Sunrise Operations Purley 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?	Requires Improvement

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2012 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 2012 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

In February 2014, our inspection found that the provider was not meeting the regulation in relation to the management of medicines. Following this inspection the provider sent us an action plan to tell us the improvements they were going to make. During this inspection we looked to see if these improvements had been made.

Summary of findings

Sunrise Operations Purley Limited provides residential and nursing care for up to 119 older people and accommodation is spread over four floors. A separate specialised "reminiscence neighbourhood" is situated on the second floor for people living with dementia. Some people use the service for respite care breaks. There were 112 people using the service at the time of our inspection.

At this inspection we were told that the registered manager had left the service the week before and a new manager had been appointed. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The manager had begun an application to register with us.

The provider had improved the way medicines were managed and people received their medicines safely and as prescribed.

People and their relatives said they felt safe. Staff had training and knew how to recognise and respond to concerns about abuse and poor practice. The provider took action to assess and minimise risks to people.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We found the location to be meeting the requirements of DoLS. The service was reviewing whether any applications needed to be made in response to the supreme court judgement in relation to DoLS.

There were enough qualified and skilled staff at the home and staff received regular training and support to meet people's needs. The service had sought views of dementia specialists about the environment and managing aspects of behaviour safely. Staff had received training in dementia and behaviour that may challenge.

People told us that they were happy with the care that staff provided and that their privacy and dignity was respected. Staff knew people's needs and preferences well and interacted positively with people. We saw that staff showed understanding, patience and gave encouragement when supporting people. People and their relatives were supported sensitively during end of life care.

People's needs were assessed and care and support was planned and delivered according to people's wishes. Care plans contained personalised information to ensure staff knew how to support people and meet their needs. People were provided with a range of activities in and outside the service which met their individual needs and interests.

The service encouraged people to raise any concerns they had and responded to them in a timely manner. Although there were effective systems in place to monitor the quality of care and review any issues arising, feedback and communication with people using the service on issues they raised needed improvement in some areas.

Frequent changes in management had resulted in some inconsistency although the new manager had plans to improve the service and people spoke favourably about them. Staff were also positive about the new manager and felt supported.

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?

Good

The service was safe. People we spoke with told us that they felt safe and well looked after.

Staff knew how to recognise and respond to abuse. Staff understood their responsibilities in relation to the requirements of MCA and DoLS.

Risk assessments were in place which included information about how to manage and reduce risks that people faced.

People were receiving their medicines as prescribed and medicines were managed safely.

We found there were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective. People received care from staff who were trained to meet their individual needs. Staff working in the home had good support and were provided with regular opportunities to learn new skills through training.

People's health and support needs were assessed and care records reflected this. People could also access appropriate health, social and medical support as soon as it was needed. Staff worked well with health and social care professionals to identify and meet people's needs.

People were protected from the risk of poor nutrition and hydration because their needs around eating and drinking were monitored and reviewed. Relevant professionals were involved where necessary and people received appropriate support from staff.

Is the service caring?

Good

The service was caring. Staff spoke with people in a courteous manner and treated people with dignity and respect. Staff were kind and compassionate and took time to listen to what people had to say.

People were involved in making decisions about their care, treatment and support. The care records we viewed contained information about what was important to people and how they wanted to be supported.

People were able to make choices about their end of life care and relatives were also involved in this process.

Summary of findings

Is the service responsive?

Good 

The service was responsive. People using the service had personalised care plans that were regularly reviewed to make sure they received the right care and support. Overall, care records provided up to date information about people's needs and staff understood how to support each person and provide consistent care.

There was a choice of activities and entertainment for people to participate in if they wished.

People told us if they had any concerns or complaints they would speak to the staff and were confident they would be addressed.

Is the service well-led?

Requires Improvement 

The service was not always well-led. There had been frequent changes in management which had resulted in some inconsistency although the new manager had plans to improve the service and people and staff spoke favourably about their leadership style.

The provider regularly monitored the care, facilities and support for people using the service. Where issues were identified, action was taken where necessary although some systems for feeding back to people could be improved.

