before they came to live at Sunnymede. This meant that that the home could judge whether they could meet people's need before the moved to the home. They said they were involved with developing their care and support plan. We looked at six care plans for people using the service in detail. These were personalised and provided clear guidance about how their needs should be met. Information found in the care plans showed that people using the service, their representatives and staff were involved in developing care plans.

Each person had a set of risk assessments which identified risks that people may face and how staff were to support people in order to minimise or to prevent those risks. Examples of those risks included manual handling, risk of falls and pressure ulcers. However we observed staff using an unsafe method while transferring three people from their chairs to wheelchairs in the dining area at lunch time. We checked the peoples' care plans and found that the staff members were not following the instructions written in the manual handling profiles. This meant that the people were put at risk of injury as staff were not promoting people's safety by not following the planned instruction. We discussed this with the acting manager and the provider representative present at the home.

In the six care plans looked at we found that most of these care plans identified people's needs and were reviewed monthly and when a person's need changed. However we saw

that one person who suffered from pain and was taking regular medicines did not have a care plan in place which would enable staff to support the person in managing the pain. This meant that there was a risk that the person would not consistently receive the care they needed as there was no guidance to staff on how to support the person. Following our inspection the acting manager informed us that care plan had been put in place to reflect this need.

We also looked at the care file of a person with a pressure sore and saw that wound management care plans were in place. We saw that staff kept an up to date record of how the person was cared for including how much food and fluid the person had eaten and drunk. We saw that the staff recorded entries of when the wound was dressed and there was a body map of the wound however there was no photographic evidence or measurements to monitor the progress of the wound. The home had made a referral to the Tissue Viability Nurse and a dietician. At the time of our inspection they had not visited.

Healthcare records were kept to show when the GP had called in and the outcomes of the visit plus other health professionals' visits such as opticians, chiropodists and social workers. We saw that details of the meetings were recorded in each person's care plan. We spent time in the home observing the interaction of staff with people who live in the home. We saw that staff were respectful and caring and spoke with people in a personalised manner.
We saw that there was an activity schedule for the people living in the home however there was no activity taking place on the day of our inspection and some people were noted sleeping in the chairs and other people were interacting with each other. The acting manager told us that the home's activity coordinator was on a day off and that normally people would be supported to sit out at the back garden or taken out for a walk but on this occasion the weather was not favourable.

When we asked people living in the how they spent their day, some said there was usually something going on during the day, for example entertainment, bingo and sing-along and that they had a choice to take part or not.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider was meeting this standard.
People who use services were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening
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Reasons for our judgement

People we spoke with told us that staff treated them kindly and politely. For example one person said "I feel safe here there is nothing to worry about. I have no complaints. Another person said "If I am not happy I will let staff know but I am ok".

The home had a policy and procedure for reporting suspected abuse abuse. The policy was regularly updated in line with the local authority safeguarding policy. There was also a whistle blowing policy which enabled staff to have the confidence to report incidents of abuse without fear that they would suffer as a result. One staff member stated "I will definitely report any form of abuse regardless of who it was."

A number of staff we spoke with were knowledgeable about the different types of abuse and the action to take if they witnessed or suspected an abuse incident. We looked at the home's training record and noted that all staff had been provided with safeguarding people from abuse training. Staff demonstrated awareness of a range of places outside of the immediate management structure where they could raise concerns for example, the Care Quality Commission and Care Direct. We saw that the local authority safeguarding procedures were available for reference on the notice board outside the manager's office. The manager told us that training on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) was being planned. This was so that staff would understand how this legislation protects the rights people who are unable to make decisions about their own care.
Staff said that the service did not use restraint on people who used services and that they were aware of how to support people whose behaviour was challenging.

We saw that the home had regularly checked the Personal Identification Numbers (PIN) of t nurses registered with the Nursing and Midwifery Council (NMC).This meant that the home had taken steps to provided safeguards for the people who used services by ensuring that nurses were fit to practice.

