Sunrise Operations Bramhall II Limited

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on the 6 and 7 June 2017 and was unannounced on the first day.

We last inspected the service 9 January 2017 when we rated the service as requires improvement. At that time we found the service was in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, these related to person centred care, medicines management, governance and staffing. This inspection was to check improvements had been made following the last inspection and to review the ratings.

Sunrise Operations Bramhall ll Limited is registered with the Care Quality Commission (CQC) to provide personal and nursing care and accommodation for up to 98 older people. The community is owned and managed by Sunrise Senior Living, an American based operator which provides independent living, assisted living, nursing and dementia care services for older people. The service, which is known as a 'community', is divided into two separate neighbourhoods, the 'assisted living' neighbourhood and the 'reminiscence' neighbourhood. The assisted living neighbourhood provides nursing and residential care for up to 72 older people. The reminiscence neighbourhood provides residential care and support for up to 26 older people living with dementia.

The purpose built community is located in Bramhall Stockport. Accommodation is provided over three floors and some accommodation provides single studio suites that can be shared by up to two people. Reminiscence rooms have a similar layout to those in assisted living and are situated on the ground floor. All bedrooms are single with en-suite facilities. Car parking is at the front of the building. At the time of this inspection 80 people were living in the Sunrise Bramhall community.

Systems to make sure the safekeeping and administration of medicines were followed and monitored were in place and reviewed regularly. Medicines were stored safely and administered by designated trained care workers and nurses. Any specific requirements or risks in relation to people taking particular medicines were clearly documented in their care records. At Sunrise of Bramhall a care record is known as an individual service plan (ISP).

Care workers we spoke with confirmed they had received safeguarding and whistleblowing training (raising a concern about a wrong doing in the workplace) and knew who to report concerns to if they suspected or

witnessed abuse or poor practice. We saw records to show care workers received regular supervision to help make sure they were carrying out their duties safely and effectively.

During both days of the inspection we saw people were supported by sufficient numbers of care workers. Care workers we spoke with told us they had undergone a thorough recruitment process and had undertaken employee induction and training appropriate to their job role. This helped to make sure the care provided was safe and responsive to meet people's identified needs.

People lived in a clean and well maintained environment. We saw that the community was decorated to a high standard; there was a warm and relaxed atmosphere. Appropriate equipment and health and safety checks were carried out to help maintain a safe environment for people to live in.

People who used the service and their relatives were complimentary and positive about the care and support provided and the attitude of the care team and management. They felt that the overall care provided was very good and the environment was furnished and maintained to a high standard.

We saw positive and caring interactions between care workers, nurses and people who used the service, which helped to make sure their dignity was respected and their wellbeing was promoted.

Complaints were addressed and recorded appropriately by the management team. People who used the service and their relatives told us they knew how to make a complaint and felt confident to approach any member of the staff team if they had any concerns.

Accurate and complete records in respect of the care and treatment provided to people were being maintained. Systems were in place to monitor the quality and safety of the service provided to people living in the community.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Systems were in place to make sure medicines were stored, recorded and administered safely by suitably trained nurses and care workers.

Safeguarding policies and procedures were in place and care workers knew how to protect people from the risk of harm.

Risks to people were identified and detailed in their ISP's. Written information showed how to mitigate any risks to people.

Is the service effective?

Good

The service was effective.

Care workers received an employment induction, regular supervision and training to help make sure people were provided with care and support that met their needs.

People had access to external healthcare professionals, such as specialist nurses and General Practitioner's.

Food options and refreshments were available throughout the day.

People's nutrition and hydration was monitored to ensure their nutritional needs were being met.

Is the service caring?

Good

The service was caring.

People received care and support from nurses and care workers who knew them well.

We observed positive interactions between care workers and people who used the service.

People's ISP's were stored securely to maintain confidentiality.

Is the service responsive?

Good

The service was responsive. □

People's needs were assessed prior to them moving into the community. ISP's identified risks to people's physical health, mental health and well-being.

