Sunrise Senior Living Limited

Sunrise of Esher

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Sunrise of Esher is a 'care home.' People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Sunrise of Esher provides care and accommodation for people some of whom have a diagnosis of dementia. The home is registered for 88 residents and is a purpose built home. The building consists of three floors. The ground and first floor of the building are called the Assisted Living Neighbourhood. The care provided in the Assisted Living Neighbourhood includes minimal support for peoples care. The second floor of the building is called the Reminiscence Neighbourhood. The Reminiscence Neighbourhood provides care and support to people who live with dementia as their primary care needs.

At our inspection of 15 December 2016 we found the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The assessments and care plans were not personalised. During this inspection we found the provider had met this Regulation.

There was not a registered manager in place. However the current manager was going through the process of applying to be the registered manager with the Care Quality Commission. The manager supported the inspection team throughout the day. 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.

The inspection looked into how risks to people were managed following an incident where a person using the service sustained a serious injury. Following this the local safeguarding adults board decided to look into the circumstances of the incident by undertaking a Safeguarding Adults Review (SAR). The purpose of the SAR is to identify learning and good practice for all agencies involved in people's care and to promote areas where improvements can be made. At the time of the inspection the SAR, and any learning from this, had not been completed.

People and their relatives told us they felt the home was safe. They told us they had no concerns about being safe. All staff had received training about safeguarding and they were knowledgeable about the processes to be followed when reporting suspected or actual abuse. Medicines were managed in a safe way and recording of medicines were completed to show people had received the medicines they required. Risks to people had been identified and documentation had been written to help people maintain their independence whilst any known hazards were minimised to prevent harm. People were protected against the spread of infection within the service. The environment was clean, tidy and free from malodours. Infection control processes were followed by staff to minimise the risk of cross infection. The management of the home and staff had learned lessons from when things had gone wrong and put systems in place to help prevent a repeat of these.

There were sufficient numbers of staff on duty at all times to ensure that people's assessed needs could be met and these were reviewed on a daily basis. The provider had carried out appropriate recruitment checks so as to ensure that only suitable staff worked with people at the home. Staff had a good understanding about people's life histories, their preferences and how to attend to their needs.

Where there were restrictions in place, staff had followed the legal requirements to make sure that this was done in the person's best interest. Staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that decisions were made in the least restrictive way. People were supported to ensure they had enough to eat and drink to keep them healthy. Healthcare professionals were involved with people's care that ensured their healthcare needs were met. The environment was suitable for people living with dementia.

People's visitors were welcomed at the home and there were no restrictions on the times of visits. People's privacy, dignity and independence were promoted by staff who showed kindness and understanding of people's needs. People were able to make choices about how they received their care, support and treatment.

A variety of activities were available for people to take part in both internally and externally on trips to places that interested them. Documentation that enabled staff to support people and to record the care they had received was up to date and reviewed on a regular basis. People received person centred care and they or their representatives had signed their care records that signified their involvement in their care, treatment and support. People's likes, dislikes and preferences were recorded and known by staff. Staff were knowledgeable about people's needs and had received training that helped to attend to the assessed needs of people. People's end of life care was attended to in a sensitive and caring way that encompassed their preferences and needs.

Complaints were taken seriously by the provider and staff and addressed within the stated timescales to the satisfaction of complainants. A complaints procedure was available to people, relatives and visitors.

The provider and staff undertook quality assurance audits to monitor the standard of service provided to people. An action plan had been produced and followed for any issues identified. People, their relatives and other associated professionals had been asked for their views about the service through surveys and resident meetings.

The interruption to people's care in the case of an emergency would be minimised. The provider had a Business Continuity Plan that provided details of how staff would manage the home in the event of adverse incidents such as fire, flood or loss of gas or electricity.

The provider was aware of their responsibilities with regard to reporting significant events to the Care Quality Commission Accidents and incidents were recorded and monitored to by staff to help minimise the risk of repeated accidents.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were knowledgeable and understood the process to be followed if they suspected or witnessed abuse.

There were sufficient staff deployed throughout the home to meet the assessed needs of people.

Risks to individual people had been identified and written guidance for staff about how to manage risks was being followed.

People were kept free from infection because staff understood the infection control processes to prevent cross infection.

The provider had carried out full recruitment checks to ensure staff were safe to work at the service.

People's medicines were managed, stored and administered safely.

Accidents and incidents were recorded and monitored by staff at the home to help minimise the risk of repeated events.

Is the service effective?

Good

The service was effective.

