Sunrise Operations Sonning 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

Overall summary

This inspection took place on 18 August 2015 and was unannounced. This was a comprehensive inspection which included follow-up of progress on the non-compliance identified in the reports of the previous inspection on 8 and 10 December 2014 and at the 'Warning Notice' follow-up inspection on 11 May 2015.

At the previous comprehensive inspection we identified non-compliance against Regulations 9 (Care and welfare of service users), 10 (Assessing and monitoring the quality of service provision), 12 (Cleanliness and infection control), 13 (Management of medicines), 14 (Meeting nutritional needs), 18 (Consent to care and treatment), 20 (Records), 21, (Requirements relating to workers) and 22 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Summary of findings

From April 2015, the 2010 Regulations were superseded by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider was meeting the requirements of the comparable current regulations. Regulations 9 (Person-centred care), 17 (Good governance), 12 (Safe care and treatment), 14 (Meeting nutritional and hydration needs), 11 (Need for consent), 19 (Fit and proper persons employed) and 18 (Staffing).

The service provides care or nursing care to up to 103 older people, some of whom are living with dementia. The building is divided into two units. The ground and first floors (known as assisted living), accommodate people with care and nursing needs, some of whom may be living with the early stages of dementia. The second floor (known as reminiscence), accommodates people living with dementia. Communal areas are available for people on all floors. At the time of this inspection the service was supporting 83 people and a further two people were in hospital.

The service is required to have a registered manager but had not had one since the departure of the previous registered manager in May 2014. The current general manager was in the process of applying to become registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Significant improvements had been made in the areas previously highlighted to be of concern. Permanent staffing levels were improving and staff were more enthusiastic and motivated. People, relatives and staff reported positively on the changes made in the service and the new management. People felt safe and told us staff were more attentive and quicker to respond.

We saw that people's care plans and associated records had improved and were now maintained up-to-date by regular interim updates in between reviews. Where people needed additional support around wound care, hydration or nutrition, this had been identified and records were used effectively to monitor changes. Medicines management was managed effectively and any errors or omissions were identified in a timely way so they could be addressed.

Support was sought from external health agencies and others in a timely way. The service had engaged with the local authority care home support team for advice and development. Where issues had arisen with external agencies the manager was actively addressing these. Staff training had improved and support through supervision, appraisal and regular meetings were all improving.

People were involved in planning their care and were encouraged to make decisions about their day-to-day care. People's dignity, privacy and rights were protected. People's consent was sought by staff before care was provided. A wide range of activities and opportunities for social interaction were provided and people's views about the service were sought and acted upon.

The service was well led with staff knowing what was expected of them. The operation of the service was effectively monitored by the general manager and the registered provider and action was taken to address identified shortfalls.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Good

Improvements had been made to permanent staffing levels and recruitment records.

Infection control and medicines management had improved and were better monitored to reduce the risk to people.

Additional training had been provided in key areas relating to safety and staff competency had been assessed.

Is the service effective?
The service was effective.

Good

People's hydration and nutrition needs and wound care were identified, monitored and managed effectively. Appropriate training was provided to staff to equip them with the necessary skills.

Staff awareness and recording of people's consent had improved and staff actively sought consent in the course of providing care and treatment.

Understanding of people's rights, where they lacked capacity had improved and decisions made in people's best interests were recorded.

Staff support through supervision, appraisals and meetings had improved and was continuing to do so.

Is the service caring?
The service was caring.

Good

People were treated with dignity. Their privacy and rights were respected. People felt the attitude and approach of staff had improved.

People or their representatives were involved in decisions about their care.

People were encouraged to be involved in their day-to-day care.

Is the service responsive?
The service was responsive.

Good

People and their representatives were involved in assessment and care planning.

Their preferences and wishes were respected and a wide range of activities, events and outings were available. People's involvement in social activities was monitored.

Staff responded to people's needs in a timely way and had access to accurate information about them which was regularly reviewed.

People's views about the service were sought through surveys, resident's committee meetings and comment cards. Complaints were addressed and monitored to identify themes.

Summary of findings

Is the service well-led?

Good

The service was well led.

The general manager and provider had established/re-established a range of appropriate monitoring and audit tools to oversee the operation of the service. Action had been taken to address the issues identified.

The morale of staff had improved since the appointment of the general manager and staff felt more motivated.

The accuracy of people's records had been improved through more regular and effective review and monitoring.

The general manager was in the process of applying to become registered manager.

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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 18 August 2015 and was unannounced. The inspection was carried out by three inspectors and a specialist advisor with experience in dementia care and complex healthcare issues.

This was a comprehensive inspection which included follow-up of progress on the non-compliance

identified in the reports of the previous inspection on 8 and 10 December 2014 and the progress identified at the 'Warning Notice' follow-up inspection on 11 May 2015. Where applicable we have referred back to these previous inspections to report the progress made since those visits.

