Sunrise Operations Sevenoaks Limited

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Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

Sunrise Operations Sevenoaks Limited provides accommodation, nursing and personal care for up to 102 older people. There were 94 people living at the service during our visit, some of whom were living with dementia, Parkinson's disease and other complex needs. A number of people had other conditions including stroke and diabetes, and some people had reduced or impaired mobility and used wheelchairs to move around.

There were also people who lived independent lives, continuing to drive and come and go as they chose. Accommodation is provided over three floors with communal areas on each floor. The third floor, known as 'the reminiscence neighbourhood', was for people who were living with dementia which had progressed and impacted on their daily lives. The ground and first floors were known as 'the assisted living neighbourhood', some

Summary of findings

people who were living with dementia also lived accommodated on these floors. There was a passenger lift between floors and all areas of the accommodation were accessible to people who used wheelchairs.

The service did not have a registered manager. The previous registered manager had resigned the week before our inspection and interim management arrangements were in place to cover the service whilst recruitment to the post was in progress. 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.

This inspection took place on 15, 16 and 22 December 2014 and was unannounced. The previous inspection was carried out in May 2014 when we found the service met the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Some people made complimentary comments about the service they received. People felt safe and well looked after. However, our own observations and the records we looked at did not always match the positive descriptions people had given us. Relatives who we spoke with before and during our inspection raised a number of concerns about the service their family members' received.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The former registered manager had submitted four Deprivation of Liberty Safeguards (DoLS) applications, one of which had been authorised by the local authority. The management understood when an application should be made and how to submit one and were aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

Less than half the staff had received training in MCA to make sure they understood how to protect people's rights. There were procedures in place and guidance in relation to Mental Capacity Act 2005 (MCA). People were asked for their consent before staff carried out care or treatment, although

The provider had not taken adequate steps to make sure that people were protected from abuse. There had been numerous incidents of abuse, some of which the local authority safeguarding team had investigated and found that abuse had taken place. Staff training in safeguarding people was not up to date and staff did not have access to all the information they needed about reporting abuse.

The risks to people had not been updated following changes in their safety or welfare including when they had experienced falls. Staff did not have the guidance they needed to take appropriate action to keep people safe.

The provider did not always follow safe recruitment procedures to make sure staff were suitable to work with people because full employment histories were not always obtained. There were not always enough staff employed in the home to respond in a timely manner when people called for assistance.

Safe medicine administration procedures were not always followed so that people got their medicines when they needed them. Medicines were stored safely.

Staff had not all received the essential training or the updates required. This included training in safeguarding adults and managing behaviour that may challenge the service. Staff had not attended training in caring for people with specific needs such as Parkinson's disease, sensory impairment and other conditions.

Care staff had not received the supervision, appraisals and support they needed to enable them to carry out their roles effectively. Staff told us that morale was "Very low" because they did not feel supported by the management and were not involved or consulted in decision making as they did not have supervisions, or regular team meetings.

Staff told us that they felt people were moved into the service when there were not enough staff to meet their needs. A GP told us they were concerned that people were moved into the service without adequate assessment.

Summary of findings

A number of people had complex needs which staff did not feel they were equipped or resourced to meet. Staff said they did not have time to read care plans and the written information they were given was inaccurate and out of date.

People's weights were not monitored and recorded regularly to make sure they were getting the right amount to eat and drink to protect them from the risk of malnutrition. There were mixed views about the meals provided. Some people were complimentary but most people told us the food was bland and not to their liking. Staff made sure that people's dietary needs were catered for. Staff did not consistently respect people's dignity. People who needed support to eat were not always helped in a dignified way. People's information was treated confidentially. Staff made sure that any personal care people needed was carried out in private.

People were not supported adequately to manage their health care needs. A relative told us that an appointment had been missed because a letter from a health professional was not given to the person or their relative in time. Relatives also gave examples of infections and injuries which had gone unnoticed until relatives pointed them out to staff. Pressure ulcers were not managed effectively to make sure these wounds were prevented. A GP shared concerns with us about how the staff managed people's health and communicated with the GP surgery.

Some relatives expressed concern about the general care of their family members and told us that poor communication meant they were not always kept informed about changes and decisions, or listened to when they expressed concerns about the way their family members' care was being delivered. One relative told us they had removed their family member from the service because they were not getting the care they needed.