Staff received training and had opportunities to meet with their line manager regularly to ensure they provided effective care to people.

Where people's liberty was restricted or they were unable to make decisions for themselves, staff had followed legal guidance. People's consent was sought at all times.

People's nutritional needs were assessed and individual dietary needs were met. People enjoyed the food and could choose what they ate.

People had involvement from healthcare professionals as and

when they became unwell and staff supported people to remain healthy.

The environment was clean and suitable for people living with dementia.

Is the service caring?

Good

The service was caring.

People's care and support was delivered in line with their care plans.

People's privacy and dignity was respected. Staff were knowledgeable about the people they cared for and were aware of people's individual needs and how to meet them.

Staff were caring, gentle and kind to people.

Visitors were welcomed at the home and people could meet with them in the privacy of their bedrooms.

Is the service responsive?

Good

The service was responsive.

Staff responded well to people's needs or changing needs and person centred care plans were written with people and their relatives.

People had opportunities to take part in a variety of activities that interested them.

Information about how to make a complaint was available for people, their relatives and visitors.

People's end of life care was provided sensitively and in line with people's needs and preferences.

Is the service well-led?

Good

The service was well led.

People and their relatives had opportunities to give their views about the service.

Staff felt supported by the manager.

Staff met regularly to discuss people's needs, which ensured they

provided care in a consistent way.

The provider had implemented effective systems of quality monitoring and auditing.

The provider was aware of their responsibilities in regard to sending Notifications about significant events to the Care Quality Commission.

Sunrise of Esher

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 23 January 2018 and was unannounced.

The inspection was carried out by three inspectors and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke with 15 people, two relatives, the manager and nine staff members. We looked at the care plans for 10 people, medicines records, accidents and incidents, complaints and safeguarding. We looked at mental capacity assessments and applications to deprive people of their liberty. We reviewed audits, surveys and looked at evidence of activities taking place at the home.

We looked at four staff recruitment files and records of staff training and supervision, appraisals, a selection of policies and procedures and health and safety audits. We also looked at minutes of staff meetings and evidence of partnership working.

Good

Is the service safe?

Our findings

People told us that they were safe living at Sunrise of Esher. People were complimentary about how safe they were. One person told us, "Yes, I am safe and I really like it here. Another person told us, "I do feel safe; staff are very good at this." A relative told us, "I feel that my [family member] is very safe here and that there are enough staff who are all very caring."

People were protected from abuse because staff understood their roles in keeping people safe. Staff were very knowledgeable about abuse and the different types. Staff explained the signs that would raise suspicions about mistreatment, for example, unexplained bruising. Staff told us that they would not hesitate to report any bad practice to the manager or the provider. One member of staff told us, "I would report everything to the manager and if I did not think they had acted on it then I would contact the local safeguarding team. Their telephone numbers are displayed in the staff office."

People were kept as safe as possible because potential risks had been identified and assessed. Each person had risk assessments in place to help them maintain their independence in a safe way. Risk assessments had included falls, manual handling, skin integrity and nutrition. Staff were aware of the risks to people and the action to take to minimise the risk. People also had individual personal emergency evacuation procedures (PEEPs).This informed staff how to safely evacuate people from the home in the case of fire or other such emergencies. The interruption to people's care in the case of an emergency would be minimised. The provider had a 'Business Continuity Plan' that provided details of how staff would manage the home in the event of adverse incidents such as fire, flood or loss of gas or electricity. Staff were knowledgeable about these procedures that would help to ensure people were kept safe during an emergency.

We looked at how well people were kept safe from risks involving other people using the service. We could see that risks had been assessed appropriately and documented which provided guidance for staff to follow. Learning from past events had shaped an appropriate and thorough process and took into account the layout of the service and people's needs whilst maintaining a good focus on their independence. For example, one person whose behaviour challenged and entered other people's bedrooms uninvited. Risk assessments in relation to these behaviours had been written and reviewed regularly. The provider had considered how risks to people were managed as part of a 'memory care strategy.' This included how safe care was provided to people where their physical needs exceeded their mental health needs. The assessment process had been updated to ensure that risks to people living at the service were considered, managed and mitigated.

