Sunrise UK Operations Limited

Sunrise of Solihull

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection at Sunrise of Solihull in January 2018 and rated the service as 'Good'.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sunrise of Solihull on our website at www.cqc.org.uk

Since that inspection we received information of concern about people's safety which we shared with the local authority safeguarding and commissioning teams for investigation.

However, as the information we received indicated potential concerns about people's safety, the delivery of planned care and the management of the home we undertook a focused inspection to check people were safe and the service was well-led.

This inspection took place on 9 October 2018 and was unannounced.

We focused on two of the five key questions we ask of services. Is the service 'safe,' and is the service 'well-led.' This report only covers our findings in relation to these topics.

Sunrise of Solihull provides residential and nursing care to older people, including people who live with dementia. The home has three floors accommodating up to 109 people in one adapted building. The Reminiscence unit cares for people living with dementia and the Assisted Living unit supports people with higher levels of independence. On the day of our inspection 80 people lived at the home. The home is in Solihull in the West Midlands.

Since our last inspection, the registered manager had left the service. 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. An 'interim' manager from one of the provider's other services was supporting the home. The 'interim' manager is referred to as the manager in this report.

On the day of our visit the manager was not available due to pre-planned leave. The home was being supported by one of the provider's 'pipe line' general managers and the deputy manager.

People told us they felt safe living Sunrise of Solihull but some were concerned staff were not always available to respond to their requests for care and support at the times they needed. Staff were recruited safely and understood how to protect people from harm. Medicines were not always managed safely and in line with the provider's policy.

Some records relating to people's planned care and associated risk were not being accurately maintained and did not provide staff with the detail they needed to ensure care and support was provided safely. This meant we could not be sure people's care was delivered as planned and known risks were being effectively managed to keep people safe. Other records were detailed and complete. Staff demonstrated a good understanding of the needs of the people they supported.

Some staff felt the management team were approachable and supportive. Other staff said they did not feel valued or that the management team provided meaningful opportunities for them to discuss their role and development. Staff felt communication from the management needed to improve.

People, relatives and a visiting health professional spoke positively about the way the home was managed and the service provided. The provider's systems to monitor the quality and safety of the service provided and to drive improvement were not always effective. Some improvements had been made in response to feedback from people and relatives.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People felt safe living at the home; however, staff were not always available to respond to people's request for assistance at the times they needed. Medicines were not consistently managed safely and in line with the provider's procedure. Some records relating to people's care and the management of risk were not detailed, accurate or up to date. Other records were detailed and completed. Staff were recruited safely and understood their responsibilities to keep people safe.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People, relatives and a health care professional felt the service was well managed. Most staff did not feel valued or supported by the management team. The provider's systems to review the quality and safety of service were not always effective in identifying and driving improvement. Some improvements had been made in response to feedback from people and relatives.

Sunrise of Solihull

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 was an unannounced focussed responsive inspection prompted by information received by the Care Quality Commission (CQC) which indicted potential significant concerns about the safety of some people living at the home.

This inspection took place on 9 October 2018. The inspection team consisted of an inspection manager, two inspectors, a member of the CQC medicines management team and an expert by experience. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses this type of service.

Before our visit we looked at the information we held about the home including, 'share your experience' information received via our website from the public; the statutory notifications received from the home; and information provided to us from Solihull Local Authority, Solihull Macmillan nursing service and The Support to Care Home Team. Statutory notifications include information about important events which the provider is required to send us by law.

We spoke with eight people, three relatives of people and eight staff, including care co-ordinator's, a nurse and care staff. We spoke with the 'pipe line' general manager (responsible for providing management support during the managers planned leave), the deputy manager, the regional head of care and nursing, one of the provider's registered manager from another home and the deputy manager. We also spoke with a visiting health care professional.

We looked at six people's care records and other records related to people's care, including medicine, daily progress, catheter care and position change records. This was to see how people were cared for and supported and to assess whether people's care delivery matched their records. We also looked at records of the checks the provider and manager made to assure themselves people received a good quality service.

After our visit, we spoke with the director of operations and received further information from the 'pipe line' general manager by email.

Requires Improvement

Is the service safe?

