Sunrise Senior Living Limited

Sunrise Operations Esher Limited

Inspection report

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Esher
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Tel: 01372410000

Date of inspection visit:
15 December 2016

Date of publication:
01 June 2017

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

Summary of findings

Overall summary

Sunrise 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 home is a large, bright and airy building split into two units, based on the needs of the people that lived there. There was a reminiscence unit for people that lived with dementia, and an assisted living unit for people that did not require much support from staff. Communal areas, for the use of people from both units, include a large dining area, large lounge, gardens.

There was a not registered manager in post. 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 new manager had just started at the home, and had begun the process of registering with us.

The inspection took place on 15 December 2016 and was unannounced. At our last inspection in September 2013 we had not identified any breaches in the regulations. There was positive feedback about the home and caring nature of staff from people who live here.

People told us they were happy living here. Comments such as, "It's a lovely place. I couldn't be looked after better," "very nice people," and, "I'm comfortable and satisfied." Were made to us during the inspection. Staff were happy and confident in their work and proud of the job they do.

Care records were not always person centred, and people did not always receive the support they needed to meet identified needs. We have identified one breach in the regulations. You can see what action we have asked the provider to take at the back of the full version of this report.

People were safe at Sunrise Esher because there were sufficient numbers of staff who were appropriately trained to meet the needs of the people who live here. Staff understood their duty should they suspect abuse was taking place, including the agencies that needed to be notified, such as the local authority safeguarding team or the police. Risks of harm to people had been identified and clear plans and guidelines were in place to minimise these risks.

Staff recruitment procedures were safe to ensure staff were suitable to support people in the home. The provider had carried out appropriate recruitment checks before staff commenced employment.

Staff managed the medicines in a safe way and were trained in the safe administration of medicines. People received their medicines when they needed them.

Staff received comprehensive training, to ensure they could meet and understand the care needs of the

people they supported.

Where people did not have the capacity to understand or consent to a decision the provider had followed the requirements of the Mental Capacity Act (2005). An appropriate assessment of people's ability to make decisions for themselves had been completed. Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) to ensure the person's rights were protected.

People were supported to maintain good health as they had access to relevant healthcare professionals when they needed them. People's health was seen to improve due to the care and support staff gave.

People had enough to eat and drink, and received support from staff where a need had been identified.

People's individual dietary requirements where met. Where people had commented on the preparation of the food, the provider had investigated to try and see if they could put things right.

The staff were kind and caring and treated people with dignity and respect. People had access to a wide range of activities that met their needs. Activities were based on individual interests and people were supported to continue with hobbies.

Feedback was sought from people, and complaints and compliments were reviewed to improve the service. When complaints were received these had been dealt with quickly and to the satisfaction of the person who made the complaint. Staff knew how to respond to a complaint should one be received.

The service was well led. Quality assurance records were kept up to date to show that the provider had checked on important aspects of the management of the home. The manager had ensured that accurate records relating to the care and treatment of people and the overall management of the service were maintained. The provider had effective systems in place to monitor the quality of care and support that people received.

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 felt safe living at the home. The provider had identified risks to people's health and safety with them, and put guidelines for staff in place to minimise the risk.

There were enough staff to meet the needs of the people.

Appropriate checks were completed to ensure staff were safe to work at the home.

People's medicines were managed in a safe way, and they had their medicines when they needed them.

Is the service effective?

Good

The service was effective

Staff had access to training to enable them to support the people that lived there.

People's rights under the Mental Capacity Act were met. It is recommended that the provider review whether relatives have lasting power of attorney for care and finances where they are making these decisions for people.

Assessments of people's capacity to understand important decisions had been recorded in line with the Act. Where people's freedom was restricted to keep them safe the requirements of the Deprivation of Liberty Safeguards were met.

People had enough to eat and drink and had specialist diets where a need had been identified.

People had good access to health care professionals for routine check-ups, or if they felt unwell. People's health was seen to improve as a result of the care and support they received.

Is the service caring?

Good

The service was caring.

Staff were caring and friendly. We saw good interactions by staff that showed respect and care.

Staff knew the people they cared for as individuals, however peoples care records did not always contain relevant information about people's lives.

People could have visits from friends and family whenever they wanted.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans were not person centred and people did not always get the support identified in their assessments. People were involved in their care plans, and their reviews.

