Sunrise Operations Knowle Limited

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Inspection report

1270 Warwick Road
Knowle
Solihull
West Midlands
B93 9LQ

Tel: 01564732400
Website: www.sunrise-care.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Sunrise Operations Knowle Limited is registered for a maximum of 131 people offering accommodation for people who require nursing or personal care. At the time of our inspection there were 109 people living at the service. The home is divided into two areas, Assisted Living and Reminiscence. The Reminiscence area is for people living with dementia.

At our last comprehensive inspection in March 2016, we found there was a breach in the legal requirements and Regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to good governance. Systems and processes to monitor and improve the quality and safety of services provided, and to manage risks related to the health, safety and welfare of people, were not established. This included records not always being sufficiently detailed and accurate to support safe and appropriate care.

We asked the provider to take action to improve the areas we had identified as being of concern. The provider sent us an action plan which detailed the actions they were taking to improve the service.

Following this inspection we were made aware of further concerns in relation to people's safety and how risks were managed, particularly in the Reminiscence area. As a result we undertook a focused inspection to look into how the risks associated with people's care was managed, whether people were safe and whether the home was well – led.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sunrise Operations Knowle Limited on our website at www.cqc.org.uk

At this inspection we found that whilst some actions had been taken to drive improvement in relation to the processes to support people's safety and manage risks, further improvements were still required in relation to the governance of the service. This meant there was a continued breach of this regulation.

A requirement of the service's registration is that they have 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a registered manager in post who had been registered since July 2016.

There were not always enough staff available to provide the support people required in order to meet their needs and preferences, particularly over the lunchtime period. New staff had been recruited resulting in a reduction of temporary staff being used, but at times people were still not supported effectively.

Risk assessments were completed to reflect the risks to people's health and wellbeing; however we found

some had not been reviewed regularly and were inaccurate, so we could not be sure people would be supported correctly. However, staff spoken with knew the risks to people when providing care and other care records were now being completed accurately and in a timely way following the introduction of a new system.

Continued changes within the management team had affected staff confidence and some staff told us they found the changes unsettling. Some staff told us they felt supported through meetings and supervision, however other staff did not.

Overall people, relatives and staff felt there had been some improvements at the home. More staff had been employed and less agency staff were used. There were opportunities for people and staff to raise concerns with the management team.

People and relatives told us people felt safe at the service. Medicines were administered as prescribed, and stored and disposed of safely.

People had opportunities to feedback about the service they received through surveys and meetings.

Staff were trained in safeguarding adults and understood how to protect people from abuse. The provider ensured checks were carried out prior to new staff starting work to minimise the risk of recruiting unsuitable staff.

The management team had identified care records required further improvement and had plans in place to address this area. Audits had been undertaken to check the quality and safety of the service and to identify areas which required improvement.

We found a continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

People and their relatives told us they felt safe at the home. Staff were not always available at the times that people needed them. Risk assessments did not always reflect the current risks to people's health and wellbeing as they had not always been reviewed regularly. However, staff knew the risks, and how to manage them safely, when providing care. Staff knew how to safeguard people from abuse and actions to take if they had concerns. Recruitment checks reduced the risk of unsuitable staff being employed at the service. Medicines were stored safely and given to people as prescribed.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There were mixed views from staff about whether they felt supported by the management team. Staff told us they had found the continued changes in management unsettling. People, relatives and staff were given opportunities to feed back about the service; this was through meetings and surveys. Audits were in place to check the quality and safety of the service. The management team had identified that further work was required to ensure care records accurately reflected people's needs and some improvements had already been made in this area.

Sunrise Operations Knowle Limited

Detailed findings

Background to this inspection

The inspection of Sunrise Operations Knowle Limited commenced on 29 September 2016 and was unannounced. This focused inspection was prompted in part by notification of an incident following which a person died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with us about the incident indicated potential concerns about the management of the risk of falls. This inspection examined those risks. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led?