Ways to enable people living with dementia or other conditions to remain as independent as possible had not been explored such as dementia friendly signage and adaptations to the premises and equipment people used. Staff were very busy carrying out tasks and mostly did not have time to initiate conversations with people other than when they were providing the support or treatment people needed. Most of the staff were kind, caring and patient in their approach and had a good rapport with people.

People did not always know who to talk to if they had a complaint. Relatives told us that the manager had not been around for weeks and there were always different faces. They did not know if concerns they raised were passed on to the right people and gave examples of complaints they had made that had not been addressed. The changing management team meant that staff, people and their relatives did not know who to go to with any concerns.

The approach to activities was to entertain, do to, rather than support people to participate in activities. There were no individual activity programmes to ensure people living with dementia were provided with meaningful activities to promote their wellbeing. People told us they enjoyed the activities they were able to choose from but their individual needs had not been considered in planning the activities.

People were supported to maintain their relationships with people who mattered to them. Visitors were welcomed at the service at any reasonable time and people were able to spend time with family or friends in their own rooms and other areas. There were links between the home and the local community. Children from the local school were giving a Christmas concert for people during our inspection.

People and their relatives had raised concerns about the leadership of the service. They had not been kept informed about changes in the management team and did not know who was in charge. There had been no recent residents or relatives' meetings or customer satisfaction surveys to show that people were consulted and their views taken into account in the way the service was delivered.

There was an interim manager at the service. At other times during each week, relief managers and other senior managers were present at the service. Communication was not always effective in ensuring that important information was passed on to appropriate people to make sure that action was taken in a timely manner to address issues relating to people's safety, care and welfare.

Quality assurance systems had not been effective in recognising shortfalls in the service. Although some shortfalls had been recognised and an action plan had been developed, improvements had not been made in

Summary of findings

response to accidents and incidents to ensure people's safety and welfare were promoted. Records relating to people's care and the management of the service were not well organised or adequately maintained.

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?

Inadequate 

The service was not safe

People were not protected from abuse or the risk of abuse.

There were not enough staff employed in the home to meet people's needs.

People were not safeguarded because risks to people's safety and welfare were not identified or managed to make sure they were protected from harm.

The provider did not follow safe recruitment procedures.

Improvement was needed to make sure people consistently received their medicines safely and at the prescribed times.

Is the service effective?

Inadequate 

The service was not effective

The provider met the requirements of the Deprivation of Liberty Safeguards. There were clear procedures in place in relation to the Mental Capacity Act 2005.

Staff did not have all the essential training or updates required. Staff did not receive the supervision and support they needed to carry out their roles effectively.

People were not supported effectively with their health care needs.

People's weights were not monitored and recorded regularly to make sure they were getting the enough to eat and drink.

Is the service caring?

Requires Improvement 

The service was not consistently caring

People were not always consulted about their own care.

People's dignity was not consistently protected.

Staff were kind, caring and patient in their approach and supported people in a calm and relaxed manner.

Is the service responsive?

Inadequate 

The service was not responsive.

People and their relatives did not know who to talk to if they had a complaint. Relatives told us that complaints they had made had not been addressed in a timely manner or not at all.

Summary of findings

People's care plans had not been updated to reflect advice from health professionals and changes in their care and support needs which meant they did not receive the support they needed.

People were not supported to remain as independent as possible through appropriate adaptations to the environment and equipment.

People living with dementia were not supported to take part in meaningful, personalised activities. People were supported to maintain their relationships with people who mattered to them.

Is the service well-led?

Inadequate 

The service was not well led.

Communication was ineffective and people and their relatives were not informed about significant changes in the management team.

Quality assurance systems were not effective in recognising shortfalls in the service. Action and improvements plans were developed but necessary action had not been taken to make sure people received a quality service.

Records relating to people's care and the management of the service were not well organised or adequately maintained.

Sunrise Operations Sevenoaks 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 checked 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, 16 & 22 December 2014 and was unannounced.

The inspection team included one inspector, a pharmacist inspector, two specialist advisers, one of whom was a dementia specialist, and one who was a registered nurse. They advised us on aspects of nursing care and the quality of services people living with dementia received. The team also included an expert-by-experience who had personal experience of caring for older family members. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We gathered and reviewed information about the service before the inspection including information from the local authority and previous reports. We looked at notifications we had received from the provider. This is information the provider is required by law to tell us about. We looked at information relatives, staff and the local authority safeguarding team had sent us about the service.