Prior to the inspection we reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

We contacted the local authority care commissioners to obtain feedback from them about the service. During the inspection we spoke with nine staff and the general manager who has applied to become the registered manager. We also spoke with ten people using the service, four relatives and a visiting community nurse. We used the Short Observational Framework for Inspection (SOFI) as well as observing care informally during the inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care plans and/or associated records for 18 people, including risk assessments and reviews, and related this to the care observed. We examined a sample of other records to do with the home's operation including staff records, complaints, surveys and various monitoring and audit tools. We looked at the recruitment records for four recently appointed staff.

Good

Is the service safe?

Our findings

At our last comprehensive inspection of 8 and 10 December 2014 the provider was not meeting the requirements of Regulations 12, 13, 21 and 22, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond to Regulations 12 (Safe care and treatment), 18 (Staffing) and 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated "Inadequate" for "Is the service safe". A warning notice was issued against Regulation 13 (Management of medicines in January 2015.

People had not been safeguarded from risks associated with the management of their medicines. People had not been safeguarded through the provision of sufficient suitably qualified and experienced staff. Recruitment procedures had not been sufficiently robust. People were put at potential risk because staff did not always follow appropriate infection control practices.

The provider sent us an action plan in April 2015 identifying the actions they would take to achieve compliance. The provider also sought advice from the local authority 'care home support team' in working towards compliance. When we visited on 11 May 2015 to follow up the warning notice regarding the management of medicines we found the service no longer in breach of the then Regulation 13. However some improvements were still required and the service was rated "Requires improvement" for "Is the service safe".

At this inspection on 18 August 2015 we found that the provider was meeting the requirements of the current regulations.

People told us they felt safe in the home. Three people said, ''I feel very safe here''. Another said, ''Oh yes I'm perfectly safe'' and another told us they had never been abused in any way and had never witnessed anything they were uncomfortable with. They added that they, ''most certainly wouldn't tolerate such a thing''. A family member told us they had every confidence in the staff and left their family member in the service's care without worrying about their safety.

Since the last inspection some safeguarding issues had arisen which had been followed up by the local authority. Some concern remained about whether incidents were seen in isolation and whether improvements in response to these concerns would be generalised and sustained. We found that in the case of three of these events, which related to one person's changing needs, appropriate steps had been taken. The provider had reported incidents appropriately. Discussions had begun about whether the service could continue to meet the person's needs in the long term. In the meantime, additional staffing had been provided to support the person to manage their behaviour and to maintain the safety of others.

In another example, a relative had expressed some safety and other concerns about the service. A meeting had taken place between them and the deputy manager which had reassured them that appropriate action was being taken to address these. One medicines omission had been reported by the service to the local authority safeguarding team and the Commission. Staff retraining and reassessment of competence had been put in place and discussions had taken place with the supplying pharmacy to improve communication. Medicines monitoring and audit systems had been reviewed and improved and 'do not interrupt' tabards obtained for staff engaged in medicines administration. Two safeguarding matters, relating to historical events, were still under investigation.

Staff had a good understanding of safeguarding and whistle-blowing and were aware of the procedures. One staff member told us that safeguarding procedures were: "put into place to protect people and keep them safe". Another said of whistle blowing that: "it's an ability to report something wrong, whilst keeping your privacy as staff, remaining confidential".

People's files contained appropriate risk assessments addressing identified areas of potential risk. These included issues such as risks of falls, dehydration, malnutrition and pressure ulcers. The risk assessments were linked with care plans through identifying appropriate actions to mitigate the identified risk or treat the resulting concern. For example, where a risk of inadequate dietary or fluid intake was identified, people's intake had been monitored through food or fluid charts. Risk assessments were reviewed regularly and updated where necessary to reflect changes. This was done through monthly hand-written updates which were then included in an updated document every six months. One staff member told us they had raised a concern about the need for risk assessments for use of the stairs for some people and said this had been actioned immediately.

Good

Is the service safe?

People identified as at risk of falls from their bed had been supplied with lower beds and/or floor mats to reduce the risk of injury. The general manager told us the service chose not to use raised bed sides as these could themselves present additional risks to people.

The service was still using agency staff to cover shortfalls pending further recruitment. To improve consistency and continuity they were using regular staff from a single agency wherever possible. The general manager had recently met with the supplying staff agency to discuss issues and agree standards of service. The agency had provided a staff member to work within the service to oversee the performance of its staff. The service was negotiating for specific agency staff who would then be provided with Sunrise induction training. The service received appropriate evidence from the employing agency, of people's suitability, experience and training to perform their duties.

The general manager had pursued a salary review to support nurse recruitment and the home was only using one agency nurse now, having successfully recruited to other nursing posts. The newly appointed nurse whose specialism was tissue viability to enhance expertise within the team. The recently appointed deputy manager was also a nurse. People had been recruited to other key posts including those of 'assisted living coordinator' and 'reminiscence coordinator'. Appropriate disciplinary action had been taken where necessary to safeguard people.