The inspection team comprised of three inspectors, an inspection manager and two specialist advisors. A specialist advisor is someone who has current and up to date practice in a specific area. One specialist advisor who supported us had experience and knowledge in nursing care for people with dementia. The other specialist advisor had experience and knowledge in physiotherapy and the management of falls.

We reviewed the information we held about the service. We looked at information received from relatives and visitors. We spoke to the local authority safeguarding team and reviewed the statutory notifications the manager had sent us. A statutory notification is information about an important event which the provider is required to send us by law. These may be any changes which relate to the service and can include safeguarding referrals, notifications of deaths and serious injuries.

As this inspection mainly focussed on the Reminiscence Area, some people who lived at the service were unable to tell us about their experiences of the care. We observed the care and support these people received. We spoke with two people who lived at the service, nine relatives, one friend and one professional. We spoke with 17 care staff, three nurses and one maintenance person. We also spoke with the registered manager, a deputy manager, the reminiscence co-ordinator, a national director and a consultant employed by the provider to support the service. We looked at nine care records and other records relating to people's health needs. We looked at the quality assurance checks made by the manager.

Requires Improvement

Is the service safe?

Our findings

This inspection was undertaken in response to concerns received about how the risks associated with people's care were managed. This included people who were at risk of falling. At our last inspection in March 2016 we found that records related to the risks associated with people's care did not reflect the current risks to people's health and well-being and there was a breach of the regulation in relation to good governance. This related to how risks were being managed.

At this visit we looked at whether improvements had been made. We found that some risk assessments, for example to reduce the risk of people falling had been undertaken and management plans were in place to minimise these risks. However, other risk assessments had not been completed on care records or were inaccurate, which posed a risk that some people may not be supported safely.

A falls policy was in place and most staff we spoke with had read this. All staff had been sent a copy by the provider. We reviewed the provider's fall policy dated April 2016. It stated, 'The falls risk assessment and plan should be evaluated every month and completely reviewed if the person has a fall, or has a significant change in their condition. All falls should be recorded in the care records. Where residents are identified as being at risk of falls, the actions required to minimise the risks must be communicated to all relevant staff.' We found that staff were not always following this policy.

For example, we looked at the care records for one person who had recently fallen, their care record had been updated to reflect that this incident had taken place and an accident form was completed. They had experienced two falls in the last six months. Suitable equipment had been provided to support them as they had fallen out of bed. There was no information within their care records to identify that they were at risk of falling or instructions for staff about how to reduce this risk. This person had been assessed as safe to walk with one member of care staff. However on several occasions we saw this person trying to stand and walk on their own, and we observed there were no staff present in the lounge area to assist them. This meant the person was at risk of falling.

For another person their care record stated they had been assessed as, 'no risk' of falls and they had no issues around their balance or 'gait' (the way they walked). At the end of June 2016 it was recorded, 'no falls this month' however, other records showed they had fallen twice in the middle of June 2016. In September 2016, they had fallen four times and had been referred to the falls team. The falls team are a community team of professionals who specialise in supporting people at high risk of falls. A staff member who knew the person well told us, "[Person] has recently been referred to the falls team for two or three falls, it is unusual for them." They told us the person had 'leaned' more recently when walking, however this was not every day. Although staff knew this, this information was not recorded within their care records, therefore there may be an inconsistent approach to how this person was supported by staff.

On another person's care record we saw that they required 30 minute checks to ensure their well – being and safety. We saw this was not happening. We discussed this with a staff member who told us this level of supervision was no longer required, however this had not been updated on their care records.

Another person's falls care record had been updated in September 2016, it stated they required 'assistance of two' when walking. This person had fallen 17 times since March 2016. We asked two staff who knew them well about this. One staff member told us the person could walk with 'supervision' of one member of staff. The other staff member told us they did not need supervision at all, but they would 'keep an eye on them' when walking. We were aware the person chose to walk alone at times, and their mobility varied, however the staff understanding of their needs was inconsistent and did not reflect what was in their care plan.