We would normally ask the provider to complete a Provider Information Return (PIR). This is a form that asks for some key information about the service, what the service does well and improvements they plan to make. However, this inspection was planned in response to concerns we had received and there was not time to expect the provider to complete this information and return it to us. We gathered this key information during the inspection process.

During our inspection we observed care in communal areas; examined records including staff rotas; management records and care records for seven people. We looked around the premises and spoke with 17 people, seven visitors, two care coordinators, the interim management team, the deputy manager, three senior managers, four nurses and 12 care staff. We also spoke with a GP and two members of the local authority safeguarding team.

Inadequate

Is the service safe?

Our findings

Most people told us they did feel safe at the service. However some people expressed their concerns about theirs and their family's safety. One person told us they could not find any staff around to ask for anything. There were mixed views from relatives about how safe they felt their family members were. Relatives shared concerns about the lack of staff and the impact this had on their family member's safety. One relative told us about occasions when they had found that their family member had sustained injuries that had not been noticed by staff. Another relative told us they had removed their family member from the service because they were concerned about their safety and wellbeing. Other relatives said, "I feel very happy that my wife is safe here" and "I feel that my husband is safe here."

The provider had not taken reasonable steps to protect people from abuse or the risk of abuse. Staff training in safeguarding had not been kept up to date and some staff had not received any safeguarding training. Two social care professionals from the local authority safeguarding team told us they had received a high number of safeguarding referrals in the last year and found that abuse had occurred on a number of occasions.

Some people presented behaviours that challenged and placed themselves or others at risk of harm. Less than half the staff had received training in managing behaviours that challenged. Staff told us about one person whose behaviour was unpredictable, "They go off like a bomb and lash out at whoever is near them". Staff told us they did not know what to do because they could not watch the person all the time. A number of incidents of abuse had occurred. Twenty incidents were reported to CQC in the last nine months. Risk management strategies were not effective or had not been put in place in response to incidents to make sure that people were protected from abuse.

People were not protected from the risk of falls. Two people's records showed that they had fallen 14 times in the eight weeks before our inspection. One other person had fallen eight times in the two weeks before our visit. There had been no analysis, risk assessment or risk management strategies put in place to protect them from the risk of falling.

Twelve people had pressure wounds, Nurses told us that treatment was delayed because of "A convoluted process" they had to use once they had clinically identified someone at risk of skin deterioration. They told us the process required them to refer the information to the deputy manager which delayed decisions about treatment by up to 24 hours. Nurses said that this delay in decisions about treatment meant that there was risk that wounds could deteriorate further before appropriate action was taken.

The provider had not taken steps to identify the possibility of abuse and prevent it before it occurred. The examples above were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider did not always follow safe recruitment procedures. The staff files did not include full employment histories. However documents did include included previous employment references and pre-employment checks. Records also showed staff were checked with the Disclosure and Barring Service (DBS) before they started work. DBS enables employers to make safer recruitment decisions by identifying candidates who may be unsuitable.

The provider had not obtained a full employment history, together with a satisfactory written explanation of any gaps in employment as required in Schedule 3. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were not always enough staff to make sure people were safe. Managers told us the dependency of people had been recently assessed and analysed to show how many members of staff were needed to meet their needs. Managers told us they had identified that they had eight staff vacancies at the service. The provider assured us that they had over staffed the service as a result of this review, using agency staff to cover absence and vacancies. The dependency tool was consistent with the number of staff working on the rota but people and staff did not think this number met people's needs safely or effectively. Staff told us that they were unable to answer call bells in a timely manner, sometimes having to leave people for up to 45 minutes because they were already attending to other people. One person told us they had a fall and pressed the call button but that it took half an hour before help arrived.

Inadequate

Is the service safe?

Staff told us they were very stressed because they could not give people the attention they needed. They told us they had raised their concerns about staffing levels with their managers but felt they had not been listened to. They said, "I feel terrible when I hear the bell going on and on and I know someone is waiting but I can't do anything about it". Staff told us that working with agency staff did not help because they had to spend so much time instructing them in what to do and how to meet people's needs. Staff told us that they would like to engage with and talk to people more but "We can't because there is too much to do and not enough time to cover the essentials".

