Inspection Report

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

Sunnymede

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Tel: 01179863157

Date of Inspection: 26 February 2014

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Management of medicines	✗ Action needed

Details about this location

Registered Provider	Woodland Healthcare Limited
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

We carried out this inspection to check whether Sunnymede had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Management of medicines

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 26 February 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff and were accompanied by a pharmacist.

What people told us and what we found

We visited Sunnymede to follow up compliance actions made following our visit in October 2013. At our last inspection we had found there were shortfalls to care planning which put people at risk of receiving unsafe care. We also found that the provider did not have appropriate arrangement in place for the recording, safe keeping and safe administration of medicines.
We informed the provider they were not compliant with these essential standards and asked them to submit an action plan. This action plan was submitted on 18 December 2013 and set out the actions which would be taken to achieve compliance. On this visit we reviewed these actions.
We spoke with six people who used the service and two relatives. People who lived at Sunnymede had varying levels of dementia, so not everyone was able to tell us about their care and support. One person "they are very nice and helpful". Both relatives told us they were happy with the care and support provided.
We saw registered nurses had sought advice and guidance from health care professionals when people had or were at risk of losing weight. People were provided with calorie dense meals, snacks and food supplements as required. This meant that staff understood how to support and care for people with dementia with their nutritional needs. During this inspection we found improvements had been made to the handling of medicines. However some further action was need to ensure that people were better protected from these risks.

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 15 April 2014, 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 ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights. Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We spoke with six people who used the service and two relatives. People who lived at Sunnymede had varying levels of dementia, so not everyone was able to tell us about their care and support. People told us they were happy with the care provided. They told us that staff treated them well. One person said "they are very helpful and very nice". Another person told us "what more can I want. I have no complaint. I want a quiet life and that's what I've got".

We observed that staff treated people in a personalised manner and involved them in their care and treatment. For example we heard staff asked a person who used the service what time the preferred to have a bath. This meant that staff understood how to support and care for people with dementia.

Both relatives we spoke with told us they were happy with the care and support provided. One person told us they were always kept informed of any changes in their relative's condition. They told us their relative needed support with all their care needs. They said they were confident in the staff's ability to provide the care required. The other person told us their relative's condition had improved since they moved into the service. They said staff had encouraged their relative to become involved in their care, and" they are now eating better than when they came here".

We spoke with the manager, who had taken up post in recent months, about the way people's care was planned.They told us about the improvements that had been made. They had given the care staff guidance on developing person-centred care planning. This was confirmed by staff we spoke with. One staff told us "yes things are definitely better".

We saw assessments were completed when a person first moved to the home. These were updated monthly and when the need changed. This information was used to develop specific care plans which described the care and support that staff would provide. The plans were recorded and included, for instance, details of how people's privacy and dignity

would be respected during personal care. One person who used the service told us "they make sure they close the door when they are helping me to wash and dress so I am not cold".

Each person also had a 'lifestyle dairy and memory book' which was completed by the person's family and or the activitiy coordinator. This was to inform staff about people's preferred routines across the day and at night. For example, their preferred time to retire.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. In the two care plans we reviewed we saw that a number of risk assessments had been completed with regard to the person's safety. The assessments completed included, for example, falls risks and hazards presented to the person. This meant that people's safety had been considered. It also meant that staff had been made aware of the risks presented and the method by which those risks could be minimised.

The care plans we looked at were regularly evaluated to ensure they remained effective. This showed us that the expected improvements had been made and people's care was now tailored to meeting their individual needs. We were told that the new care plans were designed to provide a better person centred care for the people who lived at Sunnymede.

We saw that these risk assessments were detailed in relation to the actions required to help staff minimise or eliminate the risk.This meant that staff had been given clear guidance and direction about how to ensure the safety and wellbeing for each person. We also saw that people with bedrails had detailed risk assessments to ensure their safety and to prevent entrapment and or injury.