People's health care reviews were held every six months or more frequently if necessary. Specialist guidance was included in people's ISP's to address their health changes.

People told us they felt confident in raising concerns or complaints, if they had any, with the management team, nurses or care workers.

Is the service well-led?

Good

The service was well-led.

A manager had been appointed to manage the community but was not yet registered with the Care Quality Commission.

People who used the service, their relatives and care workers spoke positively about the management team and care workers

Systems were in place in order to monitor the quality of the service and were being fully utilised.

The provider promoted a person centred approach to help make sure people's needs and preferences were met.

Sunrise Operations Bramhall II Limited

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 6 and 7 June 2017 and was unannounced on the first day. The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed information that we held about the service and the service provider. This included safeguarding and incident notifications which the provider had told us about. Since the last inspection in January 2017 we received information from the local authority adult social care team and the National Health Service (NHS) Clinical Commissioning Group (CCG) who confirmed they had no concerns about the services that were being provided at Sunrise of Bramhall ll.

During our inspection we spoke with seven people living in the community, two visiting relatives, the general manager, the reminiscence neighbourhood coordinator, the recruitment administrator, two concierges, the head housekeeper, two area coordinators, the community maintenance support assistant, five health care workers and the operational director.

We reviewed six care worker personnel files, the agency staff induction and supervision file, the registered nurse recruitment checks file, records of staff training and supervision and the care records, which are known as individual service plans (ISP), of four people living in the community.

We also reviewed a sample of medicine records that belonged to people who lived in the reminiscence and

assisted living neighbourhoods, records relating to the servicing and maintenance of premises and equipment, safety audits, a sample of the service's operational policies and procedures and the service's clinical governance audits.

Good

Our findings

At our last inspection in January 2017 we found that risks to people's safety were not managed appropriately and where risks were identified some care records did not include information to clearly identify the factors which might increase the likelihood of the risk occurring, how the risk should be managed and the impact should a risk occur. At this inspection we found improvements had been made in this area and the provider was meeting the requirements of this regulation.

We saw records to show that risk assessments were in place for people who were at risk of falls and in relation to people's skin integrity. Additional risk assessments were in place to meet people's individual needs for example specific dietary requirements or behaviours that challenge. Where necessary body maps had been completed for particular people in order to highlight any bruising, pressure sores or skin tears, we saw records to show that people's skin checks were carried out by all care workers who carried out any personal care intervention for people. From the risk assessments we examined we saw that they contained enough detail to fully identify the risk and strategies to manage and minimise those risks.

Environmental risk assessments had been undertaken using a system for documenting and recording any maintenance work required. We saw records and audits for Legionella water checks had been carried out by an external contractor. We saw health and safety audits were carried out on a regular basis by the community maintenance support assistant. Checks on windows and window restrictors, doors, lighting and heating had been carried out and were up to date. Records we examined indicated that fire equipment checks and fire drills were carried out frequently.

Records to show all of the people living at Sunrise of Bramhall had a Personal Emergency Evacuation Plan (PEEP) were in place. These plans detailed the level of support a person would require in an emergency situation such as a fire evacuation. We saw records to show that all care workers had undertaken fire safety training at regular intervals.

We examined additional records that showed regular checks had been undertaken on electrical appliances and portable appliance testing. This helped to make sure that any environmental risks to people were minimised.

An accident and incident policy and procedure was in place. Records of any accidents and incidents were recorded and analysed to check if there were any themes. Appropriate notifications had been made to the Care Quality Commission (CQC) and the local authority adult social care safeguarding team where

necessary.

People we spoke with told us they felt safe living in the Sunrise of Bramhall community and made positive comments about the care being provided to them. They said, "I've lived here since the community first opened, it is home. I'm quite safe, they [care workers] look after me nicely" and "I feel very safe here".