A 'post falls' protocol was in place which detailed actions staff should take following a fall. As staff told us they regularly supported the same people, they were aware of risks to people and how to minimise these. For example, one person was at risk of falling as they leaned back when walking. Staff were aware of this, and reminded them to learn forward. However, this was not recorded in their risk assessment in relation to their mobility.

A monthly falls analysis was completed for each area of the home and trends analysed. We checked this where people had fallen and found it had been completed correctly for most people. Some staff were completing comprehensive 'train the trainer' courses in 'moving and handling' people so they were able to train other staff in the home. We asked staff how they would support a person if they fell and needed two staff. They responded, "We have the pagers and the sensor mats. If they went off one of us would check. We would call the nurse as well if it did need two people."

Staff had been trained in risk management and falls management and had a good overall understanding of the prevention of falls. On staff member told us about this training, "It was quite interesting. It was things that can contribute to falls. A lot of older people are more prone to falls and it is a lot of environmental factors so they have walking sticks and mobility aids. Footwear is a massive one with residents with dementia. We communicate with the families for the correct footwear."

Risk assessments were in place for areas such as moving and handling, and nutrition. Referrals had been made to other professionals to mitigate risks. For example, some people were at risk of choking when eating. For one person, whose care we followed, an assessment had been completed and a health professional had recommended a special diet. This was detailed in the person's care records, staff were aware of, and provided this.

Some records detailed changes to people's care needs, but not how staff should manage these. For example, for one person a behaviour chart was completed detailing incidents when they became upset with other people, and what triggered this. This was completed, however did not contain any information about how to manage this or techniques to prevent this reoccurring. One health professional told us about the care records they had reviewed, "There is a lot of 'tick boxes' with no elaboration." They told us that a lot of important information and detail about the care was missing. However, they went on to say that staff knew the person they were seeing well, and were attentive to their needs.

Some staff told us they found the care records were confusing and repetitive in places. One staff member told us, "We have to write the same information in up to four separate places if we only put it in one or two, we can get staff saying to us they couldn't find the details, as it wasn't in the notes."

Staff told us they were confident to escalate changes or concerns about people's health and care needs with managers. A staff member told us, "If there is a change in a resident's condition we would report it as quickly as possible so their care plan could be changed."

Staff told us they had time to read care records and comments included, "Most things are recorded in care

plans and we get to know how great the risk is as we get to know the residents better," and "We will reassess if there is a change and it would be documented in the care plans." Staff told us they were aware of the importance of recording information correctly, one staff member told us, "If it isn't in writing, basically it didn't happen." However, records had not always been updated and completed. The registered manager told us further work was being done to improve this, including additional training for staff about the importance of good documentation.

Since our last inspection a new system of recording care information had been introduced with some care records now kept in people's rooms. This meant staff could record directly in them after assisting a person with their care. Staff told us this was working well. One staff member told us, "We have had good feedback and we are really pleased." The feedback had been from managers and other professionals that these records were more accurate. All of the records we checked had been completed correctly and we saw staff completing these immediately after providing the care. The registered manager told us they aimed to have all care records kept in people's rooms, except those people who requested their records be held centrally.

Information about people's care needs was discussed in a 'handover' meeting as the staff shift changed. This was led by the nurse and was to ensure staff were aware of any changes in people's health or care needs, and to provide a continuity of care. Staff told us risks to people were discussed in the handover meeting. The handover meeting format had been recently changed as it had been recognised that this could be improved. This was the first afternoon handover and staff from all floors in Reminiscence were present. We observed the meeting and overall found there was a good sharing of information; however we found some important information had not been communicated. For example, we were aware that one person had fallen during the night and this was not discussed. We raised this with the co-ordinator who told us they would discuss this with staff now.

People told us they felt safe living at the home. Comments included, "The staff ask me if I am happy, I would not be afraid to tell the staff anything." One relative told us, "They look after [person] and know how to move them safely. I wouldn't be at any other home, they are well cared for." One staff member told us, "People are safe because I know carers here do a really good job and we love the residents. Everybody puts in 100% when they are on shift."