People had access to a range of activities that matched their interests, and physical and mental health needs.

There was a clear complaints procedure in place. Complaints were used as a tool to improve the service for people.

Is the service well-led?

Good

The service was well- led.

People and staff were involved in improving the service. Staff felt supported and able to discuss any issues with the manager. Feedback was sought from people via surveys and regular meetings.

Quality assurance records were up to date and used to drive improvement throughout the home.

The manager understood their responsibilities with regards to the regulations, such as when to send in notifications.

Sunrise Operations Esher Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 December 2016 and was unannounced. Due to the size and layout of this home the inspection team consisted of five Inspectors.

Before the inspection 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.

The provider had not been requested 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.

To find out about people's experience of living at the home we spoke with 23 people and two relatives. We observed how staff cared for people, and worked together as a team. We spoke with 17 staff which included the manager and area manager. We reviewed care and other records within the home. These included 10 care plans and associated records, 10 medicine administration records, five staff recruitment files, and the records of quality assurance checks carried out by the staff.

Good

Is the service safe?

Our findings

People were safe living at Sunrise Esher. One person said, "There's always someone around so yes, I do feel safe". Another person said, "The staff care and protect people."

People were protected from the risk of abuse. Staff were aware of their role in reporting suspected abuse and were able to recognise the different types of abuse and neglect that could happen at a care home. They were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member said, "I would always let the manager know if I suspected a resident was being abused or getting poor care. I would ring Safeguarding if they didn't". Staff understood how to act as 'whistle-blowers' and report concerns outside the organisation if their manager did not take action to keep people safe.

There were safe recruitment practices in place. Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that they were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

There were enough staff deployed to meet peoples care and support needs. People said that staff were always around and they came quickly when called. One person said, "I think so, yes. I must say though that the staff seem on the go all the time." Another person said, "Staff come fairly quickly (when I call them)." A relative said, "I feel as if there are enough staff. Someone comes quickly if the buzzer is used." Call bells were responded to in reasonable time by the staff on the day of the inspection. Staffing levels were calculated on the needs of the people who lived at the home. The provider used a dependency tool to assess the care needs of people who lived at the home. Staffing rotas showed that levels of staff on shift over the past four weeks matched with the calculated support levels of the people that lived here.

Staff enjoyed working at the home, but gave a mixed response on the levels of staff deployed. This depended on the area of the home that they worked. In the assisted living part they felt there were enough of them to undertake their roles, but "We just run around all day and there is never enough time to spend with the residents." In the reminiscence part (for people with higher support needs) all the staff we spoke with said they felt there were enough of them to undertake their roles well. There were enough staff available on the unit which had a calming effect on the people who lived there. The lounge area was always supervised by staff. When staff left the area for anything they ensured there was someone around to observe incase people needed assistance. This matched with the management of falls guidance in people's care plans, demonstrating staff understood and followed the guidelines to minimise identified risks of harm to people.

People were safe because accidents and incidents were reviewed to minimise the risk of them happening again. A record of accidents and incidents was kept and the information reviewed by the registered manager

to look for patterns that may suggest a person's support needs had changed.

People were kept safe because the risk of harm from their health and support needs had been assessed. People were not restricted from doing things because it was too 'risky'. One person said, "Oh yes, there are no restrictions at all. I go out with my friends for lunch if I want". Another person said, "I feel absolutely safe. I control my own destiny." People with limited mobility, were not prevented from moving around and were actively supported by carers who ensured their safety and who respected their decisions. One staff member told us, "It depends where you work. In Assisted Living, most people just come and go as they want. In Reminiscence, things are a bit different but we do make sure residents have maximum freedom". Our observations on the day confirmed staff were mindful of people's rights to take risks. Throughout the day people were able to move freely around the home. Staff encouraged people to maintain their mobility by only offering support if the person was struggling or was at risk from falling. Where support was offered it was discrete and followed good moving and handling practice.

Risk assessments had been regularly reviewed to ensure that they continued to reflect people's needs. These were used as part of the review of accidents and incidents to people received a safe level of care, and to minimise them happening again. Assessments had been carried out in areas such as nutrition and hydration, and mobility. Measures such as specialist equipment to help people mobilise around the home, or to call staff if help may be needed, had been put in place to reduce these risks. Pressure mats were by some people's beds. These would alert staff if someone with a mobility support need had got out of bed.