Prior to the last inspection in January 2017 we received information from the local authority adult social care team who informed us they had concerns about the service that was being provided in relation to the management of medicines. At that inspection we found that medicines were not being managed safely which presented a risk to people who used the service and the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Management of Medicines.

At this inspection we found improvements had been made in this area and the provider had put appropriate arrangements in place to help maintain the safe management of medicines at the service. We saw that the service had started to use a monitored dosage system (MDS) and medicines were provided in blister packs by a supplying pharmacy. MDS is used to help keep track of what medicines are administered. This system can help to reduce the risk of medicine errors and make sure that people receive the correct medicine as prescribed by their general practitioner (GP). When we checked how medicines were being managed on the assisted living and the reminiscence neighbourhoods we saw that medicines were stored in medicines trolleys that were located in designated locked rooms. Any excess medicines were stored in a locked metal cupboard in the medicines rooms. We saw records to show that medicines delivered to the neighbourhoods had been checked in by two designated care workers or nurses who were trained in this topic. We examined a sample of medication administration records (MAR). We saw there was a photograph of each person, on their individual MAR to assist care workers in identifying them. We saw that special instructions about how particular medicines should be taken were clearly recorded. For example a MAR we examined stated 'place tablet on [Person's name] mouth using a tea spoon, drinks well with a straw'. This helped to ensure that the person received their medicine in a way that was suitable for them.

We saw skin creams and medicines prescribed to be taken as and when required had been appropriately recorded on individual medication administration records (MAR). Instructions for MAR coding, for example the use of an alphabetical letter to indicate when a person has refused their medication, were in place. An up to date care worker verification signature sheet containing the names of authorised medicine handlers was in place and had been signed by designated care workers. People prescribed Warfarin anticoagulant medicine had been provided with a Warfarin chart from the anticoagulant clinic. We saw that this chart recorded the frequency of the person's blood tests and the amount of Warfarin administered. Care workers were aware of the risks associated with this type of medication and two care worker signatures were required to confirm this medicine had been given. Anticoagulants are medicines that help prevent blood clots and are given to people at high risk of getting blood clots, to reduce their chances of developing serious conditions such as strokes and heart attacks. Whilst this medication is highly effective, it is also associated with significant bleeding risks. Therefore risk assessments and specific guidance to contact the emergency services were in place for people using this medication. Care workers were aware to contact 999 should any person prescribed an anticoagulant medicine sustain an injury, such as a fall, head injury or body bruising that might lead to bleeding.

We saw that a controlled drugs (CD) daily check sheet was in place to help ensure that the provider's protocol for CD's had been followed. When we checked the CD cabinet we found all of the CD's that we checked could be accurately reconciled with the amounts recorded as received and administered by the service. We saw that the CD record book contained the CD's remaining balance and this had been signed alongside the person's MAR by two care workers to confirm these medicines had been administered.

Controlled drugs are prescribed medicines frequently used to treat conditions such as severe pain. These medicines are liable to abuse and for these reasons there are legislative controls for some drugs and these are set out in the Misuse of Drugs Act 1971 and related regulations. These controls require services to make entries of any controlled drugs stored and administered in a separate register as well as on the MAR sheets. We saw that the service was following these regulations. This meant that the systems in place in relation to the recording of medicines were being used and followed correctly.

We saw that each neighbourhood maintained people's individual homely remedies charts for medicines such as simple linctus or paracetamol, following agreement from their general practitioner (GP). The charts had been appropriately signed when a homely remedy had been administered. A homely remedy is an over-the-counter medicine that can be administered without a prescription or professional supervision. They will generally not interact with most peoples prescribed medication and are time limited to ensure that any potential long term problems can be addressed quickly by the GP. They are normally given for minor ailments such as a tickly cough or for aches and pains.