We saw from reviewing information for two members of staff who were recently employed at the home that appropriate checks were undertaken before staff began work. This

included a satisfactory criminal record bureau disclose, and two references. This was to make sure that only people of good character, physically and mentally fit were employed to support vulnerable people living at the home.

Safety and suitability of premises ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider had not taken steps to provide care in an environment that is suitably designed and adequately maintained.
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 standard. .

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Some people we spoke with told us they liked living in Sunnymede and that they liked their rooms. In December 2011 we carried out an inspection of the home and we identified that the service needed to make an improvement in relation to eliminating an offensive odour in the main lounge. We carried out an inspection on 19 October 2012 to check what improvements the provider had made.

There was an offensive odour in the front entrance as well as the main lounge. We also found that the carpet in the lounge looked stained and worn. This meant that the comfort of the people who used services was being compromised. We spoke to the two cleaners on duty on the day of our inspection. They told us that the home had a cleaning schedule which included regularly shampooing and deep cleaning the carpets in the main lounge and the at the entrance of the building.

The provider representative we met with on the day stated that a programme of refurbishment had already begun at the home and that the plan was to replace all the flooring with a more appropriate floor covering when all planned major work in the building had been completed. We saw that some areas of the home had already been refurbished.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

The provider was not meeting this essential standard. There was not enough numbers of suitably qualified skilled and experienced staff to meet peoples' needs.
We have judged that this has a minor impact on people who use the service, and have told the provider to take action

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There were not enough not qualified, skilled and experienced staff to meet people's needs. We spoke with thirteen people receiving service at the home, they told us that staff were caring and friendly and supported them in meeting their needs. However some people said that there was always shortage of staff. One person said "I can't get up when I like because staff are too busy. They get me up between 1030 am and 11 00 am. In the evening I have to go to bed at 7pm but they will let me stay up I f I want to watch my favourite programme on the television".

Another person said "staff are good to me however I believe there is a shortage of staff here which means I have to wait some times. Staff are doing their best. It is making their work harder". Another person said "sometimes there are shortages of staff which means that I have it wait but staff are doing their best. Overall it is a lovely place."

We asked staff about staffing numbers and how it affected their work and the care they provided to the people who used services. Staff we spoke with told us that they worked below the staffing levels most of the time on almost all of the shifts. Some staff said "When there is shortage of staff we are always rushing around trying to get people up and support them in any way we can. Staffing level should be based on people's individual needs. We have people here that need hoisting and therefore two staff are needed it means that we can't leave them to go to someone else so things get delayed and people get stressed and unhappy".

One relative told us that the only concern they had was shortage of staff. The individual said "when people want to use the toilet they have to wait for nearly an hour before they are helped"

The acting manager told us that an administrator had been employed to undertake office duties to enable the manager to concentrate on caring and supporting people who used services. The new administrator was having induction on the day of our inspection.

Before we carried out our inspection we received information of concern which highlighted staff shortage of staff at Sunnymede.
We looked at the home's policy on staffing reviews to find out what tools they used to determine the staffing levels at the home. The staffing reviews policy stated "An update should be done each month, taking into account the client numbers, dependency and specific individual needs". We saw that the staffing level was reviewed in August 2012 and gave the staffing levels as follows. one registered nurse and five care assistants in the morning from 8am to 2pm, four care assistants and one registered nurse in the afternoon from 2pm to 8pm and two care assistants and one registered nurse at night. On the day of our inspection there was one registered nurse and five care assistants in the morning, two registered nurses and three care assistants in the afternoon and one registered nurse and two care assistants at night.

Following our inspection we asked the provider to send us an analysis of the staff shortages as identified in the staffing rota in the past two months. We saw from the information sent to us by the provider that on eleven occasions between August and October 2012 the home was one staff short from 2pm to 8pm.

