Four Seasons 2000 Limited

Sunbridge

Inspection Report

108, Hickory Close
Edmonton
London
N9 7PZ
Tel: 020 8804 3354
Website: www.fshc.co.uk

Date of inspection visit: 11/04/2014
Date of publication: 10/07/2014

Contents

Summary of findings

Overall summary

Sunbridge is situated in a residential area of Edmonton. It provides care home accommodation (without nursing) in purpose-built premises for up to 43 people, many of whom live with dementia. Most of the people who use the service are long stay residents, but the home also offers respite care.

We found an enthusiastic and motivated management team and, with some exceptions, a care team in need of more support and guidance. The new manager was determined to set high standards, but these had not filtered through to all care staff at the time of our inspection. There had been a high turnover of managers in the two years prior to this inspection. A real strength of the home was the presence of a number of people who used the service with plenty of ideas to contribute.

The provider was not effective in maintaining people's privacy, dignity and independence. Therefore we found the home to be in breach of Regulation 17(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report. A recurring theme during the inspection was that people were bored, they did not have enough to do and some people did not receive enough support to engage with activities or other people in a positive way. People who used the service believed that many staff were tired and stressed and this impacted on their ability to care.

People told us that their possessions kept going missing or being re-arranged. They thought this was mainly due to people living with dementia accessing other people's bedrooms. The staff we spoke with acknowledged that this could be a problem. As a result, there was sometimes friction between those living with dementia and other people resident in the home.

There was understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards had been appropriately applied for and implemented for one person. We found the home met the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People's human rights were therefore properly recognised, respected and promoted in this area.

Some aspects of medicines administration were carried out satisfactorily, however, we found inconsistencies in staff practice. The number and frequency of these inconsistencies led us to find the home in breach of Regulation 13 in relation to medicines. You can see what action we told the provider to take at the back of the full version of this report.

People were promptly assessed for admission to the home when a referral was received. Care plans and risk assessments were in place, but we identified some inconsistencies and omissions. Food and fluid charts were completed to a high standard.

We found that there were good systems in place for management oversight of the home. This meant that the management team was aware of many of the issues we identified and they were already taking steps to address some of them.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

People who used the service told us their belongings were not safe, as some people living with dementia were mistakenly entering other people's bedrooms. The provider respected the right of people living with dementia to remain integrated within the home, but people we spoke with told us that this was not as well managed as it could be.

Staffing levels had been increased since our last inspection. Recording in care files was inconsistent on occasion, but food and fluid charts were fully completed and informative.

Although medication was, for the most part, safely administered, there were too many inconsistencies in staff practice for us to be assured of everyone's safety at all times.

We found that the home was meeting the requirements of Mental Capacity Act 2005 and an application for Deprivation of Liberty Safeguards had been made successfully for one person.

The home had a contingency plan in place for foreseeable emergencies.

Are services effective?

The needs of people within the home were very diverse at the time of our inspection visit. Some staff members were flexible enough to adapt to people's different communication needs, but there was little attempt by others to engage with some individuals.

We saw that prompt assessments had been made of people's needs prior to admission. Mandatory e-learning courses for staff members had been expanded to cover relevant new topics. Regular staff supervision and appraisal had been taking place for staff members.

The premises, services and equipment were well maintained. Several bedrooms were in the process of being upgraded. The environment was clean and generally well maintained. The provider was starting to make changes to the décor to help people to orientate themselves within the building. The kitchen had recently retained its five star food hygiene rating (the top score).

Are services caring?

People who used the service and their relatives were not always positive about the way staff treated them. People told us that staff

Summary of findings

members tended to be exhausted and some were off-hand with them. Some individuals we spoke with felt that their preferences were well known and they were treated as they wished, but some other people said that their wishes were ignored.

During lunch staff were not sufficiently organised to ensure that people always got their food whilst it was still hot.

Are services responsive to people's needs?

Residents' meetings and relatives' meetings were regularly held, people who used the service told us that they used the meetings to express their views. The home had recently implemented a 'Resident of the Day' system to ensure that people's needs were regularly reviewed and their paperwork was updated.

Some people told us that they were bored and, at times, isolated in their rooms. Staff worked in partnership with community services to make sure people's healthcare needs were met. Whilst there were three assisted bathrooms, only one shower was available for 43 people.