We examined the procedure for administering medication when required (PRN) and found that the service had implemented a protocol based on the 'Abbey Pain Assessment' tool to be used prior to administering PRN medicines. The protocol described the signs people living in the community might display such as, grimacing facial expressions or making distressing sounds that care workers must be aware of. The Abbey Pain Assessment can be used as part of an overall pain management plan and can help care workers to assist in the assessment of pain in people who are unable to clearly articulate their needs. We were shown a copy of the covert medicines protocol which required written authorisation from a GP and pharmacist before such medicines could be administered covertly. The area coordinator told us that any decision to administer medicines covertly to a person would be made at a best interest meeting after undertaking a mental capacity assessment and management plans would be put in place. Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink.

The area coordinators carried out regular medicine administration spot checks to make sure medicines were being managed safely and we saw that the procedure for medicines errors, such as missed medicines, had been followed. We saw records to show that all care workers/ nurses designated to administer medicines had undertaken a medicines competency assessment. This meant risks associated to the management of medicines were minimised. A medicines policy was in place and had been reviewed to provide guidance and help care workers to ensure the safekeeping and administration of medicines. Three people who lived in the community confirmed their medicines were administered at the right time and this was confirmed when we observed part of a medicines round being undertaken on the reminiscence neighbourhood. This meant that medicines were handled appropriately and given to people as prescribed.

A recruitment and selection procedure was in place which was also used to recruit agency and bank workers. Since the last inspection in January 2017 the provider had recruited a person to focus solely on the recruitment and retention of staff at Sunrise of Bramhall. We were shown a weekly recruitment tracker that indicated a recent recruitment drive had created stability amongst the staff team. We saw that staffing numbers had increased because an additional 35 care workers had been recruited within the community since February 2017.

A bank staff register was also in place and six care workers who knew the service and people living in the community well, had received the necessary mandatory training to be ready to work any shifts at short notice when they became available. This meant that the provider was using less agency workers to help make sure that the care provided to people was safe and consistent. People we spoke with told us that they

had noticed an increase in staffing levels and felt the atmosphere within the community was bustling. From our observations we saw there were sufficient care workers to safely meet the needs of people living in the community. This was confirmed when we checked the staff roster. We saw staffing levels were reviewed daily to ensure appropriate staffing levels were in place and the number of agency workers being used. The area coordinator confirmed that on both inspection days no agency workers had been rostered to work within the community.

We saw that care workers had access to personal protective equipment (PPE) to help reduce the risk of cross infection and was being used when providing personal care to people. Care workers we spoke with knew to use disposable gloves and aprons provided for them. This helped to protect them and people using the service from the risk of cross infection whilst delivering care. They were aware of the need to make sure they used the protective equipment available and confirmed to us there was always plenty of PPE available for care workers to use.

We looked at five care worker personnel files and found that they had been recruited in line with the regulations, including the completion of a disclosure and barring service (DBS) pre-employment check and at least two recent references from previous employers. Such checks help the registered provider/ manager to make informed decisions about a person's suitability to be employed in any role working with vulnerable adults. We spoke with five care workers who described their recruitment to the service. They told us that after completing an employee application form and attending a face to face interview to assess their suitability for the job the provider carried out the necessary pre-employment checks. When we examined the care worker induction records we saw evidence that they were not assigned any work until the appropriate ID, references and clearance from the DBS had been received and found to be satisfactory.

A person we spoke with said, "You can really notice the difference within the community. There are many more staff and they all seem to be staying. It's a lot different to when you [Care Quality Commission inspector] came here came in January. We've got the CQC to thank for this it's made a huge difference for us all".

Good

Our findings

At the last inspection in January 2017 the system of ongoing supervision and appraisal was not used for agency workers employed at the community. We found the provider did not have full oversight and assurance that agency nurses and care workers were competent and appropriately supported to carry out their role safely. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Staffing.

At this inspection we examined an agency workers supervision file which contained agency worker induction sheets that had been completed on the first three occasions they worked at the community. The file also contained agency workers work monitoring sheets and supervision records. Agency workers received a condensed induction and thorough handover of information about people living in the community at the start of each shift which meant the provider had a clear oversight and assurance that agency nurses and care workers were competent and appropriately supported to carry out their role safely.