Medicines were administered, recorded and stored safely. People received their medicines when required and as they were prescribed by their GP. One person told us, "I get my medicine on time and I know what they are for." People's medicine records were accurately maintained and included the stock balances of medicines. There were no omissions of signatures on the medicine administration records (MARs). Medicines that required refrigeration were stored in lockable fridges which were not used for any other purpose. The temperature of the fridges and the rooms in which they were housed was monitored regularly. The administration of medicines followed guidance from the Royal Pharmaceutical Society. Staff did not

leave unlocked medicines trollies unsupervised at any time. Staff did not sign MAR charts until medicines had been dispensed. Records provided to us evidenced that staff had received training in the administration of medicines and competency checks were undertaken.

People were supported by sufficient numbers of staff with the right skills and knowledge to meet their individual needs. The manager told us that there were three units in the home. One was for dementia, known as the reminiscence neighbourhood; the other two were for people who required personal care and these were called the assisted living neighbourhood. The manager told us that the staffing for the reminiscence was six staff in the morning, five staff in the afternoon and three waking night staff. The assisted living had six staff all day and three waking night staff. There was also an activities co-ordinator, maintenance staff, chef and housekeeping staff. These staffing levels were confirmed during our observations, discussions with staff and the viewing of the duty rotas. Staff told us that there were enough staff. One member of staff told us, "I think we have enough staff. I have sufficient time to care for people well." Another member of staff told us that they could discuss the staffing levels and the changing needs of people with the manager and extra staff would be deployed as and when required. We observed staff respond to people in a timely manner when they asked for support, no one was kept waiting.

People were protected from unsuitable staff because safe recruitment practices were followed before new staff were employed. All the required documentation, including a full employment history, references and Disclosure and Barring Service (DBS) checks had been obtained for new staff. The DBS helps providers ensure only suitable people are employed in health and social care services.

People were protected against the spread of infection within the service. People lived in an environment that was clean and hygienic. All areas of the home were very clean and tidy. Personal protective equipment (PPE), such as aprons and gloves, were readily available to staff. All hand basins contained hot running water, liquid soap and disposable towels. Bathrooms and toilets were clean and free of litter or debris. Staff told us they had undertaken training in infection control and records confirmed this. Daily, weekly and monthly cleaning schedules were maintained. Records of audits and spot checks were maintained for the home. This ensured that people lived in a clean and hygienic environment. Domestic staff were knowledgeable about how to minimise the risk of cross infection and were observed changing their PPE after cleaning each room. Accurate records of the cleaning that had been undertaken were maintained that included the daily cleaning of all mattresses. People told us that the home was always clean. One person told us, "I have seen staff cleaning, and if it is not convenient for me they will always come back at an agreed time. This happened today because I slept later than I usually do. Staff came and did my bed when I went to get some breakfast."

When people had accidents or incidents these were recorded and monitored by the registered manager. Records of accidents and incidents were detailed and included the action staff had taken, the outcome and any lessons learned. The management and clinical teams met regularly to discuss incidents and accidents and to identify any trends and help to prevent a repeat of these.

Good

Is the service effective?

Our findings

People's needs, choices and preferences were assessed and care, treatment and support was delivered in line with current legislation. For example, NICE Guidance in regard to supporting people with dementia and how to support people to maintain their independence and stay healthy. Pre-admission assessments had included information about the person's health, medicines, communication, nutrition and likes and dislikes. For example, one person's assessment had included that they had a strong accent and required time to communicate clearly. It recorded that they liked sugar in their tea and did not like fish. Information gathered during the assessment process were all added to the person's care plan. People told us that they had been consulted about how they would like to be looked after by staff.

People received effective care from staff who had the skills, knowledge and understanding needed to carry out their roles. People and their relatives told us that they though the staff had been trained. One person told us, "Staff are well trained, they are patient and very helpful." Records evidenced that staff had received the required mandatory training. Other training had included the falls prevention, behaviours that challenged and dementia. Records also showed that staff received an induction when they commenced their duties at the home. One member of staff told us, "My induction included me shadowing with another member of staff until I felt confident to work on my own. The induction included all the mandatory training and helped me in my role." Staff were able to describe what they had learned from the training. For example, one member of staff told us, "In the behaviour that challenged I learnt that I must talk to the person in a calm manner and to use any distraction techniques that were recorded in the person's care plans. If this did not work then to go back a short time afterwards. We change staff as well as this sometimes works." They stated that they record these types of behaviours in the person's care plan and have consultations with the community psychiatric nurses (CPNs.)

People were supported by staff who had regular supervisions (one-to-ones) with their line manager. Staff told us that these helped them to discuss their roles, the people they worked with and identified their training needs. Records maintained showed that staff had regular supervisions and an annual appraisal of their work. The home also had meetings that were called 'The daily Huddle. This is when all staff met at the beginning of each shift where staff discussed their roles for the day, which people were on fluid and fluid charts, summary of call bell response time, accidents and incidents and the activities for the day.