Are services well-led?

The manager had only been in post for a month at the time of inspection. The current management team led by example and the new manager was setting high standards. As yet there was little evidence that this had impacted on all members of the team, although the manager told us they were finding them to be 'responsive'. Staff we spoke with said they generally felt supported in their work.

There were monthly quality monitoring visits by the regional manager and any actions were recorded in the home's on-line 'remedial action plan'. Few formal complaints had been submitted. The provider reliably submitted notifications of relevant events to the Care Quality Commission.

The provider had a committee system in place to discuss issues and we saw that these meetings were held regularly. There was evidence of learning from accidents and incidents in the minutes of the different meetings and we saw that actions were generally followed up.

Summary of findings

What people who use the service and those that matter to them say

When we spoke with nine people who used the service, the majority were well informed about the running of the home and attended the regular residents' meetings. They acknowledged the home had improved, but they were critical of some aspects of care. One person told us, "it's so boring. Everyday we do the same things'; another person said, "sometimes [staff] say 'good morning' and walk away, sometimes [they do] not even say this." Another person separately said something very similar. The people we spoke with made it clear that, whilst they did not blame those people living with dementia for walking into their bedrooms uninvited, they did not feel that there was sufficient supervision to minimise the risk of this happening.

We spoke with seven relatives of people who used the service. Some were content with the care provided; one told us, "the home is lovely. We looked at four homes and we wouldn't like [our relative] to go anywhere else." Another told us, "[the staff] are nice and friendly. It's very clean and homely." Others were more critical; one relative said, "sometimes staff are not there when someone shouts and [they] want to go to the toilet."

Sunbridge

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 was planned to check whether the provider was meeting the legal requirements of the Health and Social Care Act 2008. It was also part of the first testing phase of the new inspection process CQC is introducing for adult social care services.

The inspection team was made up of three people - a lead inspector, a specialist advisor who was a qualified pharmacist with a specialism in dementia care and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

When the home was last inspected in May 2013 it was found to be compliant with those regulations which were checked.

The home's manager was new in post and had started the process of registering with the Care Quality Commission. The team spoke with six staff members, the manager and seven relatives who were visiting the home on the day of the inspection. We also spoke to many of the people who lived in the home, nine were able to discuss the care provided. We observed the others in the communal areas of the home to try to gauge how they felt about their surroundings and the people who lived with them or supported them. We reviewed four people's care files, recent staff supervision records and looked at medication records, fluid and food intake monitoring forms, many of the home's policies and procedures, as well as viewing the premises. We also looked at the home's computerised records and action plan.

On this occasion we did not speak to any external stakeholders prior to our visit due to the timing of the inspection and we did not receive the Provider Information Return in advance due to technical issues.

Are services safe?

Our findings

Although some aspects of medicines administration were in line with best practice, the number and frequency of inconsistencies led us to find a breach of Regulation 13.

The medicines rooms on both floors were found to be tidy and well ordered. Environmental monitoring charts were in place and completed, however, the fridge on the middle floor repeatedly measured temperatures above eight degrees Celsius, which was above the recommended maximum. The deputy manager reported that the fridge had already been changed once but the problem had remained. The fridge housed food supplements and different types of insulin which needed to be kept at the appropriate temperature to remain effective.

The provider used a monitored dosage system supplied by a pharmaceutical chain. This meant the medicines were dispensed in four weekly strips to help staff identify the correct day of the cycle for administration. However, on the day of inspection, it was evident that staff were, on occasion, randomly removing doses from any week. This undermined the safety features of the system.

The drug trolleys were locked and immobilised and on inspection they were clean and tidy and stocked with the medicines required by people who used the service. All medicines were within date and labelled correctly. There was an auditable trail of medicines no longer required that had been returned to pharmacy.

We found that some medicine labelled for regular use had been converted to 'when required' medicines, with no record to show who made this change, when and why. Medicines which were prescribed to be taken 'when required' were not always accompanied by guidance about the circumstances in which the medicine should be offered. The provider's own policy stated that a protocol should be in place for each 'when required' medicine.

The controlled drug cupboard was locked and the balance of drugs in stock matched that recorded in the register. We saw that, during March, the home had received 28 controlled drug tablets and this quantity had been entered into the balance section of the register. However other sections of the register had not been completed, including the date of receipt and the supplier. Furthermore, the doses of controlled drugs administered from the current blister pack did not match the Medicines Administration Record (MAR) chart entries.