Sunrise Operations Purley Limited

Detailed findings

Background to this inspection

We visited the home on 15 and 16 July 2014 and spoke with 39 people living at Sunrise Operations Purley, eight relatives, five nurses, 23 care staff, the home manager, the deputy manager and another deputy manager from one of the provider's other homes who had been providing extra management support to this home. We also spoke with some of the kitchen staff, an activities co-ordinator and a visiting healthcare professional. This inspection was unannounced.

We spent time speaking with people on each floor and observing their care and support in communal areas. We observed how people were being supported with their meals during lunchtime. We looked at records about people's care, including eighteen files for people who used the service. We reviewed how the provider safeguarded people, how they managed complaints and checked the quality of their service. We also looked at records kept for staff training and staff allocation.

The inspection team consisted of three inspectors, a pharmacist inspector, a specialist advisor in dementia care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we reviewed the information we held about the home, this included the provider information return (PIR), notifications, safeguarding alerts and outcomes and information from the local authority. The PIR 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. The PIR also provides data about the organisation and service.

Following our inspection the service sent us some information about their quality assurance arrangements.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

At our inspection in February 2014, we were concerned about the management of medicines in the home. The provider sent us an action plan outlining how they would make improvements. At this inspection, we found that improvements had been made.

Since our last inspection, a new medication system had been implemented. The supplying pharmacist had provided training and ongoing support and advice on the new system, and we found that staff were now consistently managing medicines in a safe way. Records showed that all staff handling medicines, except for one, had received medication training in the new system and had been assessed as competent to manage medicines. Staff who were involved in medicines administration confirmed this.

All prescribed medicines were available, and there was a robust system in place to ensure medicines were re-ordered on time so that people did not miss any doses of prescribed medicines. People's medicines were reviewed regularly, to ensure the effective use of medicines particularly in the management of challenging behaviour. Medicines, including controlled drugs, were stored safely and at the right conditions to ensure they remain fit for use.

To protect people with limited capacity, we saw that the correct procedures were followed when medicines needed to be administered covertly to one person. We saw that the service was supporting a few people to manage some of their own medicines to retain their independence. The service had assessed the risk when people wished to manage their own medicines to ensure it was safe to do so. People we spoke with confirmed that they received their medicines regularly and in one case were assisted to safely self-medicate.

Clear, accurate and up to date records were kept on the receipt, administration and disposal of medicines. These records showed that people were receiving their medicines as prescribed.

Written guidance was in place about the use of medicines to manage pain and agitation. Some people were not able to communicate verbally when they were in pain. More personalised guidance was needed for staff to enable them to tell when these people were in pain.

The service had written information available about medicines to give to people if they wanted this; however we found that care staff did not always know what medicines they were administering were for. Medicines' profiles would provide staff with important information about why people were prescribed medicines and potential risks associated with their prescribed medicines. Similarly, there were no individual protocols for administration where a person needed medication 'as required' or only in certain circumstances. This would give staff written information about the circumstances and frequency of when these medicines should be administered to ensure that these medicines were used appropriately. However staff we spoke with were aware of when these medicines should be used as protocols had been available until the recent change of medicines' supplier.

We brought these issues to the attention of management. The deputy manager also confirmed that PRN protocols and information on medicines had been available until recently and the pharmacist from the new supplier was at the service on the day of our inspection. The deputy manager discussed this with them, and told us that this information would be made available by the next month.

All the people we spoke with said they felt safe and did not have any concerns about abuse or poor practice by staff. Three visitors we spoke with also said that people were "in good hands" and referred, when necessary, to health professionals. A person visiting said, "I have no concerns about my relative's safety at the home, we find everything is so well kept, my relative is safe and well cared for, staff are vigilant too." One person spoke about a safeguarding concern which they had raised through their relative. This was immediately reported to the home management and it was dealt with promptly and appropriately. The person was very satisfied with the outcome and felt confident that any issues raised would be addressed.

We saw that there were notices in the home with contact numbers that staff, people who used the service or visitors could use to report any concerns regarding abuse.