People we spoke with told us they felt the care workers and nurses were competent and were able to provide care and support that met their needs. People said, "I am looked after very well" and "The staff are helpful; they really are wonderful".

We saw records that showed the provider was continuing to provide care workers, nurses and other members of the staff team with an annual appraisal and on-going supervision (which is known as a supervision tickler within the organisation). This system promoted discussion and evaluation of individual staff performance including best practice and where necessary improvements in practice could be made. Records of these discussions were also examined and were seen to be maintained and ongoing.

Care workers we spoke with said, "When we were agency heavy everything was rushed because we had to support the new agency workers and show them what to do" and "It's a lot better now that we have more permanent staff" and "Now there is time to receive supervision and appraisal which is a powerful tool and makes our work life better".

The recruitment administrator shared with us records that showed new permanent care workers and nurses undertook a 12 week induction throughout which their work was monitored. New care workers and nurses undertook a minimum of four shadowing shifts (working under the supervision of an experienced care worker) within the community, before they worked unsupervised. This could be extended if the care workers/ nurses performance did not meet expectations or they felt they required additional time to

develop their skills. All care workers and nurses were issued with an employee handbook which contained information about Sunrise of Bramhall policies, procedures and the organisational expectations of employees.

Care workers and nurses undertook mandatory training through a comprehensive system of online training (E-Learning) and practical assessments in topics such as dementia awareness, moving and handling, fire awareness and infection control. Additional nurse training in clinical subjects for specific conditions such as wound care were undertaken as part of the registered nurse individual competency learning and development. Care workers we spoke with told us that staff training was ongoing and appropriate courses were available where it was identified particular skills and knowledge would help to meet people's specific health and wellbeing needs. They told us that additional training such as tissue viability training could be provided via the district nurse if necessary. This meant care workers and nurses had received training appropriate to their role and helped to make sure people received safe and effective care. New care workers were provided with National Vocational training in Health and Social care and induction training provided via the Care Certificate. These are professional qualifications that aim to equip health and social care workers with the knowledge and skills they need to provide safe and compassionate care.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the 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 were being met. An area coordinator told us that where DoLS applications were required, they had been submitted for people living in the community. We saw a tracker was in place to monitor when applications had been made to the supervisory body (the local authority) and when any applications had been authorised. The tracker also monitored DoLS expiry dates to ensure people's liberty was not deprived unlawfully. We saw that nobody was being deprived of their liberty without lawful authority.

Care workers and senior workers we spoke with were knowledgeable about the MCA, issues relating to consent and the need to carry out mental capacity assessments for people who required them. This meant there were suitable arrangements in place to obtain and act in accordance with the consent of people who lived in the community.

People living in the community had choice about what they wanted to eat and where required they were supported to eat their meals with prompts from care workers and their nutrition and hydration was monitored to ensure their dietary and nutritional needs were being met. Care records are known within Sunrise Operations as individual service plans (ISP).

We reviewed people's ISP's and observation charts which had been completed regularly to show the type and amount of food people had eaten and what they had drank. The dining services team were knowledgeable about the dietary needs of individual people in the community. People's named photographs assisted the dining services team to identify individuals who required a specific diet or meal such as gluten free, diabetic or vegetarian meals. We saw a three course menu was available at breakfast, lunch and dinner and a varied range of dishes were available including vegetarian, meat, fish and salad options. In addition, omelettes, jacket potatoes and freshly prepared sandwiches, fresh fruit and a selection

of snacks were available. This helped to make sure people received meals that met their dietary requirements.

The dining services team followed a meal tracker checklist based on a traffic light system of red amber and green which alerted them to individuals who were at high medium or low nutritional risk. For example people requiring a pureed diet because they were at risk of choking would be identified as 'red'. This meant people could enjoy their food because any specialised food and dietary needs were known and any risks were mitigated. Following the last inspection the provider had introduced 'hydration stations' at various locations on each neighbourhood. People had been assessed to use the facilities in the bistro area, and where safe to do so they were enabled to access hot drinks, fresh fruit and snacks. A refrigerator containing bottled fruit drinks and water was also available for people to access at any time of the day or night. This meant people's hydration and nutrition needs were being met.