The general manager told us care staff recruitment and retention were improving and some staff who had previously left, were returning to the home. Some turnover was still occurring but we saw that staff on duty were engaging with people and had a positive opinion of the direction things were going. Vacancy levels were monitored and discussed daily by management. The general manager acknowledged that addressing recruitment had taken some time and said she wanted to employ the right people, not rush just to fill vacant posts.

Previous concerns about recruitment practice had been addressed. The recruitment records for four recently recruited staff were examined. They contained the required evidence to demonstrate that the process was robust in order to safeguard people from unsuitable staff being employed. One staff member told us that recruitment was thorough and the service aimed to make sure they obtained: "the right person for the job".

The regular staffing levels in 'assisted living' were nine care staff and either one or two nurses on the morning shift and seven care staff and one or two nurses on the late shift. The deputy manager and care coordinator were also based in this unit. The 'reminiscence' unit staffing was seven care staff in the morning and six in the afternoon/evening, with three care staff at night. At the time of inspection, this was supplemented by an additional care staff supporting one person on a one-to-one basis. At night there were three care staff and a nurse in the 'assisted living' unit and three care staff in the 'reminiscence' unit. The general manager had the authority to increase staffing levels by up to 10% at her discretion where necessary, without requiring external authorisation. She also had additional flexibility to address additional care needs which arose which were not covered by current fees. The staffing needs of the service were reviewed weekly. We saw that for the 83 people currently receiving care, the current staffing levels were sufficient to meet people's needs including at mealtimes.

People were given medicines by nurses or trained 'Medicines technician' care staff. Three separate medicines trolleys were used, reflecting the staff team's responsibilities across the home. These were stored securely when not in use. Medicines to be given at specific times were identified, so their administration was prioritised and the time of administration was recorded.

People's medicines record included a photograph to confirm identity and identified their preferred way of taking the medicine and any relevant special instructions. The medicines administration record (MAR) sheets we saw had no gaps in records. Where changes had been made to MAR sheets each was countersigned by a second staff member to confirm the accuracy of the content. Where people had medicines prescribed 'as required' there was generally a written protocol for how the need for them should be established. Records were checked at the end of each medicines round to identify any issues and allow them to be addressed in a timely way. Medicines were individually prepared and offered to people to take it themselves with a drink provided. The administration record was completed after each event.

The service did not use a monitored dosage system. A monitored dosage system provides medicines pre-packaged by the pharmacy in blister packs separated by the due dates and times of administration according to the prescription. Instead, medicines were kept in their

Good

Is the service safe?

original packets or bottles as supplied by the pharmacy. The staff felt this complicated medicines administration. Remaining tablets were individually counted after each administration to check remaining stock as part of the in-house auditing process so the system was robust, if time consuming. This was passed on to the general manager.

The staff confirmed they had received medicines training and had their competency assessed. We noted that the GP instructions for one person's paracetamol were not specific enough and they had been given doses at slightly less than the generally recommended time gap. One other person's medicines instructions needed additional clarity about what constituted agitation, to determine when it was appropriate to administer and reduce the risk of over-medication. This information was present in their care plan but this would not necessarily be referred to each time administration was being considered. Covert medicines were only given following a 'best interests' decision. Controlled medicines were stored and administered safely according to the medication administration policy and procedure. People could manage their own medicines following a risk assessment if they wanted and were able to.

The pharmacy audit on 10th June 2015 identified a number of issues which required action. The development plan for the service and the action plan from the previous inspection included reference to various improvements such as improving practice around the return of unused medicines. A new returns book had been obtained to facilitate this. The medicines administration record format had also been improved and identified medicines errors or omissions were now monitored, discussed and analysed to identify any learning. Representations had been made to the GP regarding clearer guidance for staff on 'as required' medicines.

Nurses and other staff responsible for administering medicines had recently been provided with a medicines training update by the pharmacist. These and the other improvements in medicines management and monitoring had reduced the risk of errors. Staff responsible for administering medicines also had written guidance on the new procedures. The start and end times of medicines rounds were also now recorded to monitor for any issues with undue delay in administration which could impact on appropriate dosage spacing or time-critical medicines.

An audit had taken place in May 2015 in response to the concerns raised about risks due to infection control practice. The action plan identified a range of actions to improve practice although these were not signed off as completed on the copy provided. The service development plan made reference to arranging training on effective handwashing technique for staff to assist with infection control. Staff had recently received this training which would be passed on to new recruits. Equipment had been purchased to enable ongoing monitoring of hand-washing efficiency.

The action plan from the last inspection referred to the provision of handwashing guidance to staff and people in the service and this had been provided in bathrooms and toilets. Advice and information had been obtained from suppliers with regard to the use of cleaning chemicals. Daily audits of cleanliness were now being completed sampling different parts of the service in rotation and monthly infection control audits had been introduced.