We noted that one person who used the service was having medicine administered covertly. We saw that this decision had been taken at a best interests meeting following an assessment of this person's capacity to make informed choices about their medicines. This was in line with the requirements of the Mental Capacity Act 2005. However, the MAR chart did not distinguish between tablets taken overtly and those which had been administered covertly. The guidance was to offer the tablets openly in the first instance, only resorting to covert methods if they were refused. Therefore, a record needed to be kept.

Creams were stored in people's bedrooms and were freely accessible, we were concerned that this could present a risk to some individuals. We found that one person was sometimes only recorded as having had their cream applied once a day, although the label said twice daily.

A review of MAR charts on the top floor showed that the pharmacy labels indicated that some medicines should be taken 'once daily' and a specific time was not mentioned. For some medicines, the timing could impact on treatment outcomes and the management of possible side effects, so 'once daily' instructions needed to be clarified with the GP or pharmacist.

One person told us, 'I've been to three homes. This is the tops. Safer here than anywhere.' However, this was not the view of the majority of people we spoke with. They told us their belongings were not safe, mainly due to the habits of others living within the home. The provider respected the right of people living with dementia to remain integrated within the home, but people we spoke with told us that this was not as well managed as it could be.

We looked at the recent safeguarding alerts for the home and saw that they had been followed through appropriately. The two members of staff we asked about procedures to protect people from abuse were able to tell us the signs they looked out for and what they would do if they had concerns. They said that they had never had cause to use the procedures.

We found that the manager had a good understanding of the requirements of the Mental Capacity Act 2005. Another member of staff we spoke with could tell us the main

Are services safe?

principles of the Act and knew how to find out more. Other staff were not confident about answering questions on this topic. We saw that one person who used the service was currently subject to Deprivation of Liberty Safeguards (DoLS) which protected them from unlawful restrictions. We noted that during the admission process there were routine checks to find out if anyone had been granted Power of Attorney on behalf of the person. We found the location to be meeting the requirements of the DoLS. People's human rights were therefore properly recognised, respected and promoted in this area.

We reviewed four care records. Most sections were satisfactorily completed. In one file there were no monitoring forms for staff to use, or written strategies for them to follow, when supporting a person who had behavioural issues. In another file, sections of the care plan had not been updated to record monthly skin evaluations or changes to the person's support needs of account of their fragile skin.

The premises, services and equipment was well maintained. We saw that there were arrangements for regular pest monitoring and control with a specialist company.

Call bells were available in each bedroom, although we noted that some people did not have an extension cord in place so that they could use them, for example, from bed. The manager told us that this was because some of the sockets for the extension cords were broken and they could not be replaced as the system was too old. We heard that the provider had approved funding for a new system, in the meantime, 30 minute checks were taking place on the people without access to their bells. This was an extension of the existing system of checks made on people who did not remember to use their bells. Records indicated that the checks were being made, but two people told us that this had not been the case the previous Sunday and they had been left unattended for several hours. We alerted the manager to this issue and were assured that the matter would be investigated.

There had been a recent increase in staffing levels, we saw a note from a relative acknowledging this. Most care staff worked 12 hour shifts. Some people who used the service said they thought the long shifts wore staff out. Domestic staff were available every day, with slightly less coverage at weekends. We saw that staff could contact on-call managers for advice out-of-hours and there were systems in place to deal with urgent repairs if needed. We noted that the provider did not use agency staff to cover absence, only its own bank staff. If a person needed additional support, the manager told us they could bring in additional short term cover, whilst negotiations took place with the person's placing authority. We checked recent care staff rotas and saw that they reflected what we had been told.

We saw that there was a 'grab bag' stored near the main entrance which contained the home's contingency plan, new torches and batteries and some foil blankets. This showed that the home was prepared for emergencies. We noted that there was an extensive fire risk assessment in place which had been updated in January 2014.

Are services effective?

(for example, treatment is effective)

Our findings

We observed that the needs of people within the home were very diverse at the time of our inspection visit. For example, we noted that some people could no longer easily make their needs known, whilst others were sharp observers of care practice. One person with sensory impairments was helped to communicate by means of a white board. Whilst we observed that some staff members were flexible enough to adapt to people's different communication needs, we saw that there was little attempt by some staff to engage with some people.