People at risk of falls were not left unattended in communal areas and call bells were within easy reach of people who stayed in their bedrooms. People had personalised mobility equipment to enable staff to move them in a safe way. People who may need help mobilising, such as with the use of hoists had their own slings. This reduced the risk of accidents as the sling was the correct size for each person, and held them securely and safely when in use. In addition individual slings also reduced the risk of cross infection because other people did not use them. Observations made during the inspection confirmed that people were assisted by staff in a safe way that matched the information in risk assessments.

People lived in a safe home. The home was well maintained clean, and decorated to make a pleasant and interesting environment for people. Assessments had been completed to identify and manage any risks of harm to people around the home. Areas covered included infection control, and fire safety. The manager had regularly reviewed the needs of people to ensure the environment met those needs.

People's care and support would not be compromised in the event of an emergency. Information on what to do in an emergency, such as fire, was clearly displayed around the home. People's individual support needs in the event of an emergency had been identified and recorded by staff in fire evacuation plan. Emergency exits and the corridors leading to them were all clear of obstructions so that people would be able to exit the building quickly and safely. Fire safety equipment and alarms were regularly checked to ensure they would activate and be effective in the event of a fire. Staff were able to tell us how they would support people to evacuate the building in an emergency that matched with the evacuation plan.

People received their medicines in a safe way, and when they needed them. Staff who gave medicines were able to describe what the medicine was for to ensure people were safe when taking it. Staff followed safe medicine administration procedures. They wore a special apron to say they were not to be disturbed while undertaking a medicine round, they locked the medicine trolley while it was unattended, washed their hands between and people and only signed Medicine Administration Record (MAR) charts when medicine had been given.

The ordering, storage, recording and disposal of medicines were safe and well managed. Medicines were stored securely in the clinical room which was clean, spacious and well arranged. Medicine was stored at the correct temperatures as detailed on the prescription. There were no gaps in the medicine administration records (MARs) so it was clear when people had been given their medicines. Medicines were stored in locked cabinets to keep them safe when not in use. For 'as required' medicine, such as medicines that may help people to relax or give pain relief, there were guidelines in place developed by the GP which told staff the dose, frequency and maximum dose over a 24 hour period. Medicine documentation recorded that these guidelines had been followed. We saw the team leader ask people if they required this medicine for example "Have you got any pain" and would you like something for that."

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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. The provider had not always complied with the requirements of the Mental Capacity Act 2005 (MCA). Some people were unable to understand why they had to stay at the home, or how to manage their finances.

Where people could not make decisions for themselves the management had not always had effective processes to ensure decisions were made in accordance with the Act. For example when financial decisions were made by relatives, the provider had not always ensured the relative had the legal authority to do so. It is recommended that the provider review records of who can make decisions for people's health and finances to ensure these individuals have the legal authority to do so.
Care staff had a good understanding of the Mental Capacity Act (2005) and were seen to work within the legal framework of the act when supporting people. One person said, "Oh they (staff) wouldn't do anything without asking first." Staff sought people's permission before providing care, and took time to explain choices that were available to help the person understand.

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). Some people's freedom had been restricted to keep them safe. Where people lacked capacity to understand why they needed to be kept safe the registered manager had made the necessary DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible. One person had a history of leaving the home, but was unaware of the dangers they could face if not accompanied by staff. The appropriate DoLS application had been submitted as staff understood that the person did not have capacity to understand how they had restricted that person's liberty to keep them safe.

People were supported by trained staff that had sufficient knowledge and skills to enable them to care for people. Staff had effective training to undertake their roles and responsibilities to care and support people. The induction process for new staff was robust to ensure they would have the skills to support people effectively.

Staff received on-going training to ensure they were kept up to date with current best practice. Staff training included safeguarding adults, first aid, health and safety, food hygiene, infection control, end of life care, dementia awareness, moving and handling, and behaviour management. Staff were also encouraged to take qualifications such as the care certificate in social care. This is a national qualification that gives staff a

grounding in all aspects of care. The effectiveness of the training was displayed during the inspection where staff responded with calmness and confidence to help people when supporting their mobility. Staff also demonstrated the correct use of equipment such as walking aids, mobility hoists, foot rests for wheelchair use, and pressure cushions when supporting people.