Our findings

This key question was rated as 'good' at our last inspection visit. At this inspection we identified areas where the home had previously performed well now required improvement.

One of the concerns shared with us, by the local authority, prior to this inspection was the accuracy of records related to people's planned care. Since our last visit and following staff training the provider had implemented an electronic recording system known as 'care connect'. The deputy manager explained staff now recorded the care and support they provided to people by inputting information onto the system via monitors located within the home.

Staff told us they found the electronic system problematic to use because it regularly froze and took a long time to re-start. One commented, "Using the care record system is time consuming and takes us away from providing care to people." The deputy manager agreed the new system could impact on staff's time. One reason being because sometimes agency staff did not have a 'log in' (necessary to access the system) so the home's staff had to complete records on their behalf. On the day of our visit one staff member was still updating records on behalf of an agency nurse 50 minutes after the end of their shift. A visiting health care professional told us they found the new system to be beneficial because specific information they needed could be printed out.

During our visit we found a significant number of records did not show planned care had been provided at the frequency assessed as needed to reduce known risk, others records lacked detail and contained conflicting information. This meant we could not be sure the provider's systems ensured planned care was provided and risks were managed and minimised.

For example, one person was known to be at risk of falling and had fallen on 15 separate occasions. To reduce this risk staff had been instructed to complete 'safety checks' every 30 minutes. However, electronic records did not show these instructions had been followed. For example, on 6 October 2018 a check had been recorded at 21.24pm with the next check being documented on 7 October 2018 at 1.37 am, some four hours later.

Another person had damaged skin. We saw the guidance for staff to follow to manage this risk was unclear. The 'support action' record instructed staff to assist the person to change position every two hours. This conflicted with instructions later in the person's care records where the 'position change frequency' was detailed as four hourly. Furthermore, electronic records showed neither instructions had been followed. For example, an entry dated 2 October 2018 had a gap of seven hours between assistance being provided.

A third person's care plan detailed the need for a daily fluid intake of 2000ml because they were prone to urine infections. When we calculated the person's electronic daily fluid intake records we found for example, a total intake of 840mls on the 3 October and 495mls on the 4 October 2018. There was no information to show the low fluid intake had been identified or addressed. This meant we could not be assured the known risk was being effectively managed.

In contrast other records, for example catheter care and wound management plans were comprehensive in detail and had been regularly updated.

Despite omissions in records people told us they felt safe, and relatives too felt their family members were safe at the home. One person explained they felt safe because there was always 'someone' around. Another person commented, "Yes, I feel safe 99.9% of the time. It is extremely good here."

However, we received mixed feedback about whether there were always enough staff to respond to people's needs in a timely manner. One person said, "Yes I think they have got it right now in the day…" Another said, "The worst thing is, about 11am in the morning and I need the toilet they [staff] seem to have all gone on break." Most people spoken with had concerns about the timeliness of call bell answering. One person said, "The buzzers are not answered enough, the main problem here are they are short staffed." Another person said they found it 'infuriating' that staff responded to their request for assistance by turning their call bell off.

Most staff said they felt there were not always enough staff on duty and current staffing levels affected the standard and consistency of care they delivered. One said, "We have to answer call bells within seven minutes. …if we are helping someone we have to stop and go and answer the call bells. Well, we just switch it off and say we will be back but sometimes they [people] have to wait 40 minutes." Another told us morning staffing levels had recently reduced. They said, "… some people have died but it doesn't make sense because new people moved in and the number of staff on duty doesn't go up." They added, "Agency staff don't know the resident's which puts more pressure on us."

The deputy manager acknowledged staff concerns about the use of agency staff. They told us there had been a high use of agency staff during the summer to cover staff vacancies and staff holidays. However, they told us agency use was gradually reducing as newly recruited staff started working at the home. They added, "The home is 'almost' fully staffed now." The 'pipe line' general manager explained staffing levels were determined through an initial assessment of a person's needs which following admission was reviewed at monthly intervals, or sooner if their needs changed. They added, "We also review staffing levels every day in our daily meetings." Following our inspection visit the home manager sent us further information about the provider's staffing level assessment tool.