Staff had received additional training to keep people safe including first aid, moving people and dementia care. Staff told us, "We have been first aid trained. I felt as lead carer I couldn't help people effectively if I hadn't had this." They had also received training around moving people safely, "We had an outside trainer come in, that was useful."

We received mixed views about whether there were enough staff available to support people to keep them safe. A dependency tool was used to assess staffing numbers in relation to people's care needs. Many people in Reminiscence had high level care needs, requiring supervision of one or two care staff. Some people required continued reassurance from staff, in order to keep them safe.

One relative told us, "Overall it is very good, but they do have issues. It is the staffing levels we are concerned about. We don't think four is enough and at the weekend there are not always four on. If people need to be moved, it takes two people, so you are 50% down straightaway." They went on to say staff were not always present in the lounge area, and at lunchtime if no staff were around, relatives felt unable to leave in case a person fell. Another relative told us they felt their family member was overall safe, however when they had not got enough staff, it was unsafe. Another relative commented that staff were 'always stretched'.

Some people were more positive about staffing levels. One person told us, "I feel safe here, I can't fault the

staff numbers. There is always someone available," and "If I need them at night time they (staff) are there." Another person told us that at times they were short staffed, but mostly it was not a problem. Relatives told us staff were more consistent now with less agency staff used. People told us in the past there had been issues, but recently it had been better and new staff were being recruited.

Staff also had mixed views. Comments included, "Staffing is a joke. We are always short, especially at weekends." "You don't need a degree to work that out, you can see for yourself that there is not enough staff." Other staff told us, "On paper it looks good, but we still seem to be short," and "Everybody would agree we are understaffed."

Other staff were more positive, and told us, "There is enough staff at the moment because the care plans generate the care hours, now they are being done, people are getting more care hours," and "We have seven on here, we are fully staffed. Staffing is a lot better, the pagers are better." A pager was an electronic device used by staff which alerted them when a person pressed a call bell to summon assistance.

Staff told us deployment could be a concern at times, and they were moved between different floors to assist, for example at mealtimes as it could be a 'struggle' to support people with eating their meals. Comments included, "It is really personal care in the mornings which on current staffing levels, is a bit of a rush. We are faced with a decision sometimes whether to leave people in bed and give them breakfast in bed or get them all up which makes breakfast quite late." "The trouble with staffing levels is that we do try and have one member of staff on the floor at all times, which means there are only two people to do personal care." They told us this meant it was difficult to maintain a staff presence in the lounge at all times. Following our visit the registered manager told us that a new rota had been devised which took into account the skill mix of the staff further.

Some staff told us that extra staff had been asked to come in to support on the day of our visit. We asked the registered manager about this and they told us that they had asked extra staff to come in to ensure continuity to the care provided whilst staff were speaking with inspection staff.

We asked the registered manager whether staffing ratios took into account the layout of the building and the levels of people's dementia needs as a group, however they were unsure. Following our inspection they told us that due to the layout of the building extra staff had now been added, to ensure they could support people with their care needs.

A new allocation sheet had been devised to assist staff with division of tasks. This detailed information such as training, professional visits and allocation of pagers. People's dependency levels were reviewed on a given day each month or as their needs changed.

The registered manager told us there were currently two vacancies for registered nurses (one part time) and all vacancies for care staff had now been recruited to. Some bank staff were employed who worked 'as and when' required and regular agency staff. On the day of our visit no agency staff were working. The registered manager explained that some further 'team building' work was being done, so staff felt able to utilise support from staff in the other areas of the home when this was required.

During our observations we found there were not always enough staff available to support people and there were times when people had to wait for assistance. For example, one person was left in the dining room after lunch and it was clear this person required support with personal care. Staff were aware of this person, but were unable to support them as they required the support of two staff, and this meant the person had to wait. There were periods of time where there were no staff present in the lounge areas to support people,

who required supervision, as they tried to stand. We observed no staff were present for a 10 minute period to support people, and one person had to wait for 20 minutes to go to the toilet. Staff told us that due to the new handover system, this had delayed the afternoon staff working on the floor that day.

