Sunrise Care Limited

Viola House

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

Summary
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Viola House provides accommodation and personal care and support for a maximum of 12 adults with a learning disability and autistic people. There were seven people living in the home at the time of our inspection.

People's experience of using this service and what we found

Right support:
The application of COVID-19 restrictive visitor policies meant some people did not always have maximum possible choice, control and independence. The service has since made adaptations to ensure restrictions are reasonable and equitable. We also observed elements of right support. Staff enabled people to access specialist health and social care support in the community. During the COVID-19 pandemic, we saw reasonable adjustments for people so they could have day centre activities at the home. The service people received was provided in two adjacent houses, which were similar to the other houses in the area. People's rooms were clean and personalised with their belongings.

Right care:
There were elements of right care. Whilst the service could have done more to make sure restrictions were equitable, largely people's equality and diversity were supported. Staff spoke knowledgeably about how they ensured people received care that met their diverse needs, including spiritual and cultural differences. They understood how to protect people from poor care and abuse. They had received training on how to recognise and report abuse and they knew how to apply it. People who had individual ways of communicating, using body language, sounds, pictures and symbols could interact comfortably with staff and others involved in their care and support because staff had the necessary skills to understand them.

Right culture:
The management did not sufficiently enable people and those important to them to work with staff to develop the service. Whilst there was evidence the provider had explored opportunities for collaborative work with local agencies, more should have been done to facilitate effective working with families and across health and social care services. We found responses to complaints and opportunities for improvements unsatisfactory. There was no clear escalation and resolution process, where there were

disagreements with other agencies. This meant issues were left unresolved for a long time.

We have made two recommendations for an improved complaints, escalation and resolution process, and arrangements for learning lessons.

People lived safely because the service assessed, monitored and managed their safety well. Risks to people had been identified, assessed and reviewed. The assessments provided information about how to support people to ensure risks were reduced.

People received their medicines safely. They were supported by staff who followed systems and processes to administer, record and store medicines safely. We observed from records people received their medicines on time.

People's health needs were met. Staff from different disciplines worked together to make sure people had no gaps in their care. The care files we looked at included details of health action plans and management of day to day healthcare needs.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 4 May 2018).

Why we inspected
We undertook this targeted inspection to follow up on specific concerns about the safety and wellbeing of people using the service. A decision was made for us to inspect and examine those concerns.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question. We found no evidence during this inspection that people were at risk of harm from these concerns.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question Good. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question, we had specific concerns about.

Is the service responsive?

Inspected but not rated

At our last inspection we rated this key question Good. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question, we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question Good. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question, we had specific concerns about.

Viola House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act.

Inspection team
The inspection was carried out by one inspector and one Pharmacist Inspector.

Service and service type
Viola House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Viola House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who had begun the process to register with the Care Quality Commission.

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since it was registered with the CQC. The provider completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR also provides data about the organisation and service. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with two people using the service. Some people who lived at Viola House had learning disabilities and other complex needs. They were unable to communicate with us in a way which we always understood. We spent considerable time observing care to help us understand their experience. We spoke with four members of staff and the manager, area manager and operation director. Two out of five families we

contacted responded to our enquiries. Three out of 15 health and social care professional we contacted, responded to our enquiries. We looked at four people's care records, one member of staff's recruitment background information, audits and other records about the management of the service, including selected policies and procedures.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good.

The purpose of this inspection was to check specific concerns we had about the application of COVID-19 restrictions, safeguarding and medicines management.

Learning lessons when things go wrong
• The service had an incident and accident reporting system. Accidents were documented timely in line with the service's policy and guidance. These were analysed for any emerging themes and learning. However, we identified the service did not always identify solutions and learn from conflicts.
• Whilst by the third wave of the COVID-19 pandemic, the government had introduced less restrictive policies, the service did not sufficiently relax visitor restrictions. It was evident from the concerns we received from some professionals and some families that more adaptations were required in the application of restrictive policies.
• We received concerns from the local authority relating to blanket restrictive visitor policies, which were associated with disruption of routine to some people receiving care. Whilst there was evidence creative electronic means had been adopted in the initial phases of the pandemic to improve communication between people and their families, some families still found the policies restrictive. The service had not reflected satisfactorily upon their experience during the first and second wave and taken advantage of learning opportunities.
• Conflicts were not resolved in a timely way. For example, there were long standing concerns regarding 'delayed transfer of care' from hospital to Viola House. Delayed transfer of care occurs when a patient is ready to leave a hospital but still occupies a bed, waiting for onwards care. Whilst there was evidence the service had been unsuccessful in their attempts to have this issue resolved, they did not effectively escalate to upper management of agencies involved. This would have provided a means to raise concerns and identify solutions sooner.

