Sunrise Operations Mobberley Limited

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Inspection report

Sunrise of Mobberley
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an inspection over a period of three days on 5, 12 and 13 May 2016. The inspection was unannounced.

Sunrise of Mobberley is a large care home in Mobberley, East Cheshire. It is registered to support up to 108 people. The home is split into two areas; The Assisted Living Neighbourhood which provides residential and nursing care and The Reminiscence Neighbourhood which provides residential care for people who have dementia.

During the inspection there were 88 people living at the home. There were 30 people living within the Reminiscence Neighbourhood and 57 within the Assisted Living Neighbourhood. Of these people, 28 were in receipt of nursing care.

There was a registered manager in post at the time of our inspection. 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.

We identified two breaches of the relevant legislation, in respect of staffing and medicines. You can see what action we told the provider to take at the back of the full version of the report.

We found that there had been a period a time when the home had depended upon agency staff to ensure that there were sufficient staff and this meant that there was less consistency of care. There had been a recent focus on the recruitment of new staff and the registered manager told us that the home was now fully recruited with several staff awaiting start dates pending necessary recruitment checks. The registered manager told us that where possible they used regular agency staff to ensure consistency of staff. However during the inspection we found that people's needs were not always met in a timely manner. We saw that people sometimes waited a long time for a response to calls for assistance. Staff had not always responded promptly to sensor mats being alerted. Staff also told us that they were short staffed at times and could not always respond to people quickly enough. There were certain times of the day and night when this had more of an impact on people. People were also concerned about the lack of support and supervision available to people within the bistro area in the evening.

Medicines were not always managed safely. The local authority told us about a number of medication errors that the home had reported and investigated. The management team were taking action to address any poor practice. We saw that an action plan had been developed. At the time of the inspection, we found that a significant number of staff had not fully completed the training required by the company for staff to administer medication safely. There had been a recent audit which had highlighted a significant amount of recording errors, this indicated that staff had not always followed the company's medication policy. The registered manager informed us that action was being taken to ensure that all the required staff had

completed this training within the next few weeks.

We found there were policies and procedures in place to guide staff in how to safeguard people who used the service from harm and abuse. Staff received safeguarding training and knew how to protect people from abuse. Staff knew where they could report safeguarding concerns to outside of their organisation. Risk assessments were completed to guide staff in how to minimise risks and potential harm.

People lived in a clean and very well maintained environment. We saw that the home was decorated to a high standard, there was a warm and relaxed atmosphere. Appropriate equipment and health and safety checks were carried out to ensure that people lived in a safe environment.

Records demonstrated that staff had completed a thorough induction before commencing their employment at the home and staff completed on-going mandatory training. People were able to access bespoke training where required. Although as noted above not all staff had fully completed medication training and competency assessments.

Not all staff had received regular supervisions meetings and some staff told us that they did not always feel supported by the senior management at the home.

Staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. They were aware of the need to gain consent when delivering care and support and what to do if people lacked capacity to agree to care or treatment. Not all people had signed consent to their care within the care records. We also found the recording of MCA assessments and best interest decisions were inconsistent. Where a person was being restricted or deprived of their liberty, some applications had been made to the supervisory body under the Deprivation of Liberty Safeguards. However, the management team were aware that they had focused on the Reminiscence Unit and that applications may also be required for people living in the Assisted Living Unit.

We saw that people were well cared for and very comfortable in the home. The people and visitors that we spoke with were positive about the care they received and told us that the staff were kind and caring. We observed that staff were skilled and patient, treating people with dignity and respect.

Care records were personalised and up to date, they reflected the support that people needed so that staff could understand how to care for the person appropriately. We saw that staff responded to people's changing needs and sought involvement from outside health professionals as required. We found that in some care records and daily charts there were gaps in the information recorded and they had not always been completed at the time that the care had been provided.

People had access to activities both within the home and local community. A full activities and entertainment programme was available to all residents, as well as one to one support for people who stayed in their bedrooms. People were very positive about the activities that were organised.

There was a clear management structure in place. The registered manager and staff team had clear lines of responsibility. Staff were familiar with the needs of the people they supported. There were comprehensive quality assurance processes in place and people's feedback was sought about the quality of the care.

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 always safe.

We found that people's needs were not always met in a timely manner. People told us that they were kept waiting for assistance, especially when they used their calls bells.