We observed relatives supporting their family members to eat lunch and staff were busy trying to support people effectively. We observed a consultant appointed by the provider tidying the dining room and they told us they had identified this was a difficult time and had put the case for a dining room assistant to support the lunch time period. The registered manager told us that relatives that came into support their family members did this as they liked to do this and this was not due to staffing levels.

Staff in all areas supported people gently, respectfully and with a caring manner. Staff used reassurance and distraction techniques. One relative told us, "I like all the staff, they are very loving towards [person]. I enjoy coming here, its very family orientated." We observed staff safely moving people and taking time to do this. For example, for people who were hoisted, staff ensured they removed their hoisting 'sling' correctly when they were seated to ensure they were comfortable. Lots of encouragement was offered and reassurance. Staff talked to one person who was upset in a soothing voice to calm them. We heard happy banter with staff, people and relatives. Staff did not rush people and they were supported at their own pace.

Checks were in place to ensure when new staff started they were suitable to work with people at the home. One relative told us, "I think it's pretty good, carers are well vetted." Disclosure barring service checks and references had been completed and we saw these on two staff files. The disclosure barring service helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services.

All staff received an individualised induction based on their role when they first started and this included agency staff. Staff were positive about this. One staff member told us, "The new staff have got a much better induction programme. it is a much longer process. I think they have to shadow for two weeks." Nurse mentors were also in place to support new clinical staff.

At our previous inspection we looked at the management of medicines and found they were administered, stored and disposed of safely. At this visit we found medicine management continued to be safe. Comments included, "I get my medicines on time and staff get me pain killers if I need them," and "[Person] gets their pain relief on time and in between if needed." One relative told us their family member had 'time specific' medicine and received this at the correct time. This was important as their health condition could be affected if this did not happen.

Medicines were administered by medicine technicians and nurses. Medicine technicians are care staff with additional training in this area. Detailed guidelines were in place for people who required medicine 'as required' so staff were able to know, for example, if they were in pain, if they could not tell staff.

In the Reminiscence area, staff supported people with medicines at their preferred pace. One staff member told us, "A morning round can take between an hour and two hours. It depends day to day with our residents because some need a lot of encouragement." We observed people taking their medicine from staff who sought their consent and encouraged people to take this in their own time. We observed one person was reluctant to take their pain killing medicine. The member of staff spent several minutes trying to persuade them to take this and did not rush them. Monthly medicine audits were completed by senior staff to identify any areas for improvement. We looked at the medicine administration records and found these had been completed correctly.

However, in one instance we found a person had received an additional painkiller during the night which was above their prescribed amount. This posed a risk of harm to the person from receiving an overdose of this medicine. We raised this with a staff member who addressed this immediately by speaking with the GP and also the person's family to inform them. Further training support was to be given to the staff member who made the error to ensure this did not reoccur. Any medicine errors were recorded to identify any patterns or trends. An audit from a pharmacy had been completed. This was positive and had some minor suggestions such as staff were to ensure details were recorded more thoroughly if medicines were discontinued.

Staff received training in administration of medicines. Staff administering medicines told us they were confident with ordering and ensuring the availability of medicines for people. No one in the Reminiscence area self-medicated.

Staff understood how to safeguard people and had received training in relation to this. Staff completed safeguarding e-learning every six months. One staff member told us, "All new starters get it before they can work on the floor." Another staff told us, "Safeguarding training is done on line." Some staff told us that they preferred 'face to face' training.

Staff were able to tell us about safeguarding and whistleblowing. Whistleblowing is when staff raise concerns in relation to the service where they are employed. Policies were in place to tell staff what to do if they had any concerns. One staff member told us, "All that information is in the Sunrise handbook which we are given when we start working here."