When we walked around both neighbourhoods we saw that the home was furnished to a high standard. Neighbourhoods had recently been re-carpeted which provided a fresh appearance alongside the soft furnishing and ornaments. A parlour, sun room and individual bedrooms/suites were decorated and maintained to a high standard. Bedrooms contained a kitchenette, a sitting area and en-suite wet room with a toilet. People had been encouraged to bring their personal items from their home and many rooms were personalised with people's own furniture and pictures.

People living in each neighbourhood had access to well-maintained picturesque gardens and it was apparent that people's needs and preferences had been considered regarding the design and decoration of the community. For example, we saw that a secure and separate reminiscence garden was easily accessible for people living with dementia to go outdoors and enjoy nature or carry out gardening whilst being supervised by care workers.

It was clear that consideration had been given to the décor within the reminiscence neighbourhood which had been designed specifically for people with living with dementia. For example we saw memory boxes contained items that each person could associate to their work and home life before they moved into the neighbourhood. Toilets and bathrooms could be easily identified because good clear signage was in place to help signpost people around the neighbourhood. We found that both neighbourhoods smelled fresh and looked very clean. People's bedrooms and suites were being kept clean and tidy by the housekeeping team.

We saw that both laundry rooms operated a dirty to clean work flow system so that clean and dirty items were physically separated throughout the laundry process. An area coordinator told us that the community had a high standard of cleanliness and this was maintained to make sure the environment was suitable for the people who lived there.

Good

Our findings

People we spoke with told us they were very happy with the care being provided to them and the staff team were very caring. People said, "It's a lovely community, how could you not be happy here" and "They [care workers] are very good". A visiting relative we spoke with said, I'm totally satisfied with the care provided to my relative".

People's ISP's showed and we observed that people were encouraged to remain as independent as possible, and care workers supported people to manage tasks such as mobilising around the home within their capabilities. We spoke with five care workers who were knowledgeable about people's identified needs and they gave examples of how people preferred their care and support to be given. We saw these details had been accurately reflected in people's ISP's which showed the care workers and nurses had a good understanding of individualised care. From the ISP's we examined we saw that they had been written with empathy and understanding of people's individual needs and there was a culture of promoting and maintaining people's independence wherever this was possible. For example one care record described that a person living in the community enjoyed staying in their room with their cat and this brought them a lot of comfort.

We saw care workers, nurses, members of the management team and hospitality team had developed a good rapport and understanding of the people living in the community, were very friendly towards people and treated people with courtesy and respect. We observed care workers and nurses interacted with people well, engaged them in conversations interesting to them which helped them to feel relaxed and promoted their dignity. For example we observed care workers displayed a gentle approach, showing kindness and warmth to people throughout both days of the inspection whilst people walked around the community. It was clear that people were happy and felt at home in the community because of the time being spent with them.

The provider was aware of how to link in with a local advocacy service to ensure that people who did not have any relatives living nearby had someone they could turn to for independent advice and support when needed. An advocate is a person who represents people independently of any government body. They are able to assist people in ways such as, writing letters for them, acting on their behalf at meetings and/or accessing information for them.

An end of life policy was in place and included procedures which were person centred and supported the person to have full control about decisions relating to their future care and end of life needs. An area

coordinator told us that nobody using the service required end of life care at the time of the inspection, however if a person was nearing end of life the relevant palliative care professionals would be involved including the District Nurses and the person's GP. In addition to this an appropriate ISP would be implemented.

We saw that people's records and any confidential documents were kept securely in secured rooms accessible only by designated staff and no personal information was on display. This ensured that confidentiality of information was maintained.