People were supported to ensure they had enough to eat and drink to keep them healthy. People told us that the meals provided were good. One person told us, "The food is very good, very well cooked and with lots of variety." Another person told us, "The food here is absolutely wonderful, check my comments in the book." We looked at the book and the person had written a compliment every day in the book. A relative told us, "My [family member] enjoys the food here."

People's dietary needs were recorded in their care plans and the chef had a list of these in the kitchen along with photographs of the person. The chef also had a list of people's likes, dislike and allergies. The storage of food was in line with current legislation. For example, all foods stored in the fridge were covered and dated. Pureed food was presented in different colours on plates to make the meal look more appetising for the

person. The provider sends recipes to the chef and they automatically came with the nutritional values of meals and any associated allergens. This would enable the chef to check which people would be affected and who would require alternative meals. Although people had been told what the choice was for lunch and a menu was displayed throughout the home, we observed in the reminiscence unit that staff showed people plated meals that helped them to decide which meal they preferred. Staff were available to provide support people during lunch as and when required and they engaged in conversations with people.

Care plans included information about people's nutritional and hydration needs. There were assessments, such as Multi-Universal Screening Test (MUST) in place for those at risk of malnutrition. We noted a variety of referrals and assessments had taken place, including those involving dieticians and speech therapists. There were several people living at the home who were at risk of choking. We noted these people's care plans contained up to date choking risk assessments with clear instructions for staff on how to prevent or manage emergency situations.

People had access to all healthcare professionals that supported them to live healthier lives. We saw evidence of people attending a variety of health appointments such as GP, and hospital consultants. Other professionals visited people at the home, for example, community nurses, speech and language therapists. This demonstrated that people's healthcare needs were monitored by staff and that relevant healthcare professionals were consulted about people's care where necessary. For example, one person had recently seen the district nurse about a suspected skin breakdown. Staff had noted a blister and this had been looked at by the GP and cream had been prescribed. Another person had seen the GP due to behaviour that challenged. The GP referred them to the community mental health team (CMHT). The GP also noted that the person had difficulty hearing which may have caused frustration. Records evidenced that the person had been for a hearing test and letters from audiology department confirmed no problems but they had their ears syringed as a precaution.

People benefitted from staff who worked across organisations and communicated well with each other to deliver effective care, support and treatment. There was evidence within the care plans of regular meetings and consultations with the GP, Dietician, Tissue Viability Nurse, CPNs, Hospital Consultants and speech and language therapists.

People lived in an environment that that was adapted to meet their needs. All equipment used at the home was serviced in line with the manufactures' guidance to ensure it remained in a good state of repair and was safe for people to use. There was good signage throughout the home that enabled people to find their way around to communal areas of the home, this also included information written in brail to help those who had sight issues. For example, the dining room, toilets, bathrooms and their bedrooms.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as the Mental Capacity Act 2005 (MCA). Where people lacked capacity to make certain decisions, appropriate assessments had been completed to ensure the requirements of the Act were met. People had been assessed as having the capacity to understand and agree to live at this supported living service.

Staff had an understanding of the Mental Capacity Act (2005) including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. We saw staff asking for people's consent before giving care and support throughout the inspection.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Staff understood that people's capacity could change, and if they had to restrict someone's freedom to keep them safe, they knew they would have to do an MCA assessment, have a best interest's decision, and apply for a DoLS. As people had capacity to agree to live at this service the DoLS did not apply at this inspection.
least restrictive as possible.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. For example, One person had an MCA in their file for the decision to move them downstairs and recorded that the person lacked the capacity to make the decision to move floors. A best interest decision that had involved staff and the person's family member recorded that it was in the person's best interest to move. A DoLS application had been approved. There was evidence in care plans that people had representatives' in regard to making decisions, for example Lasting Power of Attorney for Health and Welfare.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. People told us that staff were caring and kind people. One person told us, "I have found staff to be caring, meticulous and interested in what I want to do." Another person told us, "They are wonderful staff; they are very helpful and understanding." Relatives were also complimentary about the care provided to their family members. One relative told us, "I think they [staff] are brilliant, I really do. When my [family member] had a fall they were really kind to them. They always inform me when anything is wrong."