Staff told us, and records confirmed that they had recently received training in safeguarding vulnerable adults. All members of staff we spoke with were able to tell us how they would respond to allegations or incidents of abuse; they were familiar with the lines of reporting. A member of

Good

Is the service safe?

kitchen staff told us that they would report any of their colleagues to the manager if they showed disrespect to any person living in the home, but they had never had to do this in six years.

Records held by CQC showed the service had made safeguarding referrals when this had been necessary and had responded appropriately to any allegation of abuse. Where safeguarding concerns had been raised, the provider had liaised with the local authority and other professionals to investigate events. This meant they had followed the correct procedures, including notifying us of their concerns. We saw evidence that the service had cooperated in any investigations and taken action to review or improve practice where necessary.

Risks to people's safety were appropriately assessed, managed and reviewed. Each care record we looked at included a series of detailed risk assessments that were centred on the person's needs. Risk assessments covered areas such as nutrition, pressure area care, mobility, continence and behaviour that may challenge. Risk assessments clearly identified what each person's care risks were and how they were to be managed. One example included, "Please help me to calm down, talk to me, and reassure me, remove me from the area or situation which is causing the upset." The number of staff assigned to help mobilise people was determined by individuals' moving and handling risk assessments. All support plans and risk assessments were regularly reviewed and adjusted if a person's needs had changed. Staff had information to provide care safely, and in the most appropriate manner.

One person told us that they watched the staff being careful in how people were moved when in wheelchairs or with frames. A relative told us that people with mobility problems were always advised to use the lifts rather than the stairs for their own safety. We observed that appropriate actions were in place to keep people safe while new carpet was being laid.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA) and are in place to ensure people are looked after in a way which does not inappropriately restrict their freedom. We were told that no one was subject to DoLS. We saw policies and procedures were in place in relation to MCA and DoLS. The manager was aware of the need to adjust the home's practice in relation to restriction of liberty following the supreme court ruling, and understood that DoLS applications might be needed for people on every floor. They told us the service was reviewing the needs of everyone in light of this judgment.

The majority of staff had completed MCA and DoLs training and there were plans for remaining staff to complete training by the end of September 2014. Staff we spoke with understood what processes to follow if someone lacked capacity to make decisions or was likely to be deprived of their liberty. One member of staff told us, "We can't stop people going out", but added that if they were concerned for their safety they would arrange for someone to accompany them.

The deputy manager told us that there were four vacancies for nurses and they had recently recruited to two posts, subject to satisfactory recruitment checks. We were told that the service had a full complement of care staff and that agency staff were only used to cover sickness and emergencies. There was a nurse assigned to each floor, aside from the Reminiscence Neighbourhood which was run by a care co-ordinator. Staff working there told us people did not have nursing needs but nursing support was available when they needed it.

We were informed that staffing levels within the home were assessed through calculating the care hours required to support individuals who use the service. Domestic, kitchen and maintenance staff were also employed. The manager told us staffing arrangements were always reviewed when people's needs changed to make sure staff were deployed effectively.

We looked at the staffing rotas and records on all four floors within the home. Overall, we found that there were enough qualified, skilled and experienced staff to meet people's needs at the time of our inspection. Where staff cover was needed, this was planned in advance as far as possible. There were occasional gaps, but rota records demonstrated efforts had been made to ensure staff consistency and knowledge about people's needs.

The majority of people we spoke with told us there were enough staff to care for them. For example, additional staff were made available to accompany people attending hospital appointments when no family members were available. Some people were cared for in bed due to their needs; we observed staff went in and out of the bedrooms to speak with them and to check on their welfare, records

Good

Is the service safe?

showed they were checked on by staff every hour. One person who was in their bedroom said, “There is always plenty of staff, and they respond quickly to our call bells, I like to spend a lot of time in my room reading and listening to the radio but staff keep looking in on me to see I am okay.” One member of staff we spoke with told us they were mindful of making frequent visits to check on the welfare of people who chose not to go to the lounges or into the garden.

Six people told us that they often had to wait for a carer to come to help them with tasks they could not do for themselves and it took time for buzzers to be answered. One person said, “They always seem to be short staffed.” During the inspection we identified that there were issues with call bell monitoring.