People within the service had raised a question about the cause of a recent outbreak of illness there. Discussion had helped identify some issues which were subsequently addressed. People were told about some of the steps being taken, including the handwashing and other infection control training and the appointment of four infection control 'champions' in the staff team. People were encouraged to raise any infection control concerns with the general manager, deputy manager or infection control champions.

The provider had recently asked managers to complete an audit of commode and shower chairs across its services to identify and replace any which might compromise infection control. This was in process at the time of inspection so the outcome was not yet known.

Good

Is the service effective?

Our findings

At our last comprehensive inspection of 8 and 10 December 2014 the provider was not meeting the relevant requirements of the then Regulations 9, 14 and 18, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond to Regulations 9 (Person-centred care), 14 (Meeting nutritional and hydration needs) and 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated "Inadequate" for "Is the service effective". A warning notice was issued against the then Regulation 9 (Care and Welfare of people who use services) in January 2015.

People had not been protected from the risks of inadequate nutrition and hydration. Their food and fluid intake was not always effectively monitored and those at risk of malnutrition or dehydration were not effectively identified. People had not been supported to consent to their care. Systems in place to establish who could legally consent on behalf of people unable to do so, were not robust. Arrangements to identify and act in accordance with, people's best interests were not robust. The care and monitoring of people with wounds or skin pressure damage was not effective.

The provider sent us an action plan in April 2015 identifying the actions they would take to achieve compliance. The provider also sought advice from the local authority 'care home support team' in working towards compliance. When we visited on 11 May 2015 to follow up the warning notice we found the service was no longer in breach of the then Regulation 9. However some improvements were still required and the service was rated "Requires improvement" for "Is the service effective".

At this inspection on 18 August 2015 we found that the provider was meeting the requirements of the current regulations. Since the last inspection, significant improvements had been made in all of the above areas.

Staff understanding and knowledge of the people they supported was good. They were able to understand the reason behind the training provided and how it related to the people for whom they provided care. Records showed a rolling programme of training was provided. Recent recruits had yet to complete their induction and all of the listed training but others were up to date or had a deadline date identified. Training gaps were being monitored during supervision to ensure staff undertook any required updates. A lot of training updates were provided through computer-based learning including written testing. One staff member, who stared work in March 2015 had yet to have their induction signed off as completed. Other induction records we saw had been signed of within a reasonable period. Staff confirmed they received the required training at induction and completed refreshers thereafter. Training support had been sought from the local authority and some sessions were already booked. New staff would be required to complete the new 'care certificate' induction within 12 weeks of starting work.

Training impact was being assessed through competency assessment in key areas. Two staff had attended training to enable them to train team members on moving and handling and carry out their competency assessments. This meant this training could be delivered when necessary, rather than awaiting an available external course. The 'community development plan' for the service included various aspects of training, most of which had already been signed off as completed. A new provider 'Dementia pathway' training programme was due to be rolled out for all staff.

New staff completed a period of shadowing experienced staff before starting regular duties. Staff told us that they undertook mandatory training daily throughout their first week of employment and that this was refreshed annually. Staff also told us they were supported through supervision and had appraisals to review their progress and identify any additional training needs. Daily 'huddle' meetings took place between management and senior staff to communicate any relevant issues. Daily handover meetings took place for care staff between shifts to support continuity of care. Nurses received clinical supervision from qualified colleagues. The manager had secured funding to appoint a senior clinical specialist on tissue viability to augment nursing expertise.

A relative was happy that staff appeared to be improving and felt that this was due, in part, to improved training. They gave the example that staff had been timely in identifying the early stages of dementia in their relative. The relative was aware the home had an issue with getting the GP to visit when asked. But felt the service was acting to address it.

Good

Is the service effective?

The general manager acknowledged that gaps in staff supervision and appraisal were still an issue but these were being actively pursued and monitored to address the shortfall. We saw that supervision regularity had increased since the general manager came into post. The 'Clinical governance meeting' minutes for June 2015 identified that supervision and appraisal was then at 30% completed. Significant further progress had been made since then and around 55% of staff had attended supervision since May 2015.

People's files included capacity assessments under the Mental Capacity Act 2005 (MCA) where there was some question about capacity. The MCA provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The MCA also requires that any decisions made in line with the MCA, on behalf of a person who lacks capacity, are made in the person's best interests. Files included evidence of best interests meetings where appropriate, to make decisions about people's care and welfare. The office administrator was not fully aware of whether people had appointed someone with 'power of attorney' (POA) (a person who could legally make financial decisions on their behalf). However, people's files generally contained evidence confirming this where POA had been granted. The service did not act on behalf of any one who lives in the home with regard to their finances. A limited amount of cash was held at individual's request, for safe keeping. People signed for their money when they withdrew it to ensure monies could be accounted for.