Staff were positive in their roles and were compassionate and committed to the people they supported. We observed care and support given to people throughout our visit. There was good, positive interaction between people and staff who consistently took care to ask permission before intervening or assisting with anything. There was a high level of engagement between people and staff and no incidents of discourteous staff actions. Staff were responsive to people's needs and addressed them promptly and courteously. For example, staff took time to explain procedures before using the hoist. Staff gave people detailed information to allow people to make choices, such as meal preferences and choice of activities.

People were supported to express their views about their care and treatment and making decisions about their care plans. One person told us, "Yes, I am involved in my care plan and it has been reviewed with me, obviously." We looked at people's care plans in order to ascertain how staff involved people and their families with their care as much as possible. Care plans and risk assessments were discussed and agreed with people or their relatives. People and their relatives told us they had been involved in their care plans and that they could request changes at any time. This was confirmed during discussions with staff. We noted from the care plans that the provider held regular meetings with people and their families in which the care for the person was discussed and agreed. Staff were knowledgeable about the needs of people and what their interests were.

People's privacy, dignity and independence were promoted by staff. Staff told us that they ensured all personal care was undertaken in the privacy of people's bedrooms with the doors and curtains closed and we observed this in practice during our visit. People told us that all staff respected their privacy and dignity. One person told us, "Staff always respects my privacy." One member of staff told us, "We always knock on people's doors and make sure that all personal care needs are undertaken in private with doors and curtains closed. We respect the views of people and if they asked for things to be done differently then we would do it, as long as it was safe." Another member of staff stated, "We always ask people if they are ready for us to help them, for example, to get a wash. We make sure that we do this in the privacy of their bedrooms. "People were encouraged to be independent. One person told us, "They [staff] let me wash myself and get dressed but if I need any help they are always there."

We observed staff interacting with people throughout the day. There was a calm and inclusive atmosphere in the home. We noted staff were respectful and kind to people living at the home. We observed many instances of genuine warmth between staff and people. On these occasions, staff took time to explain their actions in order to minimise people's anxiety. At lunchtime, people were free either to be served at the

dining table or to approach staff to look at food before making a choice. Their choices were accommodated by staff promptly and efficiently.

People's visitors were made welcome at the home. Throughout the day relatives were coming in and out of the home to see their family members. One relative told, "I can come here at any time to visit my [family member]."

Good

Is the service responsive?

Our findings

At our inspection of 15 December 2016 we found the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The assessments and care plans were not personalised. During this inspection we found the provider had met this Regulation.

People received care that was personalised to their needs. People and their relatives told us that they had a care plan and were involved in the reviews. One person told us, "Yes I do have a care plan but I have allowed my daughter to take on the responsibilities of my care." A relative told us, "I have a six monthly review for my [family members] care."

Care plans were person centred and they had been written from the information gathered during the pre-admission assessments. At the time of our inspection the provider was in the process of transferring the paper care plans to a new electronic system that would enable staff to easily access information in the care plans. Care plans recorded what was important to people and relevant up to date information. For example, we noted one person exhibited distress and/or sometimes exhibited behaviour that challenged due to their advanced dementia. We noted the provider had recorded incidents related to this in behavioural charts in order to identify potential triggers. This information was recorded in detail in behaviour care plan. These care plans also informed staff in which non-verbal ways distressed behaviour manifested itself. There was also a plan of action, outlining tried and tested methods to calm the person, such as offering lemon tea and playing classical music. A referral for the person had been made to the Intensive Support Team, part of the Community Mental Health Team, who provided ongoing support and advice to staff. Other information recorded in care plans included communication, mood, behaviour, socialisation, safety, falls, memory, moving and handling, personal hygiene, bathing, dressing and laundry.

People had a range of activities they could access every day. The manager told us that they were currently recruiting an activity coordinator, but in the meantime an activity coordinator from a sister home had been organising the activities programme so people would not miss out on their activities. People told us that activities were provided for them to take part in if they wished to. One person told us, "Oh yes, I can I do the seated exercises, games and Tai Chi. The outings are very good too, and I have been on some of them. They also have some good entertainers here, and we have someone playing the piano this afternoon." Another person told us, "I don't participate in activities but I do like the large screen and films that they show, plus the books. They have a lovely library here." Activities provided had included shopping at a local supermarket, quizzes, art and craft and flower arranging. Activities on the reminiscence unit included large picture bingo, reminiscing and themed activities about the past. People in this unit also had memory boxes outside their bedrooms that had photographs and artefacts from their past lives. This helped staff to engage in conversations with people, for example, their past employment, family and hobbies and interests.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. People and their relatives told us that they knew how to make a complaint and they had been provided with a copy of the provider's complaints procedures. One person told us, "Yes there is information, but it's never been necessary for me to make a complaint." Another person told us, "I've never had to make a complaint, but I

