Sunrise Care Homes Limited

The Mount Residential Home

Inspection report

The Mount, Heydon Road
Aylsham
Norwich
Norfolk
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Tel: 01263734516

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26 August 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 22 and 26 August 2016 and was unannounced.

The Mount provides accommodation and support to a maximum of twenty two men who have a mental health needs and/or dementia. It does not provide nursing care.

There was a manager in post who had been appointed in June 2016. At the time of our inspection, the manager had not submitted an application to the CQC to become a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

People were not protected from avoidable harm and abuse because staff did not always identify when safeguarding referrals were required. Effective systems were not in place to ensure people were safeguarded and referrals made. Not all risks to people were adequately identified or managed, this included risks relating to the management of the premises.

Staffing levels and deployment of staff was not always sufficient. Staffing levels did not always meet the level that the provider had identified as sufficient to meet the needs of people living in the home.

Medicines were managed safely and people received these in time. People were supported to access health services when required.

Staff did not feel supported to deliver effective care. They felt the quality of training was poor. Healthy eating was not always understood or promoted. There was mixed feedback regarding the quality of the meals provided. The menu offered did not always incorporate people's individual preferences or needs. The service was not always acting within the requirements of the Mental Capacity Act (MCA).

People were supported by kind and caring staff who knew them well. People and their representatives were involved in decisions about their care. Information was provided to people so they knew how to raise concerns or complaints. People told us they felt comfortable to do so.

Some practices had developed that were not always respectful of people's privacy and dignity. A closed circuit television camera monitored communal areas. However, there were no records to indicate that people living in the home and others had consented to this and privacy issues had not been considered.

People's personal preferences and needs were not always met; this included the provision of activities.

Staff morale was low in the home. Staff did not feel listened to or supported. There were no effective systems in place to gather the views of staff and people living in the home. Not all records in the home were complete. Auditing and quality monitoring had been ineffective. The provider had not identified the issues found during this inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Safeguarding incidents were not always appropriately identified and reported to the relevant authorities.

Not all risks to people, including risks associated with the premises, were adequately identified or managed.

People received their medicines safely.

Staffing levels and deployment of staff was not always sufficient.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not feel supported to provide effective care.

The requirements of the MCA were not always met.

The food provided did not always promote healthy eating or meet people's individual preferences.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always respected.

People were supported by kind and caring staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The support provided did not always meet people's individual needs and preferences.

People felt able to raise concerns. Action was taken to resolve any issues raised by people.

Is the service well-led?

Requires Improvement

The service was not well led.

Quality monitoring systems did not act effectively identify issues or make improvements to the service.

Morale was low. Staff did not feel supported or listened to by the provider.

The Mount Residential Home

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 22 and 26 August 2016 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the Provider Information Return (PIR). This is a report that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us.

During our inspection we spoke with seven people who used the service, an advocate, and nine members of staff. This included the manager, senior care assistant, six care assistants, and a member of staff from an agency. We spoke with the director of the company. We also spoke with the local authority safeguarding team. After our inspection visit we spoke with one health and social care professional and two relatives.

We looked at three people's care plans, two staff recruitment files and staff training records. We checked the medicines records for two people. We looked at quality monitoring documents and accident and incident records. We also looked at records of compliments and complaints

Requires Improvement

Is the service safe?

Our findings

During our inspection we identified several incidents that had not been identified as abuse and were not reported to the local authority safeguarding team when required. One incident involved a serious allegation and the provider had conducted their own investigation without any consultation with the appropriate authorities. This had meant appropriate actions had not being taken to deal with the situation. A member of staff told us that the new manager had spoken to staff about adult safeguarding and the importance of reporting concerns. They told us, "Prior to that things probably not reported as much." Another member of staff told us that they felt the provider discouraged the reporting of safeguarding concerns. This demonstrated that the systems and knowledge were not effective enough to ensure safeguarding concerns were reported as required.

The system in place to support people with their finances was not robust enough. Where items were purchased on behalf of people receipts were not provided. This was not in line with the providers own policy regarding management of people's monies and left people at risk of financial abuse.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with told us they felt safe living at The Mount. One person told us, "I feel very very safe here. 10 out of 10 for safety." Another person said, "Yes I do, I always feel safe here."