The provider had introduced an electronic clocking in system which included video to ensure staff were not clocking in for colleagues who were late. We saw from records that time-keeping had improved since the introduction of this system.

We saw that assessments had been made of people's needs prior to admission. One visiting social worker that we spoke with commended the deputy manager's quick response to referrals and told us that they had been impressed by their assessment skills and helpful manner. Information gathered had informed each person's care plan and risk assessments. We noted that the care plan format used required staff to flip between sections to get an overview of a person's needs and wishes. This was time consuming and there was a risk that they would miss vital information.

We reviewed five people's food and fluid intake charts and fluid balance charts. We found that these had been completed to a good standard. Fluid charts had been totalled and there was documentation to show if the person had met the target set. The deputy manager told us that they had been emphasising the importance of these charts to the staff team and they had responded appropriately.

We saw that staff supervision and appraisal took place at the intervals recommended by the provider. We saw that notes of the sessions had been completed and discussions about practice issues had taken place.

Are services caring?

Our findings

We found evidence that the home was in breach of Regulation 17 (1) (a), as attempts to provide appropriate support to assist people to maintain their dignity, privacy and independence were often ineffective.

People told us that their possessions kept going missing or being re-arranged. They thought this was mainly due to people living with dementia accessing other people's bedrooms. We saw that people who could use a key had been issued with one to lock their bedrooms, but this only addressed the issue when they were away from their room and did not stop people invading their privacy when they were in. One person told us they had to keep their valuables at their side at all times. Other people described bedroom intrusions that had taken place whilst they were using their en-suite toilet facilities. We heard that the issue had been raised with management by several people on a number of occasions, but the problem persisted. People said they understood that people living with dementia might not recognise other people's private space, but they did not think that there was enough support for the mix of people in residence. The staff we spoke with acknowledged there was sometimes a problem with people entering the wrong bedroom. We observed some minor friction between people living at the home, one or two were clearly concerned when certain individuals started walking around.

People who used the service and their relatives were not consistently positive about the way staff treated them. People told us that staff members frequently appeared to be exhausted and some were occasionally off-hand with them. Although no one suggested that staff were actively rude or unkind, one person said, "sometimes [staff] say 'good morning' and walk away, sometimes [they do] not even say this." Another person separately said something very similar and we noticed that few staff tended to address people by name. A third person said that they felt like a "nonentity" within the home. A staff member said, "it's just a job for [some of my colleagues]. Sometimes they're too complacent." During observations, some individual staff members stood out for their kindness, compassion and commitment, but others carried out tasks with little reference to the person they were supporting.

Some individuals we spoke with felt that their preferences were well known and they were treated as they wished, but some other people said that their wishes were ignored. For example, one person told us they had not been supported to maintain their indoor hobbies, even though they were compatible with life in a care home. We saw that that the items they needed to carry out this hobby were not available.

During lunch we observed that staff were not sufficiently organised to ensure that people always got their food promptly. One person had to wait an extra half hour to be served as they had ordered the alternative menu choice.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Residents' meetings and relatives' meetings were regularly held, although no family members were able to attend the most recent relatives' meeting. At least two people who used the service told us that they expressed their views at these meetings and the minutes confirmed this. The manager could demonstrate that the provider had responded to some of the issues raised and two of the people we spoke with agreed this was the case. However, there was no evidence of the views of less articulate people being represented, for example, using communication aids or advocates.

The home had recently implemented a 'Resident of the Day' system to ensure that people's needs were regularly reviewed and their paperwork was updated. The manager told us that they also used the day to deep clean the person's bedroom, to check their financial arrangements (if the home was involved with these), to prepare their favourite meal and to ensure they were treated to something special or meaningful to them.

Some people expressed to us that they were bored and, at times, isolated in their rooms. We saw some craft activities taking place led by a personal activities leader, which engaged a small group of people for an extended period. We also noted a staff member reading to someone who could not leave their bed. One person said staff were good at escorting them to the local shopping centre whenever they wanted, but others said this was not their experience.

We heard from some people that they had experienced difficulties with local healthcare services. Whilst these problems were not due to any fault of the home, some people may benefit from more support to liaise with healthcare providers in order to get their voice heard. A particular concern for three people was eye care.