Good

Our findings

At the last inspection in January 2017 we found that the provider had not ensured care was delivered to meet the needs of people living in the community and this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care. We had also received information that the nurse call buzzer was not being responded to in a timely way and people had to wait for long periods before they were attended to by the care workers. At this inspection we found the provider had made improvements in this area and was meeting the requirements of the regulation.

During both inspection days we were aware that the nurse call buzzers were not sounding and we saw that people were being assisted by care workers in a timely way. An area coordinator told us that they had done a lot of work with the care workers around response times. They told us that there had been a significant reduction in delayed care worker and nurse response times and this was mainly due to the number of extra care workers they had recruited.

People told us they felt that the service was responsive and said, "They [staff] seem to handle everything very well indeed" and "They are excellent here and they know what they are doing".

ISP's showed that people's needs were assessed prior to them moving into the community and people had signed to show their consent to the care being provided. An individual needs assessment was used to complete the ISP which enabled people to be cared for in a person centred way. Records showed that nurses and care workers used the information to develop detailed ISP's and any support records that would identify people's abilities and the support required to maintain their independence. Assessments showed people and their relatives had been included and involved in the assessment process wherever possible. Person centred ISP reviews were held six monthly or more frequently if the person experienced any health changes. Where issues were identified such as changes to the person's care these were noted and follow up action was recorded.

A wellness service was available at the home and operated an open door policy Monday to Friday 9am to 5pm for people who wished to seek advice about their wellbeing. Monthly nurse led wellness checks were carried out to assist in the early detection of any health issues. Where health issues were identified the person was referred to their GP and notes were recorded in their ISP.

We examined four ISP's which contained people's emergency contact details such as their next of kin, and General Practitioner (GP) their current support needs, the care to be provided and the desired outcome

following the care provided. Information about each person was clear and there were sufficient details to guide care workers on the care and support to be provided. They contained relevant information about people's health diagnosis and associated needs such as nutrition and hydration assessments. ISP's included information about people's mobility, moving and handling, tissue viability, social values, mental capacity and communication. Where necessary people's weights were recorded and a body map to record and highlight any bruising or injuries sustained were kept in the persons ISP record. This meant care workers and nurses could respond appropriately to help make sure people's health and wellbeing were being appropriately responded to and maintained.

We saw that the reminiscence neighbourhood was designed specifically to support older people living with dementia and provide specific facilities such as a reflection/ quiet room with mood lighting. This could help people to gain a better understanding of the environment and improve their mood and behaviour. Activities were organised by an activities coordinator who consulted people about their preferences during residents meetings before completing the activities programme. All of the people we spoke with indicated they were satisfied with the activities that were being provided. People were supported to take part in hobbies and interests and individual or group daily leisure activities were provided. We saw there was a wide range of activities available to choose from. These included planned trips to visit places of interest, a knitting circle, and live entertainment. We saw information technology (IT) resources such as computers with access to broadband were in place and we were told that some people used the IT equipment to keep in contact with relative and friends. Records of people's involvement were kept in their individual activities record and people we spoke with made positive comments about the activities that were on offer in the community. They said, "There's always something for everybody, it really is good. I join in with most things like the knitting circle and the craft group" and "I always go to the resident's meetings where we talk about the meals served, our care and other topics people want to talk about. There is always plenty to do here".

A concierge service was available in The Grand Foyer of the home seven days a week between the hours of 8am and 8pm. A bistro area which served hot and cold beverages/ snacks was open 24 hours a day and also provided daily newspapers and a fortnightly shop was opened for small personal items to be purchased.

A complaints policy which allowed for a full investigation into the complaint and for all complaints to be taken seriously was in place. The policy allowed complaints to be escalated to the local government ombudsman if the complainant remained dissatisfied with the outcome. We saw actions to complaints had been recorded and the complaint resolved to the person's satisfaction.

People we spoke with told us they knew how to make a complaint if they had any concerns and guidance telling people how to make a complaint was displayed in the community vestibule and foyer.