The people we spoke with felt there were sufficient staff to meet their needs. However, staff and relatives we spoke with raised concerns regarding staffing levels. A relative told us, "Never enough staff, especially at weekends." Six of the staff we spoke with told us that shifts were not always fully staffed. Another member of staff told us they worried about staffing and safety levels. They told us on some occasions there were only two staff on a shift. They said at weekends this meant one staff member would have to cover the evening meal and the other would administer medicines at the same time. This meant there were no staff on the floor and available to support people if they required assistance.

Several members of staff told us staffing levels impacted on their ability to interact and support people to take part in activities. One member of staff said, "There is a minimum to keep things safe but not enough to give much individual care. There are no one to ones with residents. We are supposed to operate a key worker system but do not have enough staff to make it work."

The manager told us they would try to use agency staff if shifts were not fully staffed. However, we reviewed the last eight weeks of staff rotas which showed eleven shifts were not staffed in line with numbers the provider had assessed as being required to meet people's needs.

Staffing levels and deployment of staff was not always sufficient. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at two staff files and saw safe recruitment practices were being followed. This included the required character and criminal record checks, such as references and Disclosure and Barring Service (DBS) checks, to ensure the person was suitable to work in the home.

People had risk assessments in place. Risks identified were specific to each person and detailed in their care plan. There was clear guidance for staff on how to manage these risks. These covered areas such as mental health, eating and drinking, and mobility. We saw most risks had been identified and acted on. However, we found one example where risks had not been identified and had placed a person at risk of harm. This person had been placed in an upstairs room and had been assessed as being able to use the stairs. They were also assessed as having a low risk around falls. However, incident reports showed they had fallen twice in the last nine months; one occasion was a suspected fall down the stairs. This had not been sufficiently re-assessed and their risk assessment had not been updated following the fall. This person subsequently experienced another fall down the stairs. We were concerned that this might have been avoided had the risks been properly identified and assessed.

Some risks to people from the premises were managed. Regular up to date checks and servicing had been carried out on areas such as the communal lift, electrical equipment and fire safety. Risk assessments were in place regarding fire and legionella's disease. Records showed regular fire drills were carried out. However, we saw the home's lift had been broken for some time and was not being used. Staff also told us there was no moving and handling equipment upstairs, as this had also broken and not been repaired. They told us as the lift was broken this meant they couldn't take equipment upstairs if needed. This meant there was no safe way to assist people up should they have a fall.

People told us they received their medicines on time and when they needed them. One person said, "I get my meds [medicines] on time and I know what they are all for." Another person told us, "Yes my medication is given on time." We looked at two people's medicine administration records. These showed oral medicines were administered as prescribed and the records were completed accurately. We saw there was guidance in place regarding the administration of medicines. This included where people where prescribed 'as required medicines'. We saw that there were regular medicines audits and staff competency to administer medicines was checked.

Requires Improvement

Is the service effective?

Our findings

The people we spoke with felt that staff had the required skills and knowledge. One person told us, "The staff have the skills and knowledge to meet my needs." Another person said, "They look after me well."

However, all the staff we spoke with raised concerns regarding the quality of the training and how well it equipped them to do their jobs. They told us there was no interactive or face to face training. Staff were provided with DVDs to watch. Several staff told us there was no designated area for them to watch these DVDs and they had to watch these in a communal area of the home. They said this often meant they got interrupted and it was hard for them to concentrate on the training. One member of staff told the training was, "Not good." They went on to say, "There is nothing like speaking to someone and being able to ask." Another member of staff raised concerns that watching the same DVDs each year meant they would not be aware of any changes in practice. A third staff member told us, "DVDs don't cut it."

The provider supported staff to undertake a vocational qualification up to a certain level. However one member of staff we spoke with felt frustrated that staff were not supported to gain other qualifications above this. They told us if staff wanted to gain additional knowledge in certain areas or further qualifications they had to pay for this themselves.