Staff worked in partnership with Community Matrons and their teams to make sure people's healthcare needs were met. People who came from the local area could keep their own GP if they wished, so the home liaised with a number of different practices.

The provider's mandatory e-learning for staff members had been expanded to cover topics such as use of bedrails, dignity in care, palliative care and nutrition. The Deputy Manager had been given the opportunity to participate in end of life care training accredited by the Gold Standards Framework. They told us they would be passing on their newly acquired knowledge to the wider staff team. This would enable the home to enhance its end of life care.

We heard that kitchen staff went to specialist shops to source certain products which were not available for delivery. This enabled the kitchen to meet individuals' cultural and religious needs.

We saw that several bedrooms were in the process of being upgraded with new carpets and paintwork in some areas was being refreshed. There was evidence that the provider was starting to make changes to the décor to help people to orientate themselves within the building. For example, colour was being introduced to one corridor to distinguish it from the other corridors on the same floor .The environment was clean and generally well maintained.

We heard that the provider had stripped out people's individual en-suite showers to make more room for those with mobility difficulties. There were three assisted bathrooms off the main corridors. Although there was a bath on each floor, only one of them had a fixed shower. This was not recognised as a problem by those we asked as they preferred baths or strip washes, but one shower for 43 people will be insufficient if people's needs or preferences change.

Are services well-led?

Our findings

The manager had only been in post for a month at the time of inspection and had started the process of becoming a registered manager with the Care Quality Commission. A member of staff told us that they had worked with six managers during their two and a half years at the home – whilst one or two of these were employed by the previous provider, this was a high turnover. From the information we saw, the reasons for the departure of managers were varied. We noted that, in addition to carrying out their own duties, the deputy manager had 'held the fort' whilst new managers were getting up to speed or covering more than one home.

We found that the current management team led by example and the new manager was setting high standards. As yet there was little evidence that this had impacted on all members of the team, although the manager told us she was finding them to be 'responsive'. A visiting social worker told us that, when they made referrals to the home, the deputy manager was prompt to respond and "really helpful". Staff we spoke with said they generally felt supported in their work, but they were adjusting to yet another new manager.

The regional manager made quality monitoring visits each month and undertook various audits. Any actions arising from these visits, as well as other actions that the management team had to implement, were recorded in the home's on line 'remedial action plan'. The manager had to record progress and we saw that this was monitored at senior level. Therefore, the provider had an up-to-date overview of most actions required to improve the quality of care, as audits covered topics such as admission to the home, nutrition, medication and choking incidents. It was, however, noted that recent medicines internal audits had not picked up on the majority of issues we identified during this inspection. The provider reliably submitted notifications of relevant events to the Care Quality Commission.

Although the main kitchen had recently retained its five star food hygiene rating (the top score), we found only one fridge thermometer in place when we inspected the fridges in each of the three kitchenettes where milk and snack items were stored for people. We checked the one thermometer we found on two occasions and each time it showed a temperature of ten degrees Celsius which was above the recommended level.

We saw few formal complaints had been submitted. We read the responses to those that had been made and found them to be open and honest. In one case we noted that the provider had learned a lesson that they had committed to apply across their entire organisation.

The provider had a committee system in place to discuss matters such as clinical governance and health and safety and we saw that these meetings were held regularly. There was evidence of learning from accidents and incidents in the minutes and we saw that actions were followed up. We noted that the cook was now holding regular meetings about food with some people who used the service. Fresh fruit and smoothies were available as a result. People told us that they had recently requested an overhaul of the menu, but this had not been achieved by the time of our visit.

Separate meetings were in place for different types of postholder. For example, there was a Heads of Department meeting and a Senior Care Workers meeting. Recent minutes for each meeting were sufficiently detailed so that anyone who missed them could catch up. We noted that the administrative worker received support from the manager of the home and also from the provider's regional business support manager, who carried out financial audits.

We heard that the provider had sent out questionnaires to people who used the service and other stakeholders, but this has occurred before the manager was in post and the analysis of responses could not be located so we were unable to view the results.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users. The registered person was not protecting people against all the risks associated with the unsafe use and management of medicines, by means of appropriate recording, safe keeping and safe administration of medicines.

Regulated activity	Regulation
	Regulation 17(1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users. The registered person was not making suitable arrangements to ensure the dignity, privacy and independence of service users.