The GP who visited people at the service every week told us that they felt that there were not enough staff and people were not getting the care they needed because of this. Relatives told us that there were not enough staff, they were rushed and constant 'new faces' caused distress and confusion to people. Social care professionals from the local authority safeguarding team told us that they thought the staffing levels were not sufficient to meet people's needs. They said that this meant people were at risk of harm.

We carried out observations in communal areas on all three days of the inspection. There were periods of time of up to ten minutes when there were people in communal areas without any staff present. Some people needed high levels of supervision due to their high risk of falls or behaviours that were a risk to themselves or others. Staff told us they were unable to supervise people adequately because there were not enough staff. This had resulted in injury to people through falls and altercations between people.

There were not sufficient numbers of suitably qualified, skilled and experienced staff to keep people safe. The examples above were a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In most cases people were given their medicines as prescribed and intended by their doctor. Some people were prescribed medicines, including sedatives or pain relief medicines 'to be taken as required'. There was not individual guidance for all the people to whom this applied for staff to follow to make sure a consistent approach was taken in deciding when to offer the medicines. Where creams were prescribed for one person to be applied twice each day, records showed only one application each day.

Medicines were not always given at the right time. During our inspection the morning medicine round was not completed until just before lunch time. The nurse who was completing the medicine round had not prioritised people whose medicines should be taken with food to make sure they were protected from harm.

The examples above put people at risk of having received their medicines inappropriately or unsafely and were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the records relating to medicines and found these were received, disposed of, and administered safely. The medicine administration records for all the people who were on prescribed medicines were correct. Medicines were stored securely. Suitable arrangements were in place for obtaining medicines. Records of medicines received were maintained. This meant that medicines were available to administer to people as prescribed by their doctor.

Plans were in place in case of emergencies. Plans provided guidance about what staff should do if an emergency occurred. Emergency plans included procedures to follow in case of a fire or accident. Contact details for key agencies were included in the plans. The premises were clean and free from clutter so that people could move around safely. Safety checks were carried out at regular intervals on all equipment and installations. There were systems in place to make sure people were protected in the event of a fire. Instructions were displayed throughout the home concerning what actions staff should take in case of a fire. There was equipment in place in case of fire such as extinguishers. Fire exits were clearly marked and accessible. Each person had a personal emergency evacuation plan.

Inadequate

Is the service effective?

Our findings

People told us they did not know who most of the staff were or what they did. One person said, "You don't get to know any of the carers and if I didn't feel too good I wouldn't know who to speak to as I don't know who the staff are. I'm not impressed."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the management understood when an application should be made and how to submit one and were aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. The former registered manager had submitted four Deprivation of Liberty Safeguards (DoLS) applications, one of which had been authorised by the local authority.

People's mental capacity had been assessed and staff were aware of the restrictions which had been applied to keep people safe. Applications had been made to the local authority when required to request best interests decisions if people had been restricted for their safety. This applied to people who were not able to leave the service without support because they would not be safe because of conditions such as dementia. The provider had fitted coded locks to external doors and to doors to the reminiscence floor. People were asked for their consent before staff provided care and support.

There were procedures in place and guidance in relation to the Mental Capacity Act 2005 (MCA) which included steps that staff should take to comply with legal requirements. However, the provider had not properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act 2005 in general, and the specific requirements of DoLS. Less than half the staff had attended Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training.

Staff did not all have the essential training to ensure they understood how to provide effective care, treatment and support for people. Not all staff had been trained or received refresher training in safeguarding to make sure they knew how to protect people from abuse. Staff training records showed that care and nursing staff were not trained to provide care to people with specialist needs such as diabetes, Parkinson's, stroke or sensory loss. People with these needs were living at the service and had moved in on the understanding that staff had the training they needed to meet their needs. The majority of staff had no training in nutrition and hydration. Nurses told us that more training and updating in wound care was needed. This meant that for some key areas staff were not adequately trained to effectively meet people's needs or protect them from harm.

Staff were not receiving appropriate regular one to one supervision. We asked ten members of staff if they had received supervision. Nine staff members said that they had one supervision with their manager in the last year. Staff told us they did not feel supported.