The provider used a labour management tool to assess the numbers of staff required. However, staff told us that they could not always respond to people as quickly as they would like.

Medication was not always administered in a safe manner. Staff had not all completed the necessary training to administer medication. The provider had implemented an action plan

Staff had an awareness and understood the need to keep people safe. Staff knew how to report any safeguarding concerns.

People lived in a well maintained home, which was decorated to a high standard. The home was clean and appropriate maintenance checks were made to ensure that the environment was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were aware of the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). However mental capacity assessments and best interest decisions were not always recorded in people's care records.

The service was in the process of making appropriate applications under DoLS, but needed to ensure that appropriate applications were made for people living on both of the units within the home.

Staff sought consent from people before providing care, but people had not always signed their consent to the care being provided, within the care records.

Staff received appropriate training and undertook a period of

induction when they commenced employment at the home. Supervision meetings had been carried out. However some staff were overdue an appraisal or supervision.

People were very complimentary about the food served at the home and people's nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion. People told us that the staff were caring and supportive.

Staff knew and understood people's history, likes, dislikes, needs and wishes.

We observed that people were treated with dignity and respect. People's privacy was also maintained.

Is the service responsive?

Good

The service was responsive.

People had individualised service plans, which were personalised, detailed and reflected people's individual requirements. We found that there were some gaps in the recording on daily charts.

There was a comprehensive activities plan in place. People were very positive about the activities that were available. We saw that people were supported to go on outings and there were also one to one activities carried out.

There was a complaints policy in place and people felt able to raise any concerns with staff. Appropriate action was taken in response to complaints.

Is the service well-led?

Good

The service was well led.

Staff told us that they were supported by their line manager, but did not always feel supported by senior management.

People were asked for their views about the quality of the care provided and there were systems in place to receive feedback from people using the service, relatives and staff.

The home had effective quality assurance systems in place to monitor and improve the quality of the care.	

Sunrise Operations Mobberley 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 5, 12 and 13 May 2016 and was unannounced.

The inspection was carried out by two adult social care inspectors plus 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 care service.

As part of the inspection we looked at the information we held about the service. This included statutory notifications, which are notifications the provider must send us to inform us of certain events. We contacted the local authority contracts and quality assurance team prior to the inspection and they shared their current knowledge about the home. We also read the latest Health watch report available. This information helped us to plan the inspection.

During the inspection we spoke with 25 of the people who lived at the home, together with three of their visiting relatives. We talked with 23 members of staff, including 9 members of the care staff team, four nurses (including night staff), the activities coordinator, a housekeeper, the chef, one dining room assistant, the maintenance person, two unit coordinators, the deputy manager and the registered home manager.

Requires Improvement

Is the service safe?

Our findings

We spoke with people who used the service and some people told us they felt safe living at the home. People told us "I feel safe and relaxed here" and "I feel very safe living here, I can't fault them." However, some people told us that they were concerned that at certain times there weren't always enough staff to ensure that people were safe.

We found that people's needs were not always met in a timely manner. We reviewed staff rotas, call bell response times, resident's council meeting minutes and spoke with people and staff about the staffing levels within the home. People's views were mixed. Many people told us that at times they were kept waiting for support and they did not always feel that staff had sufficient time to spend with them. Comments included "staff run around like headless chickens rush in, rush out, no time for conversation." And "The girls are wonderful, but they are rushed, they do not have enough time to talk to you."

The concerns raised about staffing levels related in the main to the assisted living unit. The registered manager told us that the provider used a tool to calculate the numbers of staff required within the home, called a "labour management tool". One of the unit coordinators demonstrated how the tool was used and informed us that an assessment was carried out on each person when they moved into the home. This assessment was reviewed and updated through a monthly wellness check. The tool calculated the amount of staff hours required to support the person, which then provided an overall number of staffing hours required by the two units within the home.

The home was large and the assisted living unit was based over two floors. Staff told us that the large size of the building impacted on the time it took to respond to people. Staff meeting minutes from April 2016 also demonstrated that staff had highlighted concerns to the registered manager. They stated that they found that there were times when people needed more support time than that calculated by the tool. The registered manager had stated that they would review this to ensure that people's needs were correctly assessed.