We received mixed feedback from staff about the staffing levels in the home. Overall, the majority of staff felt that staffing improvements had been sustained since our last inspection and that the new manager supported them. Comments from staff across all floors included, “Things are a lot better”; “The manager gets things done” and “Everybody helps each other, there’s good teamwork.” One care staff said that they felt they benefitted from the nurses’ presence on the reminiscence neighbourhood. A nurse told us, “The staffing ratio is fine at the moment.

A few staff on some of the floors felt that there were not enough of them at particular times of the day. One told us, “There are not enough of us around, especially in the afternoon, when people are more unsettled”. Another said, “There is a constant change of staff.” Two members of staff felt that time to do activities with people could be improved. Three other staff were doing double shifts due to staff shortages although they told us this was their choice and said they were not pressurised to take on extra shifts. The manager told us they would take any necessary action to increase staff if this was an identified need.

Good

Is the service effective?

Our findings

We saw that staff received the training they needed to care for people and meet their needs. Training was frequent and included an induction for all new staff. We saw induction records included training in areas such as safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards, health and safety, fire safety, nutrition and hydration, privacy and dignity and moving and handling.

The provider had its own training department and an ongoing programme of training. We checked the latest training record for all staff; it showed what training had taken place and what was planned. The information was up to date and identified clearly when staff were due to refresh their learning.

Staff we spoke with confirmed they received training relevant to their role. Recently appointed staff members said they had completed a number of e-learning (computer training) courses as part of their induction and they then had the opportunity to shadow an experienced member of staff for four days. One new member of staff said they had to complete key training before they were allowed to work on their own. A nurse told us, "There are good opportunities for training and professional development."

We saw the home had arranged specialist training for staff so they could meet people's needs. For example, staff had engaged in dementia training over the past 12 months. Our observations confirmed staff showed a good understanding of dementia care. For example, a person with dementia appeared agitated about something they mislaid. The staff calmly reassured them and engaged them in meaningful discussion, this reassured the person. A nurse told us they had recently attended a refresher course on wound care. The deputy manager had arranged additional training for staff on incontinence management, infection control and diabetes through the local authority.

A visiting healthcare professional told us this was 'the best' of the homes they visited. They said staff were always helpful and they had helped to train them to meet individuals' specific needs.

The majority of staff told us they had regular supervision from senior staff and we saw records to support this. A few staff said they had not received supervision for several months but could always speak to management if needed. The deputy manager advised that some staff had not received the expected level of formal supervision and appraisal due to the registered manager recently leaving. We saw that the provider was working to improve this such as training more staff to deliver supervision and implementing a 'supervision and appraisal tracker'.

Staff told us there were regular handover meetings at shift change overs and they had monthly meetings with management. Staff said they found these meetings useful in keeping them up to date with information about people's needs and how to care for people. Similarly, staff meetings kept them informed about organisational issues and developments. At the most recent meetings staff had discussed a range of issues including medication, staff recruitment and rota, residents' surveys and activities.

We saw information about people's nutritional needs that were gathered during their pre-admission assessment using a nutritional assessment tool. Care plans we looked at showed plans were in place to address those needs. People at risk of malnutrition were screened at frequent intervals and referrals were made to health professionals where required.

The kitchen had a noticeboard which clearly detailed people's dietary needs and allergies alongside their photos. The kitchen staff told us the nursing staff were available to advise them in the event of any queries. The chef was familiar with people's dietary needs and their personal preferences. We saw that care staff ordering and serving the meals ensured that specialist diets were provided for. One person told us they had input from a dietician and that kitchen staff were trying to provide a range of suitable food of the right consistency. For two of the people accommodated on one floor there were fluid and food intake charts used for recording they received adequate quantities. We observed staff checking on fluid intake with one person. In at least two cases however, we saw that staff were not completing the fluid charts correctly. For example, there were significant gaps; totals had not been recorded; charts were unsigned. We were told that staff would be reminded to complete charts appropriately.

One person needed percutaneous endoscopic gastroscopy (PEG) feeding. Staff providing the support to the person told us of the training received and felt competent in supporting the person. We saw recommendations were followed such as correct positioning, and accurate records were maintained. External health professionals made regular visits to check the effectiveness of the PEG feeding.