During our visit we saw staff in some areas of the home were available and spent time chatting with people. However, staff working on the Assisted Living floor were very busy and their engagement with people was limited and focussed on completing tasks. For example, we saw one person walking up and down the corridor who was upset. Staff were busy supporting other people. After 10 minutes the person was becoming more distressed. We asked a staff member to assist the person. When the person said they had 'lost their glasses', the staff member responded, "I'm really busy but I will come back to you." The staff member did return but this did not acknowledge the distress the person was experiencing prior to their return.

Staff were recruited safely. The provider's completed the required pre-employment checks to ensure, as far as possible, only staff of suitable character were employed. Staff confirmed they were not able to start work at the home until all checks had been completed.

Staff had attended training in safeguarding vulnerable adults and demonstrated they understood their responsibilities to report any concerns. One staff member said, "We tell the nurses or managers if we see bruises or if we were worried. I am confident that they would sort it out. I know I can call CQC if no action was taken."

Before our inspection one of the concerns raised with us referred to the way in which staff were providing support to people who needed assistance and specialist equipment for example, a hoist, to move around. During our visit we saw assistance was provided safely, by the required number of staff who gave verbal reassurance to the people they were supporting.

However, some people's care records did not contain detailed guidance to inform staff, particularly agency staff, how to support people to move safely. For example, one person's risk assessment did not detail any equipment assessed for use despite other records showing staff had used a hoist on seven occasions to assist the person following a fall. A staff member told us, "[Name] hasn't got her own her sling as she hasn't been assessed. So, we use a spare or borrow one from someone of a similar size." In contrast other records detailed the type of equipment assessed for use, the level of support and number of staff needed.

Despite recording omissions discussions with staff demonstrated they were aware of the risks associated with people's mobility and how to support them safely. One told us, "I know people so I know how to keep them safe…I remind (person) to use their Zimmer frame because they are a bit wobbly on their legs and might fall." Another said, "We have had manual handling training so we do know how to hoist people safely." Records confirmed this.

At our previous inspection we found medicines were managed, stored, administered and disposed of safely. During this visit people told us they continued to receive their medicines as prescribed. One person said, "Yes, they [staff] give me pills." Another commented, "The nurses put cream on my legs because I can't reach. It's always twice a day which is what the doctor had prescribed for me." Records showed staff received medicine training, which was refreshed regularly and their practice observed to make sure they continued to be competent to administer people's medicine safely.

Medicine administration records confirmed people received their medicines when needed. There were procedures in place to ensure medicines were managed in accordance with current regulations and guidance. However, we found these were not consistently followed. For example, records showed, in July 2018 staff had administered a prescribed 'when required' antibiotic. We saw the expiry date on the medicine was March 2018. Whilst the person had not experienced any ill effects this was concerning because the medicine had been administered past the date by which its effectiveness, and full safety would be guaranteed by the manufacturer.

We saw stocks of dressings, catheters and leg bags which a nurse told us were 'left over prescribed stock' belonging to people who no longer needed them or who had passed away. This was a concern as legally, these items can only be used for the person for whom they have been prescribed. We raised our concerns with a nurse who gave assurance immediate action would be taken. Following our inspection, we received further confirmation these concerns had been addressed.

Discussion with staff assured us they understood their responsibilities in relation to infection control. However, some staff told us they did not have enough gloves available to enable them to practice good infection control. We checked the stock of disposable gloves and found these were not adequate in the Assisted Living unit. We raised this with the 'pipe line' manager who gave assurance stocks were available in other parts of the home and an order would be placed.

The building was well maintained and safety checks completed to ensure equipment was safe to use. Staff demonstrated a good knowledge of the provider's emergency procedure and their responsibilities, for example in the event of a fire.

Requires Improvement

Is the service well-led?

Our findings

This key question was rated 'good' at our last inspection. At this inspection we identified areas where the home had previously performed well now required improvement.

At our last inspection, people's records were detailed, accurate and up to date. However, at this inspection we found people's records were not always maintained in line with regulatory requirements. The deputy manager told us action had been taken to address gaps in electronic records through the introduction of additional daily monitoring checks. However, our findings showed this action was not yet effective.

Previously, we found the management team regularly completed checks and audits of the quality and safety of the service provided which were effective in driving forward improvement. At this inspection we saw whilst these monitoring arrangements continued some were ineffective. For example, the introduction of daily call bells checks had improved staff response times but had not identified the delays people experienced after staff had responded by turning call bells off. Medicines audits had not identified the medicine management issues we found.