Staff told us they worked well together which helped them provide effective care. One staff member told us, "We work well as a team." They spoke positively of the support provided by the current manager. However, some staff we spoke with raised concerns regarding the staffing structure and the lack of senior staff on some shifts. We saw that on weekends there were no senior staff on shift. One member of staff told us this meant, "I've got no support." A relative told us they thought the lack of senior staff at the weekends meant it was, "Hard for staff to cope, if special problems [occur]."

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.

People can only be deprived of their liberty to receive care and treatment when this in their best interests and legally authorised under the MCA. The application procedures for this in care home and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty was being met.

The staff we spoke with told us they knew about the MCA and DoLS, and demonstrated this in our discussions with them. A number of staff could tell us about some of the key principles of the MCA. Other staff were able to tell us about practical measures they would take to support people in a decision making process.

People had in place care plans which indicated if they might have difficulty in making decisions regarding their care. However, we saw where issues had been identified, capacity assessments had not been carried out.

DoLS applications had been made where appropriate. However, no mental capacity assessments had been carried out in regards to these applications. There was also no best interest's documentation in place to demonstrate that relevant people had been consulted and the outcome. This meant the provider was not following the requirements of the MCA. We discussed this with the company director who acknowledged that some improvements were needed in this area.

We received mixed feedback from people regarding the meals provided. One person told us, "Lovely food." Another person said, "I love my meals." A third person told us, "I always like the meals." However one person told us, "No I do not like the food here. The meals are rubbish.
They swamp everything in gravy." A relative we spoke with also raised concerns about the food. They told us the quality of the meals was, "Shocking." Another relative said meals, "Could be better." They went on to tell us that frozen foods were served and they thought there should be more fresh food on offer.

Some of the staff we spoke with also raised concerns regarding the quality of the meals. One told us, "Food is unacceptable." Two staff told us there was little fresh fruit or vegetables on offer. We reviewed the food on offer. We saw that meals offered tended to be processed pre-prepared food. These types of food sometimes have additional salt, sugar, and fat added to them. This can result in such foods being high in calories. Some people in the home had been identified as needing to lose weight. The meals provided to these people did not take this in to account. One member of staff said, "No thought about what's healthy."

Not all the staff we spoke with understood how to promote healthy eating. We saw only fifty-six percent of staff had undertaken training in nutrition and hydration. There was a lack of guidance in people's care plans for staff regarding how they could support healthy eating and people's specific dietary needs. For example, we saw a number of people had diabetes and there was no guidance for staff regarding how their diet should be managed.

People we spoke with told us they were supported to access health care services. One person told us, "Many professionals come to the home like my GP. If not I get escorted leave to help me get to my appointments." Another person said, "Most professionals come here and when we need to go to an appointment we get escorted to them." Records showed that where necessary people were referred for input from a range of healthcare professionals. This included referrals such as for nursing support or specialist mental health support.

Requires Improvement

Is the service caring?

Our findings

Some practices in the home were not respectful of people's privacy and dignity. CCTV was being used in the communal areas of the home. The company director told us that they had carried out a consultation exercise at the time, but were unable to provide any records of this or records of consent provided by people. We considered that this was an invasion of people's privacy. Whilst the provider had a policy in place, we could not see that the introduction of CCTV had been subject to proper consideration in line with current published guidance about the use of surveillance and whether other, less intrusive arrangements could be made to enable the monitoring of staff and people.

Some staff and relatives also told us about some practices which had occurred that were not always respectful of people's dignity and privacy. Concerns were also raised regarding laundry and how people's clothes were cared for. A member of staff told us that cloths normally used for cleaning were used to clean and wash people. They told us they felt this was, "Degrading." We saw that the curtains in communal areas had been removed and not replaced. Several staff told us they felt this was disrespectful and did not provide residents with privacy.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the new manager had been in post staff and relatives confirmed some improvements had been made. The manager told us they were in the process of discussing the need for new curtains with the provider.

People told us they felt staff were kind and caring. One person told us, "They are kind and they are interested in me and my life." Another person said, "They are very caring." A third person told us, "They [staff] are great, honest." The relatives we spoke to agreed. One told us some staff were very loyal and committed to the people living in the home.