Good

Is the service effective?

People all commented favourably on the menu and choices available. Their comments included, "Food is excellent", "The food is well cooked with a good choice", "Very nice" and "The food is wonderful". Two people said the food available suited their diabetic condition.

We observed lunch in the main dining room. The menus for the day provided a good range of choice and the food on the plates looked appetising. We saw staff members routinely checked what people wanted to eat from the choices available and a variety of drinks were available. A range of snacks was made available when the kitchen was closed. Staff moved around helping people as necessary and took time to sit with people and engage in conversation. We saw people could come and go as they wished – so often people were at different stages of the meal on the same table. We noted some people were not offered an option to transfer from their wheelchairs into a dining chair. We also saw that several of them struggled to reach the table as their wheelchair was too low or too big to get underneath it. We brought this to the attention of the manager who told us they would review the dining arrangements.

People were supported in making decisions about their meals. In the Reminiscence Neighbourhood, we observed staff asked people where they wanted to sit and have their meal, what they wanted to drink, and what they would like to eat. Different members of staff were observed reading the menu slowly out loud to those experiencing visual and/or hearing impairments. Two people were involved with lunch preparations and supported staff to arrange and clear the tables.

People told us they could talk to staff about their care and said they had access to health care services when necessary. One person spoke of receiving regular physiotherapy to restore their mobility and improve their stability, they said they experienced pain on occasions but "staff ensure I am given my painkilling tablets and kept free from pain."

We saw people had their healthcare needs promoted. Those people, who were being nursed in bed because they were unwell, looked comfortable and well hydrated. Appropriate pressure relieving aids were in place where necessary. A person who was confined to bed had relevant care plans in place which contained guidance on minimising associated risks. They were identified as at risk of developing pressure sores, they had a suitable pressure relieving mattress on the bed and had their positions changed regularly to ensure their skin integrity was promoted. At the start of shift we observed that dedicated staff were assigned to care for the person and they kept to the prescribed routine, and recorded all care interventions.

Staff told us there were up to five GP practices involved in providing for the people using the service; this was arranged according to capacity of the surgeries and individual choice. Two of the GP practices held weekly surgeries in the home; this enabled more direct communication with staff at the home. Staff we spoke with were able to tell us about people's health care needs and shared examples of how these were met.

We found that there was good communication with other professionals and agencies to ensure people's care needs were met. The service had made timely referrals for health and social care support when they identified concerns in people's wellbeing. People's needs were closely monitored and they had regular access to healthcare professionals, such as GPs, physiotherapists, chiropodists, opticians and dentists. Other professionals including mental health teams and speech and language therapists were involved in people's care if this met an identified need. Records showed that people had attended regular appointments and staff had followed the advice and guidance provided by health and social care professionals. For example, we saw evidence of good liaison with tissue viability nurses to provide effective care which rapidly improved the situation of one person who was admitted to the home with pressure ulcers.

Good

Is the service caring?

Our findings

Many people spoke positively about the care they received. Our observations and information shared with us by visitors and healthcare professionals in the home indicated this was their experience too.

People we spoke with said the staff were kind, caring and treated them with respect. The most frequent words used were 'friendly', 'very nice', 'kind', 'caring' and 'helpful'. One person said, "The staff here are terribly dedicated and I am treated with kindness." Another person described staff as "very caring and very understanding." Many people told us, "I have no complaints about the staff." A relative said, "The staff here are compassionate and really committed, nothing is too much trouble for them."

Throughout our visit we observed that staff spoke with people in a kind and caring manner and were responsive to their requests. One person explained they suffered from short term memory loss and this was understood by the staff who were always gentle and caring with them. In the Reminiscence Neighbourhood staff provided care and support in a compassionate and attentive manner, speaking kindly with people, taking time for them to respond, and using touch and facial expression to interact with those struggling to communicate their needs verbally.

We saw people met with their visitors in the privacy of their bedrooms and some met their friends in the communal areas. People told us they could choose to see their visitors in the lounge area, the quieter dining room, the garden or in their own rooms. We saw staff knocking on doors and asking people's permission before entering bedrooms. One person told us that, at times, they put a sign up when they did not wish to be disturbed in their room and staff respected this. There were additional meeting rooms available if required. Visitors we spoke with felt welcomed at the home and were invited to social events such as parties and other celebrations.