Records showed the manager maintained a 'community development plan'. We saw the plan was updated on 4 October 2018. However, the plan was not always effective in supporting the service to make timely improvements and did not prioritise the actions needed to ensure people's safety. For example, there was no information to show the actions taken or planned to address concerns shared with the management team by the Local Authority. The deputy manager told us, "We have no evidence to show what we have done."

Furthermore, it was of concern to us that on the day of our inspection the management team were not fully aware of how these issues of concern were being addressed. This meant the management team's oversight of the home did not assure us people were always cared for safely, and staff were provided with enough guidance and support. Following our inspection, we received further information detailing how this was being addressed.

This was a breach of Regulation 17 Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

Other audits and checks had identified areas for improvement. For example, the home had seen a reduction in the number of falls people experienced following the introduction of individual analysis and joint working with health care professionals. A co-ordinator told us they were working on further developing the 'falls programme; but had already seen 'positive results'. Records confirmed this.

Accidents and incidents were recorded and where lessons could be learnt information was shared. For example, one staff member told, "We get alerts on email and we have the care home bulletin." They added, "Any learning gets messaged over, for example we recently had an alert as there had been an incident (at another service). Following this, an alert came to all of the Sunrise homes, so learning was shared."

The home did not have a registered manager. Since our last inspection there had been a change of management at the home. The previous registered manager had left their employment in June 2018 and an 'interim' manager was supporting the home. 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.'

However, our records showed the required applications to cancel the previous registered managers registration in line with regulatory requirements had not been submitted. Following our inspection, we spoke with the director of operations who assured us this would be addressed as a priority. They also told us the 'interim manager' would be submitting an application to registered with us.

At our last inspection staff told us they felt supported and valued by the management team. During this visit when we asked staff about their experience of working at the home and we received mixed responses. Two staff members told us they were happy working at the home, felt supported and valued. However, in contrast other staff commented, "I don't feel listened to at all. When we speak up we are told 'it's the Sunrise Way if you don't like it that's tough." "Morale is low, there is a blame culture here…" "The environment is lovely but the leadership is poor…" and "…It makes me feel worthless, managers don't care about us."

Most staff told us they felt communication with the management team needed to be improved. One commented, "We don't have staff meetings so I don't think communication is good at all." We saw a 'lead nurses' meeting had been held on 1 October 2018 during which some discussion took place about the concerns looked into by the Local Authority. When we asked to see other team meeting minutes for 2018 the deputy manager responded, "They have probably happened but have not been recorded." Following our inspection, the home manager provided copies of team meetings that had been held and documented with some staff.

Records showed staff were in receipt of regular individual meetings. However, most staff told us they viewed these meetings as a 'telling off' and not an opportunity to discuss their work role and any development needs. One said, "If you don't answer the call bell in time you get pulled in for supervision." Following the inspection visit the home manager sent us anonymised examples of staff supervision records which included evidence that discussions about individual staff member's learning and development needs was discussed.

People, relatives and a professional visitor were very complimentary about the way the home was managed and the service provided. One said, "I think it's good." A health care professional described staff who supported people as 'conscientious and caring'.

People and relatives said they were invited to provide feedback about the service through questionnaires and meetings. One person told us, "We have resident's meetings once a month and relatives can come if they want to." A relative told us they had raised some issues about their family member's care they said, "Everything we have suggested has been done." This showed the provider used feedback to support improvement.

We saw the provider had met their legal responsibility to display the latest rating we gave them within the home and on their website.

After our inspection visit we spoke with the director of operations who sent us information outlining the immediate actions they had taken or were planning to take to respond to our concerns and to improve the

quality and safety of care provided.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 17 (1) (2) (a) (b) (c) HSCA RA Regulations 2014. Good governance The provider had not ensured they had effective systems in place to assess, monitor and improve the quality and safety of the service provided. The provider's system of governance did not provide sufficient assessment and monitoring of risk to mitigate the risks to the health, safety and welfare of people who lived at the home and staff. Records relating to people's care did not always contain up to date and accurate information about people's care needs.