Staff were knowledgeable about the safeguarding process and different types of abuse. Comments included, "It can include unexplained injuries or any altercation between residents. We must report that to the managers" and "Anything from marks on their body which are unknown, any physical abuse or with another resident or concerns about their wellbeing. Sometimes it can be financial."

Staff told us what action they would take if they had concerns, "I would report it straightaway and remove [person] from that resident," and, "I would reassure the service user and report it to the manager." Staff told us they would deal with poor practice of other staff by speaking with a manager and suggesting the staff member might require further training.

Checks had been undertaken to assess the safety of the service. Accidents and incidents were recorded, and these were analysed to identify any trends which may assist staff in preventing recurrences. Staff told us actions to take following an accident, "We would contact the nurse, then will check them over. If there isn't a serious injury we will fill in an incident form, put it on the falls tracker and inform the family."

Personal emergency evacuation plans were on people's care records and these documented people's care needs for staff to keep them safe in the event of an emergency, such as a fire.

Equipment was available to support people who required this, such as sensor mats for people at risk of falls. We saw that there was a system in place to check this equipment was safe, and that this had been completed. Staff had received further training about usage and storage of mats and the maintenance person told us this had improved. The maintenance person told us that staff were good at reporting any issues with equipment. Some new equipment had been ordered following some safety concerns, and staff were awaiting further training for this.

At our previous visits, concerns had been raised about the numbers of staff pagers, staff knowledge of how

to use them and their effectiveness. At this visit staff told us that not all of them had pagers, but they felt they should do. The registered manager told, "We are working on this issue. We are ordering more." They explained that some had been lost or broken. Audits were being completed on times staff took to answer calls and checks on pagers. Pagers were now allocated to each floor.

Two maintenance people were employed by the service and they checked areas such as legionella testing, fire alarm testing, fire drills and electrical testing. We found these checks had been completed.

Requires Improvement

Is the service well-led?

Our findings

This inspection was undertaken in response to concerns received about how the risks associated with people's care were managed. This included people who were at risk of falling.

At our last inspection in March 2016 we rated the service as requires improvement overall. We found there was a breach in the legal requirements and Regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to good governance. Systems and processes to monitor and improve the quality and safety of services provided, and to manage risks related to the health, safety and welfare of people, were not established. This included records not always being sufficiently detailed and accurate to support safe and appropriate care.

At this inspection we found that whilst some improvements had been made, further improvements were still required. Some systems were now established; however some care records including falls risk assessments were not always sufficiently detailed and accurate to support safe and appropriate care. This demonstrated that the provider's falls policy was not always being followed and there was a risk that people would receive inconsistent care and support to maintain their safety. Some risk assessments had not been completed on care records and some were incorrect or out of date. Care records did not always document ways staff could manage or prevent behaviours re-occurring. Some staff told us they found the records confusing and the registered manager told us further work was required to improve care recording.

The registered manager told us, "We have been focussing on staffing, medicines and record keeping. We have tried to update records. I have been expressing my concerns that we are not moving quickly enough." They went on to say, "Documentation is an area we know we need to improve on." Further work was being completed in this area.

During the inspection period, the Clinical Commissioning Group (CCG) visited the home and identified that 14 people had not been correctly assessed as they were entitled to, in relation to the level of nursing care and funding they required. Some nursing staff had not received training in identifying when people required more complex nursing care, so there was a risk that people were not always receiving the correct level of nursing support or financial assistance based on their needs. The CCG told us that nurses had not undertaken training in how to complete the nursing care checklists and at the time of our inspection this task was the responsibility of the management team. This was raised with the registered manager by the CCG.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Since our last visit the manager had registered with us. They told us they were committed to the continual improvement of the service and the care people received. A new general manager was in post to manage the Reminiscence area and had been in post for four weeks and one new deputy manager had recently joined the service. In addition, a senior staff member from the provider's team had been supporting them.

One co-ordinator was moving into a role as 'clinical lead' to provide additional support to nurses.