We saw that nursing staff had completed people's nutritional assessments when people moved into the service. We saw a Malnutrition Universal Screening Tool (MUST) was used to assess nutritional needs and risks for people who used the service. Staff told us they found the tool useful, as it provided guidance on what action to taken according to the level of risk identified.

We found staff were proactive in seeking advice when people's health care needs changed, for example two people had lost weight. We saw staff had sought advice from other health care professionals, such as the GP and subsequent referral to the dietician for one person. We saw that the home had worked with the community psychiatric nurse (CPN) in regards to the other individual who had lost weight. The care plan relating to eating and drinking had been updated to include calorie dense meals, snacks and food supplements as required. This meant that the home proactively put measures in place to improve people's wellbeing.

We saw that where a person's fluid intake was being monitored that the document was being completed. This ensured that people at risk of their health deteriorating or at risk of dehydration was minimised. However, the provider may wish to note that the fluid and food charts for one person were not completed for three days. This could mean that staff were unable to monitor what the person had eaten and drank to reduce the risk of their health deteriorating.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the recording and safe administration of some medicines.

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

At our last inspection on 14 October 2013 we found that arrangements in place for the handling of medicines in Sunnymede did not protect people from the risks associated with medicines. The provider sent us an action plan to explain how this would be addressed. During this inspection we found improvements had been made to the handling of medicines. However some further action was need to ensure people were better protected from these risks.

Appropriate arrangements were in place in relation to obtaining medicines. We saw suitable supplies of medicines for the current month. Records showed that people's medicines were available for them. One person told us they thought their medicines were always available. Another person told us their medicines were available but they did not always choose to take them. People could be confident they would be able to have their medicines as prescribed for them.

Medicines were safely administered. At the time of our inspection nearly all medicines used in the home were given by staff. We saw some people being given their medicines in a safe and respectful way. A small number of people were able to look after and use their own prescribed inhalers to help their breathing. There was no record of staff having checked that people were able to safely look after and use these medicines. This increased the risk that people would not have the maximum benefit from their treatment.

Arrangements were in place for the recording of medicines. The pharmacy provided printed medicines administration records for staff to complete when they had given people their medicines. We looked at records for the current month. The majority of these showed that people had been given their medicines as prescribed for them. However one person's record for one medicine had not been signed for the first five days of the month. The medicine was missing from the blister pack. It was not clear whether this person had been given their medicine as prescribed for them during this time.

Some people were prescribed creams and ointments to treat their skin. Many of these were kept in people's bedrooms and applied by the care staff. Staff explained how they knew which preparations needed to be applied and how this was recorded. One person we spoke to confirmed that staff did apply prescribed creams to their skin. However people's current records did not show clearly which preparations were in current use. The records did not show that people had their treatment as it had been prescribed.

Some people had been prescribed medicines, such as pain relief, to be given 'when required'. For some of these medicines additional information was available for staff to help ensure that people were given these medicines correctly. However some other medicines particularly those used for anxiety or agitation had no additional information. This increased the risk that people would not be given these medicines in a safe and consistent way.

Appropriate arrangements were in place for the safe storage of medicines. Medicines were stored in locked cupboards within a locked room. A medicines refrigerator was available. Daily records showed that for the majority of time this was at a safe temperature for storing medicines. However on some days the minimum temperature recorded had dropped to 0 º C. This is below the safe temperature for storing medicines. There was no record of any action having been taken to adjust the fridge so temperatures always remained in the safe range.

Separate storage was available for controlled drugs, which needed additional security. The manager said she would check with the home's pharmacist that this cupboard met the legal requirements of the Misuse of Drugs Act (safe custody) Regulations 1973. Since our last inspection medicines no longer used by people living in the home had been safely disposed of. Records showed that these medicines had been looked after safely.

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 activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines** **How the regulation was not being met:** People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the recording and safe administration of some medicines. (Regulation 13)

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 15 April 2014.

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 other services less often. 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.

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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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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