None of the staff we spoke with had an appraisal in the last year to assess their performance, identify any training needs or look at any areas where additional support was needed. Staff told us they were feeling very stressed. One staff member told us that no support had been provided following the death of a service user. They said that when they had spoken with a manager about how upset they were feeling they were told, "That's what you expect in this job, you just have to get on with it".

Staff did not feel supported or supervised to effectively carry out their roles. This and the examples above were a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were mixed views from people about meals and mealtimes. People told us they found the food bland. They said, "The food is terrible but we are able to just take biscuits and fruit which is always around", "The dining room is too small and everyone is pushed in together" and "The food is boring". Some people were complimentary and said things like, "The food is good here".

Staff told us the food was quite bland, they often got complaints of, "Too much on the plate and it is also poorly presented. The chef told us they made sure that people's choices and special dietary needs were catered for. People were offered a choice but there had not been any consultation with people about menus for several months. Our observations during the mealtimes were that the dining room on the ground floor was crowded. People who were being assisted to eat were not spoken with by staff. The experience of people on the reminiscence floor was better with staff engaging well with people who needed support and making mealtimes a pleasant occasion for people.

Inadequate

Is the service effective?

Relatives told us they were concerned that their family members were not getting enough to eat and drink because they had noticed significant weight loss. Staff were not consistently monitoring people's weights to identify any risks or malnutrition and ensure that action was taken to protect people. In some cases there were gaps of several months between weight checks in people's records.

We recommend that arrangements in relation to food, mealtimes and the monitoring of people's weight is reviewed and best practice guidelines are followed.

Communication between the GP surgery and nursing staff was not effective. The provider's representatives and the G.P's were due to meet to discuss the problems and decide how communication could be handled more effectively. The GP raised concerns about poor communication with the service. They stated that nurses on duty during GP visits often did not have enough information or knowledge about people's conditions to be able to provide the GP with the information they needed.

One relative told us that an important hospital appointment was missed because the letter confirming the appointment was not passed on to them. Other relatives told us that staff did not notice when their family members had health issues such as infections and the relatives had to alert staff so that people received the treatment they needed. People who were more independent were supported to manage their own health care needs.

The provider had not made adaptations to the premises to make sure it was suitable for people living with dementia in a way that reflected published research evidence and guidance.

Bedrooms all had ensuite toilets but there was no dementia friendly signage to indicate where these or other toilets were located and no contrasting sanitary ware as recommended in published research and guidance. People living with dementia were accommodated throughout the home; none of the floors had been suitably adapted to meet their needs. Staff reported that people regularly selected inappropriate places for their personal hygiene needs. There were high levels of incontinence on the reminiscence floor where there were 31 people who lived with dementia. This was because people were unable to find their way to the toilet and because there were not enough staff to effectively assist people in a timely way. There was only one communal toilet near to the communal areas. This was tucked away and although people all had their own toilets and bathrooms they were not always able to find their own rooms. People frequently wandered into other people's rooms resulting in distress and sometimes missing property and injury.

Lighting in some areas was inadequate. There were lamps on side tables in the corridors but they were not bright enough to enable people to see effectively. Carpets throughout the service were patterned which could cause problems for people with perceptual difficulties associated with dementia. All corridors were decorated the same and all doors to people's rooms looked the same. Boxes had been placed on the walls outside people's rooms with some personal effects or photos in an attempt to help people identify their rooms. However, the layout, decoration and lack of suitable adaptations caused people to be disoriented and confused which made it difficult for people to locate the area their room was in.

People were not protected against unsafe or inappropriate care. The provider had not planned or delivered care which reflected research and guidance in order to meet people's needs. The examples above were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service caring?

Our findings

People said, “You don't really get to know the staff, they are always rushing around doing something or other ". A relative said, "We think our mother should have more one to one care, her nails and her glasses were really dirty, which is quite upsetting for us to see”. People told us the staff were kind and caring but they felt lonely.

Staff did not spend time with people, other than when they were carrying out support tasks for them or if someone was obviously distressed. Staff told us they were always “Very stretched” and they would like more time to “Be with the residents getting to know them and support them better”. When one person became very distressed, two care staff spent time with this person and provided reassurance. They made sure they were at eye level with the person and showed compassion and kindness. Most of the staff were kind, caring and patient in their approach with people. Care and nursing staff supported people in a calm manner. The member of staff who was administering medicines during our visit was caring and took the time that was needed to give medicines individually to people.