Staff were effectively supported. Staff told us that they felt supported in their work. One said, "We get good support." Staff had regular one to one meetings (sometimes called supervisions) with the manager, as well as annual appraisals. This enabled them to discuss any training needs and get feedback about how well they were doing their job and supporting people.

People had enough to eat and drink to keep them healthy and had good quality, quantity and choice of food and drinks available to them. Some people felt that although the quality of the food was good, the preparation of the food could be improved. Comments included, "Food is marvellous, nothing to complain about"; "Food could be better" and "Food has been mentioned to the new manager. It's the way its cooked isn't nice." The management were aware of the issues and a regional team from the provider had visited the home the day before the inspection to investigate the dining experience. A report containing recommendations would be issued subsequently.

People's special dietary needs and choices were met. People had a nutritional care plan in place and this provided staff with specific information regarding special diets. Various dietary requirements were catered for, such as soft diets, and vegetarian diets. Each new person to the home had a dietary requirement form completed by staff in conjunction with the person. The head chef then referred to this information, which was kept on colour coded boards in the kitchen. Where people had a pureed lunch each food item was kept separate on the plate so people could taste the individual components of the meal, and have different taste experiences. People were given choices about meals and choice of drinks. People's likes and dislikes were documented and kept in the kitchen, accessible to staff. These preferred choices were seen to be provided during the inspection. Ample tea and coffee was served throughout the day and staff were seen to offer encouragement to people to remind them to drink plenty of fluids.

People were protected from poor nutrition as they were regularly assessed and monitored by staff to ensure they were eating and drinking enough to stay healthy. People had nutritional care plans and their weight was monitored and recorded to identify any changes that might indicate a need for additional support.

People received support to keep them healthy. People have access to a range of medical professionals including, speech and language therapists, community nurses, audiologists and GPs. Where people's health had changed appropriate referrals were made to specialists to help them get better, for example speech and language therapists if people's eating habits changed.

Good

Is the service caring?

Our findings

People told us that the staff were kind and caring, but depending on what part of the service we were in, others felt improvement could be made. Comments included "Staff are ever so helpful." "Absolutely lovely, I can't ask for better." However other people in the assisted living area said "While they (staff) do care they're very busy. I think when you're like that you just tend to see things in terms of getting things done, like tasks." A relative said, "Care is good or very good."

People's preferences with respect to their religion or cultural beliefs were known by staff, however not all aspects of one person's faith had been recorded by staff. This could result in a person's preferences not being met, in certain situations, such as if a person passed away suddenly staff had not been given guidance on how the person's body should be treated. At the time of the inspection this only affected one person. The manager said they would review how religious and cultural information was made available to staff. People had access to services so they could practice their faith.

People's life histories were not always clearly recorded, to assist staff in getting to know people as individuals. This varied depending on which part of the home the person lived. Records in the reminiscence area tended to be more detailed than in the assisted living area. On two occasions we spoke with people in this area, and in our short time with them, found out about their life and family. This information had not been recorded in the life history section of these peoples care plans, so there was a risk staff may miss this information. This could have an impact as people may say or behave in a particular way that links back to things that happened in their life. Without this information staff may not know how to properly respond. The manager said they would review the detail in care plans to ensure they better reflected peoples life experiences. Relatives said that the staff knew people well and knew how they liked to be cared for.

Throughout our inspection staff had positive, warm and professional interactions with people. The atmosphere in the home was calm and relaxed and staff spoke to people in a caring and respectful manner. People told us that they were pleased with the standard of care at Sunrise Esher because staff were kind, and listened to what they wanted and responded quickly to their wishes. We observed good interaction between people and staff who consistently took care to ask permission before intervening or assisting people. There was a good level of engagement between people and staff. Consequently people, where possible, felt empowered to express their needs and receive appropriate care.

Staff were very caring and attentive with people. Staff never passed people without talking to them, offering them choices and reassuring them. The staff showed a caring attitude by the manner they behaved towards the people they supported. Staff engaged with the people instead of each other. They maintained eye contact when talking with people and they got close to people, sometimes getting on their knees so they person could clearly see and hear them. They showed warmth by putting their hands on the shoulders of the people and by holding their hands. They spoke slowly and sometimes repeated questions to ensure that the person had heard them. They showed respect by knocking on bedroom doors before going in, and they give information to people before, during and after giving care and support.