Good

Our findings

At the last inspection in January 2017 we found the provider did not have good managerial oversight of the management of medicines and internal audits carried out to determine any shortfalls in good practice, and had not identified any of the concerns we found during that inspection.

At this inspection we found that improvements had been made and the provider was now meeting these requirements of the regulation as discussed in the safe and responsive section of this report. This meant that the provider had fully utilised the systems in place to identify where quality and/or safety was being compromised and could respond appropriately.

At the last inspection in January 2017 a registered manager was not in place and the operational director told us that steps were being taken by the provider to recruit a suitable manager within a reasonable timescale. At this inspection the service had recruited a general manager who was in the process of submitting an application to become registered with the Care Quality Commission.

It is a requirement under The Health and Social Care Act (2008) that the manager of a service like Sunrise of Bramhall is registered with the Care Quality Commission (CQC).

A management structure was in place and the provider was committed to providing continuing management support at Sunrise of Bramhall in the absence of a registered manager. When we visited the community on 6 June 2017 we found that a general manager had been recruited and following their recruitment a deputy manager had also been recruited. The two area coordinators in post at our last inspection in January 2017 continued to support the day to day management and oversight of the service supported by the operational director.

Discussions with care workers and people who used the service confirmed management were always present in the community. All of the people we spoke with made positive comments about the new management structure and felt their needs were being met by a sufficient number of competent care workers and nurses. Care workers we spoke with understood their role and responsibility to the people living in the community. They felt management were supportive and responded well to their needs and those of the people living in the community.

Care workers were keen to tell us about the recent staff changes within the community. They spoke very positively about the new management team and told us that their morale had improved following the

recruitment of more care workers in order to provide additional support to them and the people living at the community. They told us that they enjoyed working at the community and said, "The operational director and managers are focused on running the community well. They are involved in all departments and are good leaders" and "Management have made an impact and we now have a new general manager and deputy manager. We know who to go to and have direction" and "The team have pulled together under good leadership".

People we spoke with made positive comments about the management team and the quality of the service. They said, The staff and managers are friendly; I find them very good" and "There's been a big change in staff, they are all very good and make us feel comfortable" and "There is a residents meeting which I like to go to, and you can read the notes to find out what's going on if you don't want to attend". Meetings were held with people who used the service and their representative or relatives. People were given an opportunity to say what they liked about the community but also what, if any, improvements could be made. Notes of the meetings were kept to ensure an accurate account of people's verbal contribution was maintained.

The operational director told us that the provider had implemented additional strategies to help create a vision and direction for the community which was for the whole staff team to maintain the delivery of good personal care, supported by good documentation. This vision would help to ensure the staff team did not lose sight of the aims for the service and the people who lived in the community. They told us that it was important for the senior management team to engage more frequently with people to help make sure their stay in the community was a positive experience.

Following the last inspection in January 2017 the provider had implemented clinical governance management meetings to the service. These meetings were held monthly, were mandatory and heads of departments from each staff discipline attended part of the meeting to focus on trends in relation to their area of work such as, safeguarding, control of infection, nutrition/weight loss, tissue viability, maintenance, accidents/ injuries and health and safety concerns. We examined the notes of the most recent clinical governance meeting held in March 2017. The meeting notes indicated any patterns that emerged were reported, analysed and actions taken were recorded. The results of the meetings were shared with an internal operational management group in order to assist in anticipating seasonal trends and planning prior to a potential health or environmental crisis.

A business contingency plan was in place which identified potential risks and threats to service provision and the provider's actions should they occur in order to ensure continuity of service for people.

Management shared with us copies of the various organisational policies and procedures such as, complaints and suggestions, safeguarding, accidents and incidents, medicines management and staff recruitment. Policies we looked at had been reviewed regularly and a future policy review date was planned.

The registered provider recognised staffs caring attributes through observations of staff practices and behaviours and operated an employee reward scheme to acknowledge staff loyalty. This helped the staff team to feel valued and maintain a good standard of care.