We observed positive interactions between people and staff. We saw staff speaking to people as they passed them in the corridor, having conversations and addressing people by their preferred name. One relative who visited regularly said that they "liked the way staff still speak with [the person]" as their conversations had an element of fun that used to be part of the person's personality before their dementia grew worse.

Visitors also told us staff showed concern for people's wellbeing. Their comments included "My [relative] always looks great, there are two hairdressers here every week" and another person said, "The beautician comes in weekly to do their nails, my relative enjoys the pampering- such as having [their] hair and nails done."

We saw that staff were patient when speaking with people, and understood and respected that some people needed more time to respond. During lunch one person became upset with another person who they were sharing the table with. Staff approached the former and asked "would you like to sit somewhere else?" supporting them to move to another table. The same member of staff also reassured the second person that "no one was upset", and that they could try to have supper together later in the day.

Care plan records showed people were consulted about how they wished to be cared for. The care plans were centred on the person as an individual. We saw people's preferences and views were reflected and they had signed in agreement to their care records. One person told us they appreciated they had retained their own GP when they moved to the home.

We looked at records for a person who had recently moved to the home. The records confirmed the person had been involved in planning and agreeing their care and they were provided with information about the home and services available. Documentation included a 'personal preferences and care needs summary.' This provided an overview of the person's immediate needs and choices regarding their daily routines and preferred entertainment.

Staff were able to explain to us how they offered people choices and how they knew people's likes and dislikes. We saw people's care plans contained information about people's preferences, as well as the highlights from their life history. We saw people's independence was promoted. For example, the care files were clear about the level of physical support people needed and what they could manage on their own. In reminiscence and assisted living, boxes had been built into the walls next to bedrooms, displaying photographs, personal belongings and any other objects of reference for people, in order to help with recognition of their own private rooms. Three people had their own pets living with them.

Care records contained an 'advance statement' which showed conversations had taken place with people about

Good

Is the service caring?

their wishes in the event of deterioration in their condition. We saw examples where people's end of life care needs were considered and recorded and staff worked with relevant professionals to make sure people's wishes were respected. Some of the care needs assessments and care plans we saw included information about people's requests regarding their end of life care. One example included, "I will like to be referred to the palliative care team for ongoing support with my health."

We saw the records of a person who had received end of life care; these confirmed that the person was cared for in accordance with their wishes and 'advance statement'. We saw this had been discussed with the person, their relatives and the GP. Information about people's religious and cultural beliefs were included as part of their end of life care plan.

We saw examples of 'do not attempt resuscitation' (DNAR) agreements in place. DNAR are decisions made in relation to whether people who are very ill and unwell would want to be resuscitated or would benefit from being resuscitated, if they stopped breathing. Most of the records we sampled evidenced that decisions had been made appropriately and in agreement with the person's family and GP. However, a few DNAR records had not been fully completed and we brought this to the attention of the manager. They told us they would contact the relevant health care professionals to review these records.

Good

Is the service responsive?

Our findings

The majority of people we spoke with felt the care they received met their individual needs. Comments included, "This is the perfect place to live in" and "You could not do much better". Two people said they were "content" living in the home. A person using the service commented on the "little but important things" that showed staff responded well to their likes and preferences. Another person said, "I need to take lots of fluids, staff make sure I have cranberry juice in my fridge as this is the drink I like."

People told us that staff spent time with them on admission to identify or review their care preferences and future wishes. People were provided with copies of the agreed care and support plans, as were their relatives.

Care plans were written in the first person and included details of people's choices and preferences, their likes and dislikes, interests and past occupations. Documentation reviewed was written in a clear and positive tone, reflecting ongoing involvement from both people and their relatives. People's plans also included information about how people preferred to be supported with their personal care. For example, what time people preferred to get up in the morning and go to bed at night and whether they preferred a shower or a bath. Staff we spoke with were able to tell us about people's preferences and routines. They understood and respected people's individuality.