Where people would be unable to leave the service safely without supervision or had their liberty otherwise restricted, a service must apply to the local authority for a 'Deprivation of Liberty Safeguards' (DoLS) authorisation. DoLS authorisations are provided under the MCA to safeguard people from illegal restrictions on their liberty. People had DoLS authorisations on file where appropriate. Where DoLS authorisations had expired they were being renewed. The manager maintained a list of people with DoLS authorisations to monitor this, which showed that renewal requests had been sent where due.

Sixteen of the people in the reminiscence unit and 13 in 'assisted living' had forms in place regarding non-resuscitation in the event of heart failure. Most included reference to appropriate discussion either with the person or their representatives. Most files contained written evidence of consent being sought to people's care, including signing their care plans. Some care plans were only signed by staff. People's consent was also sought by staff when providing day-to-day care.

Staff told us that where possible, consent was sought direct from people where they were: "verbally able". Visual cards had sometimes been used to obtain consent. If a person did not want to be supported staff said: "we leave them, try a different staff". Staff said they sometimes discussed issues with the person's relative to find: "ways to motivate" people.

Where people required staff support to manage their behaviour this was identified and the support required was described in their care plans. Behaviour management information included details of how to engage with the person to try to distract or divert them to a positive activity. One person was supported one-to-one by staff to safeguard them and others. The service did not usually use physical intervention except in emergency. Where other forms of potential restraint were used, such as wheelchair lap belts and the placing of beds against a wall, these were recognised as such by the service. They were discussed within clinical governance meetings and the existence of appropriate consent noted.

Significant improvements had been made in the area of nutrition and hydration support and monitoring. A range of improvement areas had been identified in the action plan from the previous inspection, which had now been implemented. Training on malnutrition screening and nutritional care was being provided to all staff. One staff member told us that two people had issues with eating and referrals had been made to the 'speech and language' (SALT) team. They said the service had worked with the SALT team, sought advice and now thickened these people's fluids, which had led to healthy weight gain.

People's care plans included food and fluid charts and other daily monitoring records, if required by the individual. These were up-to-date and accurate. The reason for the chart, the person's individual intake requirement and action to take if it was not met, were noted on the records. These were linked to appropriate malnutrition risk assessments. The records made it clear what staff should record and why. People's weight was regularly monitored, and increased from monthly to weekly checks where people were considered to be at high risk.

Good

Is the service effective?

People were helped to eat their meals as required and in accordance with their plans of care. Staff were patient and positive when encouraging people to eat. They used positive body language such as smiling and nodding and positive verbal encouragement such as, ''well done'' and, ''that's a great effort''. People responded to the positive interactions with staff and visitors. The lunchtime service was calm and enjoyable for most people.

One person told us that the food had improved over the last few months but there was not enough fresh food, particularly greens provided. This was not a view held by others and fresh fruit and salad were available at every meal. Bowls of fresh fruit and other snacks and drinks were available in the 'bistro' area where people or relatives could help themselves to whatever they wanted.

People's files contained details of specific dietary needs, allergies, likes and dislikes. This information was posted in the kitchen for access by catering staff. Referrals were made to a dietitian where concerns had been identified. A meeting took place in July to discuss the menus with people and kitchen staff had been provided with updates about people's wishes and needs.

People receiving nursing care had their respiration, blood pressure, pulse and temperature routinely monitored to identify changes in health. One person had been referred to the GP due to increased blood sugar levels to check for diabetes. Although the result was negative, their routine monitoring was subsequently increased to check their progress. People at risk of falls were identified and their risk assessments were manually updated monthly. Moving and handling risk assessments included information on staff and equipment requirements. Appropriate steps were taken to reduce risk from falls.

People and relatives told us that people's health needs were well looked after. People told us if they wanted to see a doctor they only had to ask. One person told us that they were able to keep their own doctor for as long as they wanted to. Care plans clearly noted any healthcare referrals and the outcomes of such appointments. However, staff told us it was not always possible to obtain a GP visit to the home promptly when required. The manager had met with the practice manager to try to address this and other issues. People had also raised this concern in the July 'resident's council' meeting where they felt the GP's practice of requiring people to come to the surgery room and wait to be seen, was undignified and made the process feel rushed. People were told that meetings had been held with the GP practice to resolve issues.

The minutes of the 'clinical governance meeting' in June 2015 included appropriate standing agenda items and indicated discussion of people's current and developing needs and identified how they were to be addressed. The standing items included discussion of pressure damage, nutrition and weight loss, infections and accidents.

The premises were spacious, light and airy, and free from unpleasant odours. Furnishings were clean and in good order. People had a range of communal areas available to them according to their preferences. Although some people were unhappy about it, people from the dementia (reminiscence) unit were appropriately encouraged to take part in activities provided on the assisted living floors.