People had not been involved in planning their care and they could not remember if they had been asked to contribute their views about their own care. People’s care plans did not include a record of discussions with them or signed agreements relating to their care.

People told us they were treated with dignity and respect; however comments from relatives and our observations did not always match the positive descriptions people had given us. People did confirm that staff made sure that doors were closed when they helped them with personal care. Nursing staff made sure that any treatments people needed were carried out in private. Staff were discreet in their conversations with one another and with people who were in communal areas of the home. People’s information was treated confidentially. Personal records were stored securely.

However we saw that people’s dignity was not always protected. One person was walking around in communal areas in semi sheer nightwear. No staff approached this person to assist them to maintain their dignity. Staff were not always careful to protect people’s dignity when they were supporting them to eat, sometimes supporting more than one person to eat their meals at the same time. We observed people who were being assisted to eat who were not spoken with by staff at all; staff put food into their mouths with no communication or considerate care. People told us they had not had any clean clothes because there had not been anyone to do the laundry that week.

People were not treated with dignity or respect and the examples above were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some people told us how they were able to go out whenever they wanted to and how the chef made them sandwiches if they were out during mealtimes. Relatives told us they were able to visit their family members whenever they wanted to. People were able to receive visitors in their own rooms and other areas of the home and spend as much time with them as they wanted to. There was a private dining room where people could celebrate special occasions and have a meal with family and friends. People had the opportunity to attend church services which met their need to maintain their chosen religion and worship.

Inadequate

Is the service responsive?

Our findings

People did not always know who to talk to if they were unhappy about any aspect of the service; the general view was they would talk to a member of staff. Relatives were not satisfied with the way concerns or complaints were handled. They gave examples of concerns they had raised where timely action had not been taken to address these.

There was a complaints policy and procedure in place and systems for handling complaints including a system to record complaints electronically so that records could be reviewed by senior managers. This system had not been effective in ensuring that people were listened to and their complaints were dealt with effectively. Relatives told us about complaints they had raised with staff but these had not been recorded in the complaints system so relatives could not be assured these had been properly reported, investigated or responded to. Care coordinators told us that they dealt with the concerns when they were raised with them. When we spoke with the interim management team about these complaints they were not aware of them. The complaints included people running out of clothes because laundry had not been done in a timely manner and injuries and infections which were not noticed until relatives pointed them out. This showed that not all complaints were investigated thoroughly and recorded or used as an opportunity for learning and improvement.

People and their relative's complaints were not identified, handled or responded to effectively. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us that they felt people were moved into the service or chose to move in without due consideration of the resources available to manage their care. This included the number of staff, the skills and training the staff had and the suitability of the premises to respond and meet people's needs. A number of people had complex needs which staff did not feel they were equipped or resourced to meet. A GP told us that they were concerned that people who moved into the service were not having their needs responded to appropriately or safely. They told us that people had moved in whilst in an 'unsafe or unstable medical condition'. They expressed concern about, 'the rigour of the pre-admission assessment'. They also told us about concerns in relation to continuity of care and communication between nurses and carers. They described the service as being in 'fire-fighting' rather than 'planned care mode'. The pre admission assessments had been completed with basic details about people's medical histories and needs. However, following the assessment no senior staff had made judgements about whether the service would be able to meet those needs before people were offered care, treatment and accommodation.

Some people were cared for in their own rooms. Other people spent time in the communal areas. We had to find staff on several occasions to ask them to provide help where people were not receiving the support they needed. Staff told us they were not always able to provide the support people needed and there were times when they were not able to respond when people asked for help. One person was slumped in a chair in a very awkward position with their face pressed against the arm of the chair. Staff walked past several times over a 35 minute period. We drew this to the attention of a senior member of staff who then took action to make sure the person was sitting comfortably.

People were not always receiving the care and support they needed. Some people who remained in bed due to the health conditions required repositioning at regular intervals to prevent pressure wounds. Charts were used to record each time people were repositioned. These showed that people were not being repositioned as often as their care plan required. One person's care plan stated that they required two staff to support them with all personal hygiene care and should be repositioned every two hours, day and night. The nurse said this should be every four hours. Repositioning charts showed they had been helped to move infrequently. For the 10 days we saw charts for they had been helped to move between once and six times rather than the 12 times they required.