do know how to." Staff were clear about their responsibilities in the management of complaints or concerns. They were aware of the provider's complaints policy and procedures and where to find them. We noted the complaints procedure was available in the communal areas of the home. This document included information about how and to whom people and representatives should make a formal complaint. There were also contact details for external agencies, such as the Local Government Ombudsman. The provider had received eight complaints during the last twelve months and records maintained showed that complaints had been investigated thoroughly and to the satisfaction of complainants. The provider had also received many letters complimenting staff about the care that had been provided to people at Sunrise of Esher.

End of life care was provided sensitively and in line with people's needs and preferences. Care plans included people's requests about their end of life wishes that included if they wanted to remain at the home or be admitted to hospital. For example, one person's end of life care plan recorded that staff were to liaise with their relatives around their preferences as they was not able to communicate. It clearly stated that they did not wish to be admitted to hospital. The manager told us that they would work closely with the GP and local hospices to ensure that people had a pain free and dignified end of life care.

Good

Is the service well-led?

Our findings

People told us that there had been a lot of change in the management of the home recently. Two people told us that there appeared to be some concerns regarding the lack of communication being shared between the organisation and the people about the appointment of the new manager. However, this had been discussed during resident meetings and a letter had been sent to all concerned in September 2017. The manager told us that she had informed all people in the resident council meeting that she is the acting manager and that she was applying to the CQC to become the registered manager. The manager showed us evidence that she was going through the process of submitting an application to register as the manager with CQC. Staff told us that the manager was approachable, very supportive and had an open door policy. One member of staff told us, "The home is well led and the manager is amazing, she had the team working really well together." Another member of staff told us, "The manager is doing a wonderful job, she is very approachable."

The service promoted a positive culture. There was a staffing hierarchy at the home and all staff knew what their individual roles were and the duties they were to perform. Regular staff meetings took place where staff were able to discuss people's needs to ensure they were provided with care in a consistent way. The provider had a set of values and principles that included passion, respect, trust, preserving dignity and encouraging independence. Staff were knowledgeable about these and we observed staff working within these values throughout the day. For example, we observed staff interacting with people in a caring manner, gaining eye contact when they spoke to people and waiting for people to respond to questions asked of them. Staff were respectful to people throughout our visit calling people by their preferred names and adhered to the choices people made.

Quality assurance systems were in place to monitor the quality and running of service being delivered. Audits undertaken had included infection control, the environment health and safety, medicines and the MAR records, care plans, Legionella and fire emergency systems and daily temperatures in regard to the cooking of food, fridge and freezers were maintained. Where issues had been identified an action plan had been put in place and was incorporated into the continuous development plan. For example, it was identified during an audit of August 2017 that people's personal emergency evacuation plans (PEEPs) had not been updated for all people living at the home. We saw that the action had been completed and the PEEPs we looked at were correct and up to date. Quarterly visits took place by the provider and looked at all records. The last audit undertaken in December 2017 looked at the environmental checks and audits of care plans and charts. There were no identified actions from this audit and the home had a recorded score of 100%. This showed that the home was being monitored by management of the home and the provider to monitor the service provided to people.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received and suggestions about how the home was run. Monthly resident council meetings took place. Records of these meetings showed people's involvement in the home. For example, people had asked for ice to be put in drinks and also asked for an evening quiz and these had been marked as completed. We saw quizzes had been included on the activitiy lists and ice was provided for people who

preferred this with their drinks. One person wanted to play bridge and this had been arranged and signed off as actioned. A survey had been undertaken in March 2017 to ascertain the views of people, relatives and staff about the home and a summary of the findings had been produced. The survey asked about the food provided, management responses to suggestions and concerns, rating on the care provided, staff attitude and the cleanliness of the environment. The scores in of these were high and no concerns had been identified. The manager told us that the survey for this year was about to be sent out.

The provider and staff worked with other related agencies that ensured people received joined up care, treatment and support. Records maintained at the home evidenced that staff work closely with the local safeguarding team, adult social care teams and all healthcare professionals. For example, GPs, occupational therapy, physiotherapy and dietitians.

The provider was aware of their responsibilities with regard to reporting significant events to the Care Quality Commission and other outside agencies. Notifications had been received in a timely manner which meant that the CQC could check that appropriate action had been taken.