Staff spoken with confirmed that they had attended all mandatory training and that this had helped them to provide good care for the people living at the home. Examples of trainings attended included infection control, fire training and end of life care.
The manager told us that training on pressure area care and manual handling training for trainers were also being organised for registered nurses. This was to enhance their knowledge in those areas in order to support staff in caring for people at the home.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider was not meeting this standard. We judged this to have a minor impact on the people who used services and have told the provider to take action.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People we spoke with told us that they were happy living in Sunnymede. They said that staff were good and that they were supported to be as independent as possible. The people living in the home told us that the only concern they had was the shortage of staff, however their overall experience was that the home was run well. One person said "This place is one big family".

We saw that audits of different services provided at the home were taken to identify areas of concern and an action plan completed and implemented. We saw that people who used services, families and representatives were regularly asked to provide comments about the care provided to gain feedback in order to develop a service suited for people's needs. We saw that monthly audits in relation to incident/accidents, medication health and safety took place. Other examples included an environmental maintenance summary, personnel audit, external audit and mystery shopper and care plan reviews.

As stated in Outcome 13 the staffing rota was reviewed in August 2012 in line with the home's staffing policy and the numbers of staff required on each shift was decided. However the agreed staffing level was not adhered to. This meant that the monitoring process was ineffective and there was a risk that people's needs were not being fully met.

We looked at accidents and incidents records to find out how these had been managed. We saw that when people had fallen risk assessments and care plans were reviewed to prevent reoccurrence. We saw that accidents were audited monthly to look for patterns and to develop strategies to minimise accidents. We saw that staff had attended training on health and safety along with guideline information to enable staff to protect people who used services and themselves.

Staff said they were encouraged to discuss new ideas that would raise the level and standard of care with the manager at staff meetings and at group supervision sessions.

This was evidenced in the staff meeting minutes.

We saw that meetings were organised for people who used services and their families. This was so people could make their views known and to discuss what mattered to them in the day to day running of the home. The last meeting was on 8 August 2012. Staff told us that that people who used services were supported to attend meetings by reminding then about the meeting and enabling and supporting those who wanted to attend.
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Notification of other incidents ✓ Met this standard

The service must tell us about important events that affect people's wellbeing, health and safety

Our judgement

The provider was meeting this standard.

The provider was meeting this essential standard. People who use the service can be confident that important events affecting their health, welfare or safety are reported to the Care Quality Commission so that, where needed, action can be taken

Reasons for our judgement

We did not talk to people about this standard.
We saw that a person using the service had developed a possible grade 3 pressure ulcer whilst living in Sunnymede. This incident had not been reported to the Care Quality Commission or to the local authority safeguarding team before our inspection. The provider representative who was present on the day of our inspection stated that the pressure sore had been ongoing and the grade had not been determined by the Tissue Viability Nurse and the GP.

Our records showed that the home had previously notified the Care Quality Commission of incidents that affected people who used services as required by the regulation.
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Following our inspection a notification had been sent to the Care Quality Commission and the local authority safeguarding team.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: People did not always experience care, treatment and support that met their needs and protected their rights. The provider was not meeting this standard. We judged this to have a moderate impact on the people using the service and action was needed for this standard. Regulation 9 HSCA 2008(Regulated Activities Regulations 2010.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The provider had not taken steps to provide care in an environment that is suitably designed and adequately maintained. 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 standard.

This section is primarily information for the provider

	Regulation 15 HSCA 2008(Regulated Activities Regulations 2010.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: There was not enough numbers of suitably qualified skilled and experienced staff to meet peoples' needs. 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 standard. Regulation 22 HSCA 2008(Regulated Activities Regulations 2010.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider was not meeting this standard. We judged this to have a minor impact on the people who used services and have told the provider to take action. Regulation 10 HSCA 2008(Regulated Activities Regulations 2010

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 by 14 December 2012.

This section is primarily information for the provider

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – 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.

Moderate impact – 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.

Major impact – 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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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