Numerous small seating areas were provided throughout the corridors to enable people to rest or socialise or interact with the reminiscence equipment and tactile objects provided. The garden was secure and accessible. Further work was planned to the garden areas in response to feedback from people. The minutes of the 'resident's council' meeting in July 2015 identified a number of dissatisfactions with the condition and contract maintenance of the gardens which had been raised. These had been referred to the contractors and improvements were made.

Good

Is the service caring?

Our findings

At our last comprehensive inspection of 8 and 10 December 2014 the provider was meeting the requirements of the then Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However people told us they were not always treated with dignity and their privacy and preferences were not always respected. The service was rated "Requires improvement" for "Is the service caring".

At this inspection on 18 August 2015 we found that the provider was meeting the requirements of the current regulation. Since the last inspection, further improvements had been made in terms of the consistency of people's treatment and respect for their dignity, privacy and wishes.

People said: ''carers are kindly lovely people'', ''carers always treat us with dignity, respect and kindness'' and ''some staff were terrible to begin with but they're mostly lovely now''. One person said, ''I would describe the staff's best assets as being very kind and caring''. One relative told us they were very impressed with the care. Another said, ''it is fabulous care, brilliant. Staff have a fantastic attitude and are very conscientious. I can't stress enough how kind staff are''.

People also described how staff respected their privacy. One said staff were: "lovely people, never come barging into my room without knocking". Another said: "they do what they need to do and leave, always knock, never barge in". People told us they were: "very well treated" and a relative said staff were: "supportive to us as well". Two staff were singled out for particular praise. One male staff was said to be: "just great, he's got this bonding thing" and a new female staff member was described as: "absolutely fabulous". A sample of the comment cards written by people and relatives also shows positive comments about the caring approach of the staff.

Staff treated people with kindness, patience and respect throughout the duration of our visit. They used appropriate humour and touch to offer re-assurance and give people confidence. The staff appeared to know people well and were familiar with their individual preferences. Relatives told us the service built strong relationships with families, especially with those people who did not have full capacity for decision making.

Staff mostly engaged well with people and there was evident warmth in the relationships observed. Staff gave people time to make decisions and choices to encourage them to remain involved and engaged. Refusals of care were responded to appropriately. We saw that personal care was offered discretely and provided in private to respect people's dignity and privacy. The only exception was the need for people to wait together for their turn to see the visiting GP. This was being addressed with the GP practice to try to address the dignity and privacy aspects of this.

A staff member gave some examples of how they tried to involve people in their care. They said: "I lay clothes out on bed to give choice and show plates [of meals], if they don't understand visual cards or words". The same staff explained that visual aids were useful as many staff did not speak English as their first language, therefore miscommunication was avoided by using aids especially with meals, as they: "don't know how to say or describe foods". Another staff explained how they respected people's confidentiality by: "making sure doors were closed and not discussing [people] in corridors or in earshot [of others]".

Staff described examples of being caring by giving people options and: "talking people through the process [of their care]", for example when people were supported with washing and dressing. Independence was promoted by offering a choice of what to wear and asking whether the person would like any help, rather than just providing help when a person could do something for themselves.

Care records showed that people or their representatives had been involved in planning their care and people's individual wishes, likes and dislikes were recorded so the staff could be made aware of them. The design of the accommodation helped support people's privacy. Even in shared accommodation, each person had a separate bedroom, and shared the bathroom/toilet facilities and a small kitchenette area.

Good

Is the service responsive?

Our findings

At our last comprehensive inspection of 8 and 10 December 2014 the provider was meeting the relevant requirements of the then Regulations 9 and 19, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond to Regulations 9 (Person-centred care) and 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However people told us staff were not always responsive to their needs and there were sometimes delays in responding to the emergency call system. Support was not always provided in accordance with people's wishes and preferences. People's involvement in activities was not effectively monitored to identify those who might be missing out. Some people's care plans contained inconsistent or inaccurate information about their needs and had not been updated to reflect changes. Agency staff did not always know people's needs so there was a risk that their care needs might not always be met. One relative's complaints had not been addressed to their satisfaction. The service was rated "Requires improvement" for "Is the service responsive".

At this inspection on 18 August 2015 we found that the provider was meeting the requirements of the current regulations. Since the last inspection, further improvements had been made in terms of the above shortfalls.

People and relatives told us care plans were written with their involvement. Staff told us care plans were: "written with the family" and added: "we speak with the residents to update their histories". Another staff member told us they got to know people by; "reading the care plans [and] speak to people to know their likes, dislikes and history". The care plans we saw were detailed and individualised. They included information about people's history, wishes, likes and aspirations to support staff engagement with them. One person told us they were concerned that some staff did not appear to be able to understand them, because of limited English. The service had recognised that some staff needed further help with their English which was made available to them. However, the registered manager was confident that all staff understood people's needs and were able to respond to them.

A relative described how the staff team worked with them to put in place an approach that suited their family member. They said the staff were always responsive to new ideas and ways of working. A relative told us the service was: "very quick in resolving issues" and gave an example which was promptly addressed when brought to the attention of staff. Another relative said the staff: "take our concerns seriously".