We recommend the provider considers examining existing arrangements for conflict resolution and learning lessons.

Assessing risk, safety monitoring and management
• People's support plans provided information about their care to ensure risks were reduced. Each person's care and support file contained an individualised plan of care for preventing identified risks, including those arising from medical conditions and safety in the community.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

• The service was working within the principles of the MCA. People's capacity to consent to care and support had been assessed and recorded.
• People lived safely and free from unwarranted restrictions because the service assessed, monitored and managed safety well. A relative told us, "There are no restrictions. People are free to move around the home." Another relative said, "Our relative requires 24-hour supervision and cannot go out alone but is free to move around the home."
• However, as stated above, during the COVID-19 pandemic, people's freedoms were restricted in an attempt to mitigate transmission. We discussed with the operations director to reflect on the application of the policy, and whether a tailored application could have reduced the non-desirable effect of the policy on some people and their families.

Using medicines safely
• Medicines were stored securely and within the required temperature range. Waste medicines were recorded and returned to the supplying pharmacy for disposal.
• The staff gave medicines prescribed to people and recorded this on the medicine administration records (MAR). There were no gaps in the MARs we reviewed which provided assurance medicines were being given as prescribed.
• People's medicines were reviewed by clinicians from the local GP practice to monitor the effects of medicines on their health and wellbeing.
• The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. However, staff had not received training on STOMP principles (stopping over-medication of people with a learning disability, autism or both). Following the inspection, the operations director told us all staff had received relevant training.
• There was a process in place to report and investigate medicines related errors and incidents.
• The process in place to receive and act on medicine alerts was not robust. There was a process in place to receive the alerts. However, during the inspection we could not verify if the alerts were being actioned in a timely manner as required. Following the inspection, we received confirmation from the operations director advising us that the system had been updated.

Systems and processes to safeguard people from the risk of abuse
• The service had systems in place to protect people from harm or abuse. A relative told us, "Our relative feels safe and secure with the staff. She had to leave previous homes. Here [Viola House] she has found sanctuary and we have found peace of mind."
• Staff had received training on how to recognise and report abuse and they knew how to apply it. They were aware they could report allegations of abuse to the local authority safeguarding team and the Care Quality Commission (CQC).
• At the time of the inspection there were two pending safeguarding investigations. The operations director confirmed they will share the outcome of the investigations with CQC.

Staffing and recruitment
• Staff had been recruited safely. One member of staff had been recruited in March 2020 but no others since then. Pre-employment checks had been carried out, including at least two references, proof of identity and Disclosure and Barring checks (DBS). These checks helped to ensure only suitable applicants were offered work with the service.

Inspected but not rated

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good.

The purpose of this inspection was to check specific concerns we had about complaints handling and person-centred care.

Improving care quality in response to complaints or concerns
• There were policies and processes in place to support the service to respond to complaints. However, the service did not always seek early resolutions of complaints. We received concerns from some professionals and relatives of people receiving care, which showed complaints were not resolved as close to the point of complaint as possible.
• A relative told us, "Over the past few years, I have sent numerous emails or left phone messages to the management that have been ignored or dealt with belatedly. Responses from previous management have sometimes been discourteous."
• As addressed earlier, there were also concerns regarding COVID-19 restrictions, which had not been resolved in a timely manner. The area manager advised the service could have handled this issue differently.