Staff views of the staffing levels were also mixed. One person told us that overall there were sufficient staff to meet people's needs but on occasions they found that they were short, this was mainly when staff had not been able to come to work due to ill health or holidays. We saw from the rotas that on two recent occasions the staffing numbers had been less than those identified as necessary and we were told that this was due agency staff not arriving for the shift as booked.

People told us that they were concerned that staff weren't always available in the bistro area to supervise and support people. One relative told us "another bone of contention is the lack of staff in the bistro …it's an accident waiting to happen." We discussed this with the registered manager who said that numerous staff, including the concierge were available during the day and people also had mobile pendants which were used to call for assistance whilst seated in the bistro area. We observed that a member of staff came to support someone who was seated in the bistro area to go to the toilet, after they had used their pendant to call for assistance. However other people told us that there were times, especially in the evening when staff

were busy elsewhere and there was no support or supervision available. We saw that a relative had raised this as a concern in a recent review meeting with senior staff. Staff spoken with confirmed that they felt that they didn't always have time to supervise people in the bistro and that some people who were at risk of falling may attempt to walk without assistance, they told us that they sometimes asked other people in the bistro area to shout out if staff were needed. Information was provided following the inspection which indicated that the percentage of falls in any of the communal areas was very low

During the night there was one nurse who was responsible for the people requiring nursing care, plus three care staff within the assisted leaving unit and three care staff within the reminiscence unit. The registered manager told us that these numbers were amended accordingly, dependent upon the outcome of the continual assessed need. Staff told us that it could be busy at certain times during the night shift especially during the morning when people began to wake up. For example staff told us that it was sometimes difficult to respond when several people were calling for assistance and they were assisting another person with for example a shower. the registered manager told us that a day staff member started at 06.00 to assist at this busy time of the day. The unit coordinator told us that the management team operated a duty manager system and were available as back up in emergency situations. The unit manager also told us that she also carried out night visits to monitor and speak with the night staff.

During the inspection one person told us that they had called for assistance using the call bell but had to wait too long, which meant that their toileting needs had not been met quickly enough. We found that this had therefore impacted on their dignity. We reviewed a sample of the call bell response times, which covered two recent 24 hour periods. The records indicated that there were a number of occasions when people had waited over twenty minutes for a response to either a pendant call or to a fall prevention sensor mat being activated. The registered manager told us that some of these calls may well have been responded to sooner, but that staff sometimes forgot to reset the system and the records therefore were not always an accurate reflection. However, people spoken with confirmed that there were times when they were kept waiting for support. The minutes of a recent relatives council meeting also demonstrated that people had raised concerns about waiting more than 10 minutes for their call bell to be answered, a concern had also been raised that there were "not enough staff around."

We found that there were particular periods of time during the day when this was more of a problem, such as the times when people needed support to get up. One person told us that they waited until after 7.15 am before calling for assistance, as the staff were in a staff handover meeting until then and "they don't like me to press earlier". Someone else commented "I have to wait in the morning especially when I get up. Some mornings I've waited a long time and other times they come quickly."

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Sufficient numbers of staff were not always deployed.

The registered manager told us on the second day of the inspection that they had re-launched a cascade system with regards to the call bell response. This meant that if a call had not been responded to after 10 minutes then this would be cascaded to a senior member of the team. This process had begun prior to the inspection. They told us they had already seen some improvements in the response times and were monitoring the situation closely.

The management team were taking action to address some of the staff recruitment difficulties. There had been some difficulties in recruiting new staff over the previous months. The provider had introduced incentives for staff, with the aim of supporting staff and to attract new applicants. There had been on-going recruitment and the registered manager told us that they had now been able to recruit a number of new

staff. There were people either in the process of undergoing recruitment checks or were undertaking induction training. There were three new members of staff who were due to start employment with the home the following week.

Agency staff had been used to cover where there were staff shortages. These are staff who are employed by a separate organisation which provides staff to any service which requires them. We saw from the rotas that there had been a high usage of agency staff over recent months. The registered manager explained to us that agency staff were used when necessary to ensure people's needs were met as safely as possible. They had tried to work with a particular agency to ensure that the staff used were as consistent as possible. However some people told us that they had found the changes in staffing to be quite unsettling. One person told us that "agency staff don't know where anything is." Following the inspection the registered manager sent us information to confirm that they had now been able to recruit fully to the care and nursing teams. He told us that they would continue to recruit above these numbers to provide some flexibility and confirmed that they were on target to eradicate the use of agency staff in the near future.