A full review of all care plans had taken place as part of the action plan following the previous comprehensive inspection. Care plans were in the process of further improvement to include better integration between the various elements and cross referencing between them. Monthly 'wellness' checks were now completed by nurses employed for this role, to identify people's changing needs and update care plans monthly, in between reviews. Checks of pressure relief mattress settings were now recorded within a twice daily record to ensure these were appropriate.

Care plans included individual assessments of risks and how to address them. People's mobility support needs were detailed, including the level of support and any necessary equipment. Care records were regularly reviewed and updated. Staff were provided with 'assignment sheets', which provided them with key information about the needs of the people who they would support on that shift. This helped to ensure that all staff including agency workers had access to the necessary details to enable them to meet people's individual needs. These had been set up as part of the action plan following the previous inspection.

The general manager maintained records of issues relating to people's changing needs, such as falls, illness, health concerns and referrals to external agencies. This enabled her to monitor that the appropriate response was made and followed up.

Referrals had been made to specialist external health providers as required, including tissue viability services, mental health services, dieticians and memory support services. Where people needed enhanced monitoring, for example of food or fluid intake, effective monitoring had been put in place including increased frequency of weight checks. One person, who required support with their behaviour, had been provided with one-to-one staff support throughout the day pending a reassessment of their needs. We noted that emergency bells were responded to in a timely way as were people's direct requests for support from staff.

Good

Is the service responsive?

One person had developed a pressure ulcer. The records showed a detailed and appropriate response and care was provided. A skin care plan was set up, together with a regular 'turning' regime. The skin integrity risk assessment was regularly updated and records made of the size and condition of the ulcer. Tissue viability services were consulted for advice and support, and wound care was recorded up to the point of healing. Other wound care records also showed a detailed and thorough management regime which had been improved as part of the action plan following the previous inspection.

People were happy with the activities and outings provided. One, more able person said: "we can come and go as we please". A relative told us the staff: "meet [name's] individual needs, take him out in the minibus or into the garden". One person was preparing to run a small art group. The necessary equipment had been provided by the service. People also had access to a computer with internet access, which was located in the communal areas. We saw a lively gentle exercise group taking place with a number of people and staff engaged in and enjoying the activity. People could discuss the programme of activities and outings provided, via regular activities meetings which had already taken place in March, May and June of 2015.

People had access to a variety of activities provided by the service. Some were specifically for different areas of the service but others were offered for everyone who lives in the service. People living with dementia were welcome to attend most of the activities and were not isolated. Some people who were not living with dementia were not supportive of the policy of integration. Some people or relatives had chosen to have a memory box fixed outside their bedroom, containing meaningful items or pictures, to help them locate their room. People's bedrooms were individualised and contained numerous personal items, including photographs, furniture and ornaments familiar to the person. Individual activities had been arranged for those with particular interests including computing and chess games.

The weekly activity and outings programme included a varied range of events, activities and social opportunities. Individual records of people's participation in activities and outings were kept to help identify if any individuals needs were not being met by the current activities.

People told us they knew how to make a complaint. They said if they made a complaint the registered manager would take action to rectify the problem as soon as possible. One person said that they felt the registered manager's hands were sometimes tied by the organisation but they were confident that staff in the home, ''did their best''. They added that they felt the registered manager should have more autonomy. Others told us they had no concerns or complaints about the service.

With reference to complaints, one person told us they had: "no reason to complain, If I did I would tell someone". Another said: "If we have any complaints they are dealt with quickly". One person was still unhappy with the staff response times to the call bell but this was not reflected by the others we spoke with.

The general manager maintained a monthly summary of any complaints made which were monitored by the provider. The complaints records included details of the action taken and whether the complainant was happy with the resolution. Some complaints had led to meetings with family and/or detailed action plans. The manager monitored the complaints received for any themes indicating a broader issue to be addressed. In addition to the complaints procedure, people and relatives had access to comment cards. A sample of comment cards showed that people often had positive things to say about the quality of work of individual staff. People could also raise any topics of concern via the 'resident's council' meetings. The minutes showed this was done and that issues raised were responded to.

The manager had acted to address and resolve the complaints made. Care issues had been addressed with specific staff or through feedback or training to the team. Several issues had been raised about the standard of grounds maintenance which had been taken up with the contractors and addressed. People were being invited to become more involved in developing areas of the gardens. Issues raised about the GP service had also been taken up with the practice manager to try to resolve them and a move to one or more additional GP practices was being considered. People had raised issues regarding agency staff communication in the 'resident's council' meeting in July 2015 and had commented that new staff didn't always introduce themselves to them. This was referred to the supplying agency.

A survey of people's views had just been carried out in July 2015. The response rate from people was reported to be 31% but the detailed results were not yet available.

Good

Is the service well-led?