Where people were not able to communicate effectively, care staff did not have clear information about what people could do for themselves and how to support and encourage people to manage their own care wherever possible. Ways to enable people living with dementia or other conditions to remain as independent as possible had not been explored. There was no appropriate signage or equipment such as adapted cutlery, crockery or table ware.

Each person had a care plan, called an individualised service plan (ISP) This was a lengthy, computer generated document. It was difficult to find specific information about the care people needed. There was limited information

Inadequate

Is the service responsive?

about how they wanted their care delivered to make sure staff knew how to provide care, treatment and support in a personalised way. There had been a high turnover of staff in the home, many of the care staff were new and agency staff were often used. Staff did not read people's individual care plans or care records, relying on short summaries on assignment sheets for information.

The assignment sheets contained a list of people staff were assigned to care for during their shift with a short paragraph about what they needed to do for each person. The assignment sheets were not up to date. One person had moved to the service in July 2014 following a severe stroke. There were instructions in their care records from a physiotherapist about how to prevent further deterioration in their condition. Care and nursing staff who were providing care and treatment to this person were not aware of these instructions and had not carried them out. One person was receiving end of life care but this was not reflected on the assignment sheet and there were no instructions about how staff needed to respond to this person's specific needs. This meant that people were cared for by staff who may not know them, their care needs, preferences or their personal histories.

A range of activities were offered in the home and outside in the community for people who were able to take part. The service had access to an adapted minibus, which meant that people were able to take part in outings. There were a number of different communal areas around the home where people could take part in activities of their choice. Activities included film shows, opera/ballet club, jazz club, quizzes, team scrabble, music and comedy, Pilates and 'keep fit'. There was an activities room where people could access a computer. A group of people were engaged in doing a crossword in the 'bistro'. Ministers from a local church provided services in the home for those who wished to take part.

There were no individual activity programmes to ensure people living with dementia had meaningful activities to promote their wellbeing. The activities coordinator had some dementia training; however they were unclear how they would provide activities for people in the later stages of dementia. The approach to activities was to entertain, do to, rather than support people to participate in activities. The activities coordinator said the activities department were a bit separate from the other departments and supervision was sporadic. During the morning the television was on in the main lounge of the reminiscence unit. Most people in this room had their eyes shut and were not watching the programme. Newspapers were available. Several people were unsettled, walking around the corridors and in and out of the lounge and dining room. Staff did not have time to support people to engage in activities that were meaningful to them. Some people were taken out in the service's minibus. Christmas carols were playing in the dining room where some people were sitting at tables.

People were receiving inappropriate or unsafe care because their care was not planned to meet their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

People and their relatives did not know who was managing the service. People told us they had not seen the manager for “About six weeks”. They told us there were lots of different faces but they did not know who was “In charge”. Relatives told us there had not been a ‘relative’s’ meeting for some time to inform them about any changes.

The provider’s vision and values were set out in the statement of purpose, their brochures and on their website. However, our inspection showed that these visions and values were not being met.

During our inspection senior managers told us that the registered manager had resigned following an absence of six weeks. The senior managers had informed CQC as they were required to do. Interim management arrangements were in place. A temporary manager was overseeing the service with support from a registered manager from another Sunrise service on two days each week. People and their relatives had not been informed about these arrangements.

A new care coordinator had been appointed to manage the reminiscence unit and had been in post for nearly six weeks before our inspection. People and their relatives had not been informed about this appointment. There was no forum or effective system through which changes and updates about the service could be communicated to people and their relatives in a timely and inclusive manner.

Staff were unclear about who was in charge at the service. They said, “We do not know who some of the management staff are and in the case of a risk we would find the nearest person whoever they are or failing that contact the receptionist to request her to ask for help" and "We do not feel involved or included by the management at all, it's a bit lack lustre", “We did have a home manager but haven't seen her for at least six weeks and now we see other faces but don't know who they are or what they do” and “We do not feel we are involved or included by management”. Staff told us that morale was “Very low” because it was so stressful and they did not feel supported by the management of the service.

Staff told us that they did not feel supported because communication was inadequate throughout the service. They said that they did not have an opportunity to feedback about the service and felt that they were not involved or consulted in decision making as they did not have one to one supervisions, staff surveys or regular team meetings. They said that they did not feel valued as employees. There was a copy of the minutes of a staff meeting in the staff room dated 2013. Staff said there had been another staff meeting recently although those we spoke with had not attended.