The provider had appointed a consultancy company to provide support to staff and managers through observations and supervision. Staff had been given guidance by the consultants around better ways of working, including in areas such as medicines, dignity of people and use of staff pagers. The consultants had also been working in conjunction with a national pharmacy. The consultant told us that whilst they were observing, they would stop and help staff practically if required with the care. The consultants supported the service for 18 hours a day and this was an on-going arrangement currently. One consultant told us there were no plans for them to finish this role until they, and the staff, felt that practice had improved. They told us, "I am quite proud of the staff and how they have taken the feedback, it's an investment in Knowle to get it right." Staff were positive about this support, a staff member said, "We hear of these consultants who are walking round. It is scary because you concentrate on trying to make sure it is perfect. It is good in a way because if there is a better way of doing something, it is good to be told."

Relatives had mixed views about the management changes at the service. One relative told us, "In the last 12 months there have been lots of managerial changes." Other comments included, "I would say the managers are fairly open. I think they struggle to keep good management here for any lengthy period."

People told us the managers were available to speak with and listened to concerns raised. Comments included, "We feel able to raise issues, but whether things are carried out is another matter," "I can raise any concerns with whoever is in charge," and "They are easily accessible, you can always get hold of somebody."

People told us they felt the home was improving. One person told us, "I think it is improving. I do think from when we came, there has been improvements," "I would give the management eight out of ten." And "Overall it's a good team and our welfare is at heart."

Some staff felt further improvements were required in relation to communication. Comments included, "There is no communication, always changes and we don't get told. We weren't told about the consultants." And "If you raise concerns nothing gets done. I would like more communication and appreciation." The registered manager told us that staff meetings were held, however attendance could be poor. Minutes of these meeting were available to staff however. Handover meetings and staff listening groups were also arranged to support staff further.

Staff felt the continuing changes in the management team impacted on them. Comments included, "We get quite a lot of turnaround on management. If management leaves it unsettles everybody. Not just us, but relatives because they need to build a bond with management and know they can communicate with them," and "It is a rollercoaster ride. There is a huge turnover in management." Since the recent manager had left Reminiscence, some staff told us they felt less confident within their job roles.

Overall staff felt the management team were approachable, one staff member told us, "I feel I could go to them if I had concerns." Staff told us they were encouraged to be open, "We always get told CQC are in and you can say what you want to them." "The managers have always said we should go to them if we are concerned about something so they can give us the support we need." However, one staff member said they would not raise concerns because they felt this would not always be confidential. Another staff member felt they could raise concerns about people at the home, but not about other staff or managers because they did not feel this would be listened to.

Some staff told us how they were passionate about their jobs and ensuring they provided a good service. They told us that overall Sunrise Knowle was 'homely' and a nice place to work. Comments included, "The

staff here genuinely care for the residents." "It has had its ups and downs but I have noticed a change in the last year. We are being listened to and there are positive changes." "I would like to say a lot has changed. We are aware of mistakes made and things that haven't been done." Staff told us a lot of changes had taken place and staff morale had improved.

At our previous visit, staff had not always been supported with one to one supervision meetings or staff meetings. This meant that they had not had the opportunity to put forward their suggestions about the running of the service. Most staff felt this had improved, although some told us it had not. One staff member told us, "I last had my supervision about four or five months ago. Our first point of call is [co-ordinator]. It is a lot better than before." Other comments included, "We have them every six months, but they are trying to do it every month. Seniors can give a supervision as well if they feel somebody needs one." "We are meant to have them every three months. I haven't had one for ages." Some nurses had received 'topic specific' supervision meetings on request, in areas such as nutrition and skin care.

Some group supervision meetings of care staff had been held and areas such as supporting people living with dementia were discussed. One staff member told us, "It is knowing to keep communicating in a calm tone." Changes to staff handover had been discussed in another group supervision. Another staff member told us, "We have had group supervisions with some of the managers. One to one supervisions aren't as frequent as I would like."