Staff appeared to know the people they were caring for well. This included their individual preferences and personal histories. The people we spoke with also confirmed they felt staff knew them well. One person told us, "Staff know me very well. They know me and they know what I like and my pattern of living." Another person said, "The staff know me very well."

People told us staff listened to their views about the support they required. One person told us, "They listen to me every day." The care plans we reviewed showed people were involved in discussing and writing them with staff. However, not all the people we spoke with confirmed this. Whilst two people told us they had been involved in writing their care plan, several others told us they had not. A relative we spoke with, who acted as an advocate for their relative, told us they had not been involved in writing care plans. However they said that staff were, "Very good" at involving them in decisions about their relatives care needs. They told us staff were, "Always willing to talk to me."

We saw some people in the home had formal advocates to assist them with communicating their wishes

and views. The manager was able to give us examples where they had identified people might benefit from an advocate and gone on to request one.

During our visit we saw staff interacted with people in a friendly, respectful, and professional manner. One person we spoke with told us how staff encouraged them to be independent. They told us about a number of tasks they had enjoyed helping staff with, this included assisting with laundry and helping in the garden. We could see from talking to this person that this made them feel good and proud of the help they gave staff.

Requires Improvement

Is the service responsive?

Our findings

Whilst care records documented people's personal preferences and individual needs we saw these were not always accommodated in practice. One person told us, "Yes I can do what I want. But I need help to go out. I have not been out in three months." Another person said, "I feel that I have to fit in with them, their pattern, their schedule, not vice versa." A member of staff told us, "I think things should be more person centred."

One staff member told us that people with diabetes did not get the same amount of choice when it came to meals. They told us if people had diabetes they were not always able to eat the desserts on offer and would be offered a banana and yoghurt. We saw people were asked their opinion about what they wanted to eat. However, this did not always appear to be incorporated in to the menu plans. For example, we saw one person had said they would like bacon sandwiches and salmon served. Another person had asked for crumpets for breakfast. The menus we reviewed showed none of these food items were being served. We asked two staff about this who confirmed none of these foods were part of the menu.

There was a lack of activities available in the home. One person told us, "There are very little activities to do in the day, what they offer I do not participate in." Another person said, "No, not a lot [of activities]." We saw that those people who were more independent could visit town and take part in activities of their choice. For example, reading or watching TV. However, those people who required more support with activities did not always receive this. A relative told us their relative spent most of their time in their room. They said their relative often told them they were lonely.

A number of staff told us people did not want to engage in activities. However, activities being offered did not always appear to be specific to people's needs, personal interests, or hobbies. For example, one person told us, "No hobbies now I can't see much." A relative told us their relative liked a particular activity and this had helped them engage in activities in their previous home. They said they had told staff about this but nothing had been done to support the person to participate in this interest. Another relative told us they felt people living in the home would enjoy a specific activity. They said they had brought in equipment themselves to assist this as there was none provided.

On the days we visited we observed staff tended to concentrate on task based interactions. On one day we saw there was an organised game. However, several staff and a relative told us this was not a normal occurrence. There was no planned timetable of activities or planned trips out for people. A staff member told us, "We do not have enough staff to do structured activities with residents. Residents used to be taken out on trips but this has not happened for several years." Another staff member said, "I'd like to see more [activities]." A third staff member told us, "Activities, non-existent, never got time to do that."

The above information shows care was not always provided in a way that met or reflected people's individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people living in the home had different routines depending on their own preferences. One person

told us, "They look after my individual needs." Another person said, "They look after me very well. I get up at 6am most mornings. I got to bed at 9pm. In my own time I like to ride a bike and walk every day." A third person told us, "Yes I do what I want and I go out when I want."

The care plans we looked at were specific to people's individual needs. They also showed the involvement of the person in writing them. However, not all the people we spoke with could confirm they had been involved in writing and reviewing their care plans.

We saw care plans detailed people's personal histories, interests, and personal preferences. Providing this information to staff can help them understand the people they are caring for in greater depth and helps ensure people have care provided in a way that takes into account their individual needs. Most of the care records we looked at were regularly reviewed and updated with any changes. However, we found one instance when a person's care plan had not been reviewed and updated following a change to their needs.