People's diverse needs were understood and supported. We saw people's care plans included information about their needs in relation to age, disability, gender, race, religion and belief and sexual orientation. Two staff members we spoke with about equality and diversity issues were not able to explain how people's needs were identified and met. However, they knew where to find information in people's care records. These staff were also completing their induction which included training on equality and diversity. We saw that throughout the year there were activities which celebrated different cultures. Representatives from different religions visited the home and one or two held services there. We noted at least one person was provided with culturally-specific meals.

The care plans we looked at had been regularly reviewed and updated where people's needs had changed. One care plan for example identified that a person's mobility had deteriorated and they needed assistance of two to three staff members to transfer them safely using a standing hoist.

People we spoke with confirmed a range of social activities were provided. We saw people had access to activities that were important and relevant to them and visiting family members were always invited to join in. Some of the activities that took place during our inspection included singing and exercises, mini bus outing, a visiting school choir and musical entertainer. We also observed activities were individualised and staff encouraged people to retain interests in reading and writing. We saw staff spent time sitting, talking or looking at newspapers with individuals. For a person with a memory problem staff used reminiscence to engage with them, exploring their previous profession with them. People's feedback on the activities offered was discussed at the monthly meetings and suggestions were acted upon where possible. One person told of their enjoyment playing bowls. Another person, however, expressed disappointment in the reduction of the evening entertainment.

The Reminiscence Neighbourhood presented as a warm and welcoming environment for people experiencing cognitive impairment and dementia and there were suitable activities to meet people's needs. For example, there was a sensory room where people could relax in therapeutic surroundings.

The home had a complaints procedure which clearly outlined the process and timescales for dealing with complaints. People we spoke with told us they could talk to staff or the management team if they had concerns or complaints. A person told us they complained about noise from a person next door and felt staff at night were noisy when closing the person's doors. They found their complaint was responded to and staff had been more considerate at night in keeping noise levels low. Other people we spoke with struggled to imagine needing to raise a concern or complaint and responses varied from going to a family member, to the manager or talking to a member of staff.

We saw that complaints made to the home were appropriately recorded. Records showed complaints were recorded, investigated and managed appropriately. Although complaints were reviewed as part of the provider's monthly audits there was no analysis to check

Good

Is the service responsive?

for trends, so that any themes could be identified and acted on. Following our inspection we asked the provider to send us an analysis which identified that call bell responses and communication were common themes for complaints.

Monthly meetings were consistently held to keep people informed of changes and to contribute their views about the service. We were told of one example where people had requested a photo board of staff who worked at the service and this was being developed for each floor. One person told us they had requested more culturally appropriate food. We noted that they had already requested this at a meeting in May 2014, but this had not been acted on. We brought this to the attention of management who agreed to speak with the kitchen staff.

Family support meetings had been introduced for relatives who were provided with information about the service and general care at the home and were also able to raise questions. The provider held regional 'resident council' meetings every quarter and a representative from the home attended.

Requires Improvement

Is the service well-led?

Our findings

A feedback questionnaire was available to people, relatives and professionals involved with the service. We were told that that this year's questionnaires had recently been distributed and results were being collated. The previous year's results showed that, people who participated were mostly satisfied with the care and services provided. A 'community action plan', completed by the former registered manager identified the priority areas and detailed the actions being taken to improve since 2013. Whilst we found the service had systems in place to obtain feedback about the quality of the service, it was not always clear that action plans were completed or shared with people, relatives and other stakeholders or that learning occurred as a result.

For example, we noted some relatives had raised a query about call bell responses in October 2013 and again in June 2014 and an action from the query was for staff to set up a system for monitoring call bells. The manager told us that this had not commenced but people's call bell records were always audited if there was a concern or complaint. We were shown an example where this had occurred and records showed that the person had waited up to an hour for a response. When these were cross checked against the daily care notes we saw that staff had regularly attended to the person during this time. The manager had identified that staff were forgetting to deactivate the alarm pendant which incorrectly showed that the person had experienced a significant delay. However without thorough monitoring of call bell responses over all floors and consideration of the information collected it was unclear what action had been taken for other people when they experienced a delay. Following our inspection we were told that weekly audits of call bell response times would commence later in the month.