The provider had a whistleblowing policy. This included information about how staff should raise concerns and what processes would be followed if they raised an issue about poor practice. Staff were encouraged to come forward and reassured that they would not experience harassment or victimisation if they did raise concerns. However, staff who had raised concerns told us they did not feel they were listened to. Although the provider assured us that they had over staffed the service, staff told us and our observations confirmed that there were not enough staff. Staff told us morale was very low and they were very stressed because there were too few of them to give people the attention they needed.

The provider had recognised that they needed to make improvements to the service to ensure people received good and safe care. Senior managers had visited the service and an action plan had been drawn up where shortfalls had been identified following an audit of the service. This had resulted in improvements to the way medicines were managed. Other actions had not been completed at the time of our inspection. The management team had not identified all the shortfalls or aspects of unsafe care that we found and therefore people were not protected against the risks of inappropriate or unsafe care and treatment.

Electronic systems were in place to alert senior managers to issues at the home such as incidents and accidents. However, not all incidents and accidents had been entered onto the system. There was no evidence that action or improvement plans in response to accidents and incidents had been developed or that any learning from such incidents was used to improve the quality of the service.

People were not protected against inappropriate or unsafe care because the systems for assessing and monitoring the service were not effective. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Records relating to people's care and treatment were not well organised or adequately maintained. There was a main file for each person containing among other items the ISP, risk assessments, nurses reports and medical correspondence. Daily record sheets for each person were kept in another folder and were filed according to room location. Other monitoring charts such as fluid intake, mattress pressure and repositioning charts were kept in another folder. Records for people on the ground floor were located on the first floor which meant that staff had to leave the floor to access people's records. The system was complex and staff told us it was unhelpful.

A number of records we looked at were not kept up to date, including care plans, records of people's weights, repositioning charts and records relating to wound care. This meant that staff and others did not have access to reliable information to enable them to provide the care and treatment people needed. One relative told us they had asked to see their relative's care plan to make sure it was up to date but had not been able to do so, on request. When they were allowed to see it they told us it had not been kept up to date and important information was not recorded.

People were not protected against unsafe or inappropriate care because accurate and up to date records were not maintained regarding their care and treatment. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The provider had not made suitable arrangements to ensure people's dignity was upheld.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **People's complaints were not always fully investigated and, so far as reasonably practicable, resolved to their satisfaction.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **People were not protected against risks of inappropriate or unsafe care and treatment the registered person had not ensured that there was an accurate record in respect of each person which included appropriate information and documents in relation to the care and treatment provided.** **Other records were not available or not up to date in relation to the management of the regulated activity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not ensured that information specified in Schedule 3 was available in respect of a person employed for the purposes of carrying on a regulated activity, and such other information as is appropriate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with the unsafe use and management of medicines.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against risks of inappropriate or unsafe care and treatment, because the assessment of needs and planning and delivery of care did not ensure their welfare and safety. The planning and delivery of care did not reflect published research evidence and guidance in relation to people with dementia and other conditions.

The enforcement action we took:
We served the provider with a warning notice. We asked the provider to achieve compliance with the regulation by 6 February 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People were not protected against risks of inappropriate or unsafe care and treatment, because systems designed to regularly assess and monitor the quality of the services provided to identify, assess and manage risks relating to people's health, welfare and safety were not effective. They did not take account of people's complaints and comments made, and views including the descriptions of their experiences of care and treatment

The enforcement action we took:
We served the provider with a warning notice. We asked the provider to achieve compliance with the regulation by 6 February 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse

This section is primarily information for the provider

Enforcement actions

People who use services were not protected against the risks of neglect and acts of omission that cause harm or place at risk of harm.

The enforcement action we took:
We served the provider with a warning notice. We asked the provider to achieve compliance with the regulation by 6 February 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff employed to safeguard people's health, safety and welfare.

The enforcement action we took:
We served the provider with a warning notice. We asked the provider to achieve compliance with the regulation by 6 February 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements to ensure that staff were appropriately supported by providing appropriate training, supervision and appraisal.

The enforcement action we took:
We served the provider with a warning notice. We asked the provider to achieve compliance with the regulation by 6 February 2015