Staff treated people with dignity and respect. One person said, "Staff talk to me respectfully. It's very good in that respect." Staff took time to explain things to people before they gave care or support. One person asked staff to, 'take away the curtains'. The person was referring to the curtain screen used so staff could use a hoist to move someone in private. The staff went over and calmly explained to the person what the curtain was for, why there were there and that they wouldn't be there for long. Staff took the time to check peoples clothing to make sure they were in good order, such as pulling a jumper back into place where it had rucked up, to protect the person's dignity.

People were given information about their care and support in a manner they could understand. Information was available to people around the home. It covered areas such as local and national events, in house activities, and information from the provider, such results of surveys. People told us that they were asked about their care and that staff did listen to them. People's care plans and daily records documented how staff involved people and their families with their care as much as possible. Care plans and risk assessments were reviewed regularly and signed by staff and relatives or representatives. People or their representatives had regular and formal involvement in ongoing care planning or risk assessment.

People's bedrooms were personalised with furniture from home, ornaments and personal photographs. One person said, "I have a very nice room, which I've made into my home." The rooms were equipped with kitchenettes so relative could make drinks when they visited. In the reminiscence unit people did not have capacity to use these facilities but would be supports as necessary. A relative said they could visit whenever they wished and that they were made welcome by staff. They said, "The staff are very welcoming to us as visitors. We are always made welcome. I am unable to fault this place." The reminiscence unit was dementia orientated and had a calming influence on the people who lived there. The general manager told us about the plans they had to improve the unit with personal rummage boxes with things that were important to people.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed before they moved into the service to ensure that their needs could be met. However these assessments had not always contained detailed information about people's care and support needs. The assessments and care plans were not personalised. People's choices and preferences were not always documented. The care plans and pre-admission assessments we examined did not contain detailed life or social histories. It was not possible to 'see the person' in these care plans. For example, one person's social history contained only details of what they liked to be called, their previous job and that they liked to be as independent as possible. This was repeated, verbatim, twelve times in other parts of the care plan. Consequently, staff were not able to access information that would help build meaningful relationships.

The care plans did not always contain detailed information about people's care needs and actions required in order to provide safe and responsive care. For example, we noted one person had an extensive psychiatric history of affective bi-polar disorder and depression. They had been detained under the Mental Health Act (1983) for several months in 2015. The Individualised Service Plan for this person stated they were at risk of withdrawal and social isolation if not observed and assisted to undertake meaningful activities, occupations and social contact. Under 'Special Instructions', we noted staff had stated the person could, "with encouragement live a purposeful life. They are not motivated and will not initiate things but with encouragement, will engage". However, there was no subsequent plan as to how this was to be achieved.

The daily notes we examined did not indicate any systematic approach to this issue; they only described the person's day in terms of personal care and diet. We found no evidence of meaningful occupations being offered by staff and no evidence of input from the provider's activity co-ordinator. For example, an entry on 5 December 2016 described the person doing a crossword puzzle at 10pm. There were no further references to any activities after this point to our visit, ten days later. The person often largely remained in their room for several days in a row. In addition, the staff we spoke with caring for this person were unaware of their diagnosis. One staff member told us, "I think she has some kind of problem but I don't really know what. We do try to encourage her to come out of her room; we'll get her a full English (breakfast) which she likes but it doesn't always work". We asked if the person was involved in any activities. We were told, "No, not really. It would be better if they were seen one to one but I don't think they are. People here have to fit round the activities on offer". We found the lack of detail about people's lives to be consistent in all of the care plans we looked at.

Person centred care was not always provided to meet peoples identified care and support. This was a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

People had been involved in the development of their care plans, and during the initial assessment process. One person said, "Staff came to my house and asked me questions."

People had access to a wide range of activities many of which focussed and promoted peoples well-being,

physical and mental health, such as Tai Chi. One person said, "They do their best" with regards to activities. Another person said, "If you feel like it you can join in on lots of activities." People were able to follow their hobbies and interests. Comments such as "We have trips out on the bus to see old places." "We had some Christmas dancing." "I do what I like; I like to walk around the gardens" confirmed that people were happy with the level of activities provided. There was a smoking room to meet the needs of smokers.