Some senior staff felt they would like further training to carry out the supervision meetings. Comments included, "Something I would appreciate is a bit more training myself to give supervisions to other people," and "If ever I felt I needed to give a supervision, I would make sure I was comfortable with the process and consult a manager." The registered manager told us training had been arranged for senior care staff to carry out supervisions. Appraisals were being completed so staff were able to discuss their development, goals and training needs.

Some staff told us the training they received when they became a senior care worker could be improved. One senior worker told us they had asked for more training to do this, but had not received any. They also told us they had not received any training around updating the care records or in relation to the system which assessed people's care needs.

A 'heart and soul' staff award was in place to celebrate staff achievements. The registered manager explained this was to give positive feedback to staff. They told us, "People need to know they are supported, we've worked quite hard to do that." One staff member told us about the awards, they felt this was more feedback from other staff rather than managers.

People and their relatives had some opportunities to be involved in the running of the service. A family and friends meeting had taken place in July 2016. One comment was that deployment of staff at lunchtime needed to reviewed, so there would be enough of them to assist people with eating. This feedback reflected our inspection findings and that improvements were required in this area.

People and relatives told us about the meeting and that some issues had been raised about staffing, comments included, "We try to encourage them to use permanent staff rather than agency; it seems to be mostly at the weekends," and, "We go to monthly meetings and we always challenge them on numbers particularly when there is a lot of agency staff at weekends. It is the first time in the last meeting when they declared what the numbers should be as far as they were concerned." Other comments were positive, "There are monthly relative meetings and you can discuss concerns and they will sort things out." "It's very well run…they answer any questions I have and any complaints you can speak to any supervisors and they

deal with it. I have no complaints at all." Following our visit the registered manager provided us with additional minutes from the October 2016 meeting where managerial changes were discussed and staffing, and over 40 people or their relatives attended.

A relatives' steering group met on the day of our visit. This group consisted of four relatives and senior management. It was discussed by the registered manager that they were arranging for more staff to be available to support people at mealtimes. At their previous meeting in March 2016 they had discussed that fewer agency staff were being used. A further meeting had discussed the new care folders in people's rooms and the use of consultants at the home.

A staff meeting was held in September 2016 and they discussed staff breaks and staffing allocations. One staff member told us, "We have staff meetings. They aren't that regular though. You don't really get feedback, but I guess that is what supervisions and appraisals are for."

Senior managers had undertaken listening groups for staff so they were able to feedback directly any concerns. The registered manager told us the uptake of this had not been high, so the manager's had then talked directly to individual staff. Staff surveys had been completed and we saw 62% of staff felt the service had changed for the better in the last 12 months.

The registered manager told us about challenges at the service, they said, "The next step is training staff further, we have key areas for senior carers. We want to keep on top of recruitment, we have some turnover of staff and we want to look at how we retain staff. Also staff morale, this can fluctuate on different days."

Audits of the quality and safety of the service were undertaken by the management team. Audits were completed in areas such as falls and medicines. Daily management meetings took place. We observed this on the day of our visit and accident and incidents forms were reviewed. It was identified one person's form had not been completed correctly and this was to be followed up after the meeting. Reviews of some care plans had been completed by the management team. This was an area where further work was being undertaken by the consultancy company to make improvement in the recording of care.

A manager daily walk around of the service highlighted some issues such as staff practice and equipment which had not been stored correctly. Observations were also carried out by senior staff. One staff member told us, "We do walk around and make sure everything is neat and tidy and as it should be."

The manager was able to tell us which notifications they were required to send to us so we were able to monitor any changes with the service. We were aware we had not received one safeguarding notification and the registered manager told us they would ensure we received this now.

The provider has a legal duty to display their last inspection rating. On the day of our visit we saw the rating for the service was on display, however this was in black and white and was not conspicuous. We asked the registered manager for the rating to be displayed in colour and they told us this would be changed.

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 17 HSCA RA Regulations 2014 Good governance Systems or processes were not always established and operated effectively. An accurate and complete record of each service user, their care and treatment was not always maintained. This included records relating to risks to the health, safety and welfare of service users, and how to mitigate these.