Our findings

At our last comprehensive inspection of 8 and 10 December 2014 the provider was not meeting the requirements of the then Regulations 10 and 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond to Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated "Requires improvement" for "Is the service well-led". A warning notice was issued against the then Regulation 10 in January 2015.

The provider did not have effective quality assurance systems in place to ensure that continuous improvements were made and sustained in the service. Systems to monitor the effective operation of the service were not sufficiently robust. Where issues had been identified as part of management monitoring processes, they were not always addressed in a timely way. Records of people's care and treatment needs, (particularly around wound care and food/fluid monitoring), were not always accurate or maintained, to ensure changes in people's needs were addressed. The service had been without a registered manager since May 2014 and had been led by several different people on a temporary basis.

The provider sent us an action plan in April 2015 identifying the actions they would take to achieve compliance. The provider also sought advice from the local authority 'care home support team' in working towards compliance. When we visited on 11 May 2015 to follow up the warning notice we found the service was no longer in breach of the then Regulation 10. However, improvements were still required in respect to records and the service remained rated "Requires improvement" for "Is the service well-led". A new general manager had recently been appointed and was applying to become registered manager.

At this inspection on 18 August 2015 we found that the provider was meeting the requirements of the current regulations. Since the last inspection, significant improvements had been made in all of the above areas. The general manager had signed off many of the items on the action plan produced following the previous inspection as completed and others were in hand.

People were generally happier with the service than at the previous inspection. One person told us it was still: "Early days, there have been four different bosses, now have [manager's name] who in my view is excellent". Another person said they thought things were going in the right direction now. One relative said: "Since the new manager came [there had been] a major turnaround, even the old staff had changed". The relative also singled out one new nurse for particular praise and added that staff were now: "monitoring and prompting each other [and] making more effort".

The service held regular events to which families and the community were invited and there were resident committee meetings which enabled people's views, opinions and ideas to be fed back to the registered manager.

Staff were also more positive about the service whilst acknowledging there was still some way to go. One said: "we are having to unravel two years of work that [previous managers] have put in place, [which was] taking time". Staff told us positively that now: "we have clear expectations of good practice, we have handovers, communications books and meetings". One staff felt the biggest obstacle had been: "demoralised staff" but added that this was changing. Another said we can: "always do things better, [it's] never ending, however currently moving in the right direction, [and] wanting to improve".

Staff were also complimentary about the impact of the new general manager. One said: "she is new and has made such a difference", another that: "she is really changing the home and it is so much better now". Staff appreciated her knowledge and awareness of people's needs. One said the general manager had: "not been here long but knows the residents really well and seems to really care about them". Some staff who had previous left the service had returned. One said they had left because it hadn't been a nice place to work but since the changes had been made they had returned. They said the new general manager had made it: "a service to be proud of".

Feedback from the community nursing service was also positive. We were told: "the home had some difficulties but it has been much improved". Staff were said to: "respond well to community nursing advice, particularly in the reminiscence unit".

The new general manager was clear she could not manage the service effectively unless she knew what was happening across the home. She said she tried to spend time observing care and talking to people, visitors and staff.

Good

Is the service well-led?

She had also worked over the previous weekend to see how things operated out of office hours. We saw that the general manager could model appropriate care practice to staff. Staff members observed how the general manager dealt with an individual's behavioural needs during the lunchtime period. They then used the same interventions to minimise a person's distress and successfully encouraged them to eat.

Staff were being issued with new information about the provider's ethos of care and approach. Additional training in these areas was also being provided. The manager had introduced more reflective learning through staff and management discussion of events and issues to identify possible learning points. The support of the local authority 'care support team' had been sought and planning had taken place for their involvement in training and other areas.

The general manager had set up and reintroduced a range of management meetings. These took place regularly, including 'lead care' and 'clinical governance' meetings as well as other team meetings, to discuss relevant issues. These were minuted and action points noted. Records showed the general manager had also taken up people's concerns with external agencies and the registered provider to try to resolve them, where appropriate.

More effective auditing of care records was taking place and this was being overseen by senior staff and management. We saw examples of appropriate action being taken where recording shortfalls or issues had been identified through monitoring.

The general manager had systems which enabled her to oversee aspects of the service's operation. Monitoring included accidents and incidents, falls, pressure care, complaints, staff supervision and appraisals. The general manager also countersigned other monitoring such as medicines errors and monthly infection control audits. Monitoring records included the action taken in response to identified issues. For example a tissue viability audit in July 2015 had identified good performance in 'supported living', but performance remained below expectations in the 'reminiscence' unit. The manager described the actions taken to address this. The registered provider also monitored many of these systems as part of their audit processes. The provider's July 2015 quality audit report identified action plans where improvements were required.

Records were person centred and took people's rights, wishes and preferences appropriately into account. People's right to decline aspects of their care was respected, appropriately recorded and managed. Care files were updated and showed how people's changing needs were being met. Records were current and enabled the right care to be provided whilst minimising risks to people.