People were supported by staff that listened to and responded to complaints or comments. People told us they would feel comfortable making a complaint if they needed to and were confident that any concerns they raised would be addressed. One person said, "If you have to complain you go to the chief in charge. He is very good at arranging things to be discussed. He does what he can do to help you. He is prepared to help." People told us that they had no real concerns. They went on to say that when they had mentioned something then it was sorted quickly by staff.

A relative confirmed they had been given a copy of the home's complaints policy when their family member moved into the home, so understood how to complain if they felt the need to. The policy included clear guidelines on how the registered manager should respond and when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Care Quality Commission.

Where complaints had been received these had been clearly recorded and responded to in accordance with the provider's complaints policy. The manager and staff explained that complaints were welcomed and would be used as a tool to improve the service.

Good

Is the service well-led?

Our findings

There was a positive culture within the home, between the people that lived here, the staff and the manager. The atmosphere was very welcoming and open. People were happy to share thoughts about their life at Sunrise Esher with us. Staff were seen to provide a positive experience for people living at Sunrise Esher. There was a warm atmosphere amongst staff with good support offered between themselves when helping people. Staff said, "We work well as a team."

The home was well managed to ensure people received a good quality of care and support. People and relatives described the manager as being available, visible and somebody who would help if necessary. One person said, ""The new manager seems very affable. I am hoping for good things from him." Another person said, "Management – they are very nice people." Staff said the manager had an open door policy and they could approach the manager at any time. Staff felt supported and able to raise any concerns with the manager, or senior management within the provider.

Records management was good and showed the home and staff practice was regularly checked to ensure it was of a good standard. Records of quality assurance and governance of the home were also well organised and showed the manager had a good understanding of the care and support given to people. People and staff were consulted during these audits to give their views.

Regular monthly checks on the quality of service provision took place and results were actioned to improve the standard of care people received. Audits were completed by the manager and staff on all aspects of the home. These covered areas such as infection control, health and safety, and medicines. All of these audits generated improvement plans which recorded the action needed, by whom and by when. Actions highlighted were addressed in a timely fashion. The issues we had identified during our inspection had, for the most part, already been identified by the management team and they were in the process of taking corrective action, for example the comments about the food. The information form quality assurance checks and management reports was compared against other homes within the Sunrise Group so the provider could identify if a certain home needed additional management support, or if a pattern of similar failures appeared across their services.

People and relatives were included in how the service was managed. One person said, "The manager talks with everyone." There was a 'resident's council' which took place every few months. This was an opportunity for people to talk with the management about their experiences at the home, and for the management to respond, and also share information about upcoming changes and seek people's views. Areas such as the suitability/peoples enjoyment of some of the activities offered had been discussed at the last meeting, and we saw that this had prompted a review by the activities coordinator. Families were given the opportunity to comment and ask questions about issues and what the staff had done to put things right. People and relatives had the opportunity to discuss any improvements they felt needed to be addressed. These were clearly recorded in the minutes and action had been taken to address them.

Staff were encouraged to give feedback about how the service was managed. A number of initiatives took

place to facilitate this, such as "Town Hall" meetings to celebrate staff success and achievements to Team Forums were a member of each department has the opportunity to talk with the general manager.

The manager was visible around the home on the day of our inspection, supporting staff and talking with people to make sure they were happy. The manager ensured they had a good grasp on how the service was running to ensure people had a positive experience. He chaired daily meetings with the heads of department to discuss issues around the home, and if things were running smoothly. Areas covered included staffing levels (and the skills of staff, such as first aiders) to ensure people's needs could be met to individual's birthdays to ensure staff celebrated with them. The meeting encouraged a good level of team work as each department within the home had a clear understanding of what was required from them on a daily basis. Accidents and incidents were also reviewed at this meeting, which enabled the management team to look for patterns and discuss options to prevent them happening again. For example where a person may have fallen, staff from the care team were able to discuss with the maintenance team aspects of the persons care and the environment to minimise the risk of further falls.

The manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. This meant we could check that appropriate action had been taken. Information for staff and others on whistle blowing was on display in the home, so they would know what to do if they had any concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Person centred care was not always provided to meet peoples identified care and support.