People we spoke with felt able to raise concerns and that these would be acted one. One person told us, "Yes I have made a complaint. They explained to me what they were doing and I was satisfied with their explanation. They took my complaint very seriously." Another person said, "Yes I have made complaints. They always take me seriously." We saw copies of the 'Service user guide' were available to each person. This had details of how to complain and where people could complain to if they were unhappy with the provider's response.

Requires Improvement

Is the service well-led?

Our findings

The culture in the home was not open, inclusive and empowering. Five of the staff we spoke with told us they did not feel involved or listened to by the provider in the development of the service. One member of staff told us none of the staff wanted to have CCTV installed in the home. They said they were, "Told we would have to have it, we've got no option." They told us that staff had also not been consulted when the training had been switched to DVDs. Another staff member told us the provider did not listen to staff. They said, "We don't get asked anything." A third member of staff told us they felt they could raise issues but these were, "Not always listened to." A fourth member of staff told us that raising issues with the provider was, "Like knocking your head against a brick wall." Whilst a fifth member of staff said, "I feel they don't take any notice of me."

There was a lack of systems to involve and gather feedback from people living in the home. We saw that regular resident meetings had taken place in the past however there had been no meeting since 13 April 2016. Whilst the provider had introduced a feedback questionnaire for people living in the home, they had not thought about the support people required to fill these in. The manager and company director told us they had not received many surveys from people living in the home. They told us this was because most people did not have family or advocates to help them fill in the questionnaire. They had not asked staff to support people with the questionnaires as they were concerned staff would bias the results. This meant that the service had failed to actively involve and seek feedback from people in a way that was tailored to their individual needs. We discussed our concerns with the company director and manager who told us they would review the way they collected feedback from people living in the home.

Five of the staff we spoke with felt there was a lack of investment and support from the provider in developing and improving the service. Staff told us they felt this had resulted in poor ineffective training, a lack of activities, and poor quality food. We saw for example, the lift had been broken since at least April 2016. No action had been taken to repair this or ensure moving and handling equipment was available upstairs if required.

We saw that regular weekly audits covering areas such as, care plans, medicines, staffing, and health and safety were not always carried out. Between 3 March 2016 to 22 July 2016 these audits had not been completed. We found where audits had been carried out these had not identified the issues that we found at the time of our visit. This demonstrated that audits and quality monitoring systems were ineffective.

Not all the care records were accurate or complete. For example, accident and incident forms were not fully completed. The analysis section of the report forms were left blank. This meant there was no record to show if the incident was preventable, if the risk assessment had been updated, and if consideration of any falls or patterns had been made. For another person we saw that their doctor had advised on 24 December 2015 that their blood pressure should be taken on a weekly basis. The records showed the person's blood pressure was only on the 5 and 19 of January. There was no record of any discussion with the person's doctor and why this was ceased.

The above information meant there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers and registered managers are required by law to report incidents that can affect people's wellbeing by submitting statutory notifications to the Care Quality Commission. We saw that a number of these incidents had occurred in the home but had not been reported to us.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Morale was low in the service. One staff member told us morale was, "Terrible." Another said not being listened to had impacted on this. Staff did not feel the leadership and support provided by the provider was good. Several staff we spoke with told us they did not feel appreciated by the provider. They said there was a lack of incentives to take on additional responsibilities and tasks. We saw the provider did not always tackle issues with staff performance in the most supportive and thorough manner.

The relatives and staff we spoke with were positive regarding the current manager. A relative said, "[manager] is like a breath of fresh air, they have the right ideas." One member of staff told us, "[Manager] fits in very well." Another staff member said, "You can talk to [manager]." They went on to tell us that the manager came and helped staff on the floor if needed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons had failed to notify the Commission of notifiable incidents that had occurred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and support provided did not meet the individual needs and preferences of people living in the home. Regulation 9 (1)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Their privacy was not always protected. Regulation 10 (1) (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding concerns were not reported as required. Systems did not operate effectively to ensure people were safeguarded.

Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. The service did not maintain an accurate and complete record in respect of each person who used the service. Regulation 17(1) and (2)(a)(b)(c)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels and deployment of staff was not always sufficient. Regulation 18 (1)