We recommend the provider considers relevant guidance to establish and operate effectively an accessible system for handling and responding to concerns or complaints.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• The application of the COVID-19 restrictive visitor policies impacted on person centred care. We spoke with the area manager about lessons learnt and were told that the way the service had communicated with families as changes took place during the COVID-19 pandemic could have been handled differently. The area manager was transparent about this, telling us that there could have been a different approach used to help assure families who were understandably anxious about the care of their loved ones at that time.
• Apart from the non-desirable effect of COVID-19 restrictions, people received person centred care. This was delivered through recognised models of care and treatment for people with a learning disability or autistic people, including positive behaviour support. Relatives who responded to our enquiries told us, their relatives' choices and preferences were responded to.
• People's care files contained clear information that identified their abilities and support needs. This ensured staff were knowledgeable about their individual needs and preferences. This was further underpinned by the service having a largely long-standing staff team who had a good understanding of people's history and care and support needs.
• Staff provided people with personalised and co-ordinated support in line with their support plans, health action and communication plans. There were arrangements to make sure staff were informed about any changes in people's needs. Care plans were reviewed to ensure they were up to date and changed in line with support needs. This helped to ensure people received personalised care.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• The manager was aware of the importance of making information accessible to people. People's communication needs were highlighted in their support plans. Methods of communicating varied widely and the ways of providing information as well as understanding how people made their needs and preference known was described in their care plan.
• Information was presented in different formats to support people to communicate to the best of their abilities. There were a range of communication formats, each personalised to the specific needs of the person, including understanding facial expressions and ways of responding nonverbally, pictures, objects of reference and gestures.

Inspected but not rated

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good.

The purpose of this inspection was to check a specific concern we had about governance.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Feedback suggested most relatives were happy with the quality of care. However, we received concerns which showed some relatives were not as complimentary. As stated, some relatives were not happy with COVID-19 pandemic restrictions, which they felt were the service applied excessively.
• The service has since relaxed visitor policy restrictions in line with government policy. The operations director told us they were assessing the effects of restrictive policies on people to ensure no one was disadvantaged.
• During our inspection we observed that the provider engaged staff using a variety of ways. Staff meetings were held through various IT platforms. We noted that these had been adapted to mitigate the disruptions caused by COVID-19 pandemic.

Working in partnership with others
• There were on-going points of different views between the service and some agencies. As addressed earlier, whilst we evaluated hospital delayed transfers as a local systems issue, we judged the service could have explored opportunities for more collaborative and effective working across health and social care services and escalate accordingly to constructively challenge where they had concerns.
• Following the inspection, we received evidence the service had begun exploring opportunities for effective collaboration with relevant partners in relation to the specific issue of delayed transfers. For example, the service shared minutes of a constructive meeting with a representative of the hospital discharge team, with positive recommendations. The operations director had attended a local authority forum looking into a multidisciplinary solution into the issue of delayed hospital discharges as a local issue.
• In other related areas, there was evidence the service maintained a good working relationship with health and care services to enable multi-disciplinary teamwork. A healthcare professional told us the management team knew when to seek professional input and how to obtain it. The healthcare professional said, "I have no concerns. The manager and her staff participate in reviews and are well-informed about their service users." Another health care professional said, "The manager contacted us if there was any change in needs of service users."
• There was evidence of partnership work with a range of health and social care agencies to provide care to people. These included GPs, psychologists and specialist healthcare professionals.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care

• The service had a clear management structure consisting of the operations director, area manager and a manager (not as yet registered with CQC) who had begun working at the service in January 2022. The new manager had begun the process of applying for registration with CQC. There were also team leaders who participated in the day to day management of the service.
• There were surveillance (CCTV) cameras inside the home. However, there were no clear, recorded purpose for the use of CCTV, which was supported by relevant assessments. The operations director advised that initially the surveillance system had been installed to protect people's safety from the risk of unsafe care or treatment and to keep premises and property secure. However, the system had not been used except the building exterior. Following the inspection, the operations manager told us the CCTV would not be used anywhere on the property.
• Families who responded to our questions described the service in complimentary terms. One relative said, "The service is well-led. I am on friendly terms with the management and our relative is warm and affectionate to all staff and managers which suggests that they find the service well managed."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.
• The leadership complied with the duty of candour. This is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. CQC had been notified of significant events which they are legally required to inform CQC about.