We found that the provider's quality assurance methods did not always consider the needs of all the people that used the service. For example, some people were unable to complete a questionnaire and we were told that others chose not to take part in surveys or join in with meetings to share their views. Some people relied on their relatives or representatives to provide feedback. We saw that the response rate for the 'resident and family opinion' survey in 2013 was 31 percent. The manager told us that they would look at other ways of capturing people's views and providing feedback about planned improvements.

When the service began using the new medication system, a daily procedure was put in place to check that medicines were being administered as prescribed. Nurses checked medicines records four times a day for completeness, the deputy manager audited medicines once a month, and the service had arrangements with the new pharmacy supplier to audit twice a year. These checking procedures were effective for oral medicines, but improvements were needed for checking topical medicines, such as creams. When care staff applied topical medicines, this was recorded and the records were kept in people's rooms. We checked records for four people and found that the creams were not being recorded as used as often as prescribed. This had not been picked up during the daily checking procedures, demonstrating that these audits were not sufficient. We brought these issues to the attention of management. They told us that they would include more rigorous checking of the use of creams immediately.

The new manager and deputy worked with staff overseeing the care given and providing support and guidance when needed. Their visibility in the home was confirmed by comments from people using the service and the staff. One person told us, "[the manager] is very approachable… really listens to what you've got to say." Another person said, "I like the new manager she has good ideas." In the Reminiscence Neighbourhood, one staff member told us, "The deputy comes here every day."

There was an open culture in the home. We observed that management spent time speaking with people using the service and relatives and responded to their queries or requests for information. Staff felt able to deal with concerns about each other's practice, and to approach management if and when needed. One staff member said that they knew about the systems in place for raising concerns and were confident that these would be addressed.

Staff had clear lines of accountability for their role and responsibilities and the service had a clear management structure. In addition, there were management arrangements in place for other departments within the home such as maintenance, kitchen and domestic staff.

Requires Improvement

Is the service well-led?

The registered manager had recently left, and there had been several management changes prior to their departure. We asked people and staff how well-led they thought the home was. Some people told us that the ongoing management changes had had an impact on the service such as high staff turnover and different management approaches. One member of staff commented on having four managers in four years as being difficult, particularly as they never really knew why they moved on. Another staff member commented that they constantly had to adjust to a new personality and new management style.

Staff we spoke with said they enjoyed working for the organisation and felt supported by management. Some spoke about positive changes since the arrival of the new coordinator to the Reminiscence Neighbourhood. One felt well supported by their supervisor and clinical staff from other floors, knowing that they could approach these people at any time if in need of guidance or support.

Discussions with the new manager showed they were committed to supporting the staff team to make improvements. The manager told us about the work they had been doing to improve the quality of the service. This had included reviewing staff training and allocation, improving lines of communication and undertaking more audits. A 'daily huddle' meeting was held each day. This was when the manager, nurses and other lead staff met up to discuss issues in the home, risks, changes to people's health and actions for the day. We joined one meeting and observed that there was effective information sharing between all departments.

The provider completed audits to assess the quality of the service. Audits were completed by staff within the home, by other internal teams and external organisations. The provider evaluated these audits and created action plans for improvement. The director of operations visited the home every four months and staff described this as a "mini CQC inspection" when every aspect of care was inspected and rated, and as a result an action plan was produced.

Every month the manager completed a 'quality indicators' report to check various aspects of people's care. We checked the reports for March to June 2014. These indicators covered issues such as nutrition, pressure damage, infections, reasons for hospital transfers, accidents and incidents, safeguarding events, medicines management, information about complaints and meetings. We also saw that staff undertook internal audits on infection control and care plans. Accident and incident records were fully completed and checked by the manager although there was no overall analysis of falls to check for any themes or trends. We were told that this would be implemented following our inspection.

The provider arranged an annual staff survey to gather the views of staff about how to improve the quality of the service. This had recently been completed with staff working at the home and 75 percent had responded. At the time of our inspection full results were not available to us as they were still being analysed. However, we were provided with a 'snapshot' summary and saw that there had been a slight improvement in overall score rates from the previous year.