We found there were some shortfalls in the way people's medicines were being managed and administered by the provider. During the inspection we spoke with and observed a nurse whilst they were administering medication. The nurse demonstrated a good technique and understanding of the safe handling of medication. Medicines were kept safely in a lockable trolley within a locked room. The provider's medication policy was available to staff in the medication room. Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation, these medicines are called controlled medicines. We inspected the controlled medicines register and found all medicines were accurately recorded. They were stored in a special cabinet. We found a couple of minor issues with the storage of medication. We found that a person's eye drops had not been stored correctly in accordance with the instructions and the date that a liquid medicine had been opened had not been recorded on the label.

We saw that some people were supported to take their own medication and appropriate risk assessments and stock checks were carried out to ensure that people were able to do this safely. There were some medicines which had been prescribed on a PRN or "as when required" basis. We found that there were written protocols in place which would help staff to know when these medicines should be administered.

Prior to the inspection we spoke with the local authority quality assurance and contracts team. We were told that concerns had been raised with the provider about the safe administration of medicines, as a number of errors which been identified and reported by the home. We saw from documentation within the home that medication errors had been identified through numerous audits. We discussed this with the registered and deputy managers. They were aware of the situation and told us that they were working hard to rectify the situation. Medication was administered by nursing staff, lead care staff and care staff who were called "med techs". The deputy manager had been taking steps to address training needs with individual staff. Records seen demonstrated that the deputy manager had developed a detailed action plan to make the necessary improvements. On the day of the inspection we saw that the deputy manager chaired a meeting with staff to address medication issues.

The provider had been asked by the local authority to ensure that all staff who were responsible for administering medication had fully completed the required level of training to administer medication including competency assessments. Information provided by the registered manager following the inspection identified that there remained a significant number of staff who had not yet completed this training. The deputy manager told us that a plan was in place to ensure that all of the staff had completed this training within the next few weeks and that she was monitoring this on a daily basis. The registered manager told us that they also planned to change to medication being administered from a dosage pack

system provided by the pharmacist, which he believed would be safer and more efficient. There was no date as yet for this change to occur.

We received further information which indicated that the home had carried out a medication audit in May 2106 and a very high number of recording errors had been identified through this audit. The registered manager stated that the majority of these errors were regarding the company's policy around recording rather than administration errors, however these remained very high and indicated that staff did not therefore have a full understanding of the provider's medication policy.

This was a breach of Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always ensure the proper and safe management of medicines.

We saw from the accident and incident records that there had been a high number of incidents or accidents recorded such as falls. We saw that the deputy manager had carried out a monthly audit of these incidents. She told us that these were being analysed and that they had met with representatives from the clinical commissioning group to analyse these further. The records indicated that action had been identified to reduce the risk of further incidents occurring in future. Indeed we saw that the April 2016 audit on the reminiscence unit had highlighted "considerably less falls that the previous month".

Care records, for people using the service, contained identified areas of risk. Risk assessments were in place for falls, nutrition and tissue viability. We saw where risks had been identified action had been taken to mitigate the risk. For example, one person had been assessed as being at high risk of falling, a plan had been implemented which included the use of a crash mat at the side of the person's bed and sensor mats to alert staff to when the person was mobile. However, we noted that the identified management plans for certain risks required staff to be able to respond to calls for assistance and sensor mats alerts in a timely manner, which has been highlighted as an area for improvement.

The provider had safe recruitment processes in place before new staff started working at the home. We reviewed three staff files which showed photographic identification, a minimum of two references, full employment history and a Disclosure and Barring Service check (DBS). A DBS check helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people. The recruitment process helped to ensure that staff only commenced working in the home when it was safe to do so.

Staff spoken with understood what safeguarding was and knew how to report any concerns both within the organisation and to external agencies if necessary. Staff received training on safeguarding as part of their induction training and ongoing update training. We saw that the home had both a safeguarding and whistleblowing policy. Local safeguarding policies and procedures were available for staff to access on each of the units. The registered manager and deputy manager demonstrated that they understood their responsibility to identify and report any suspicion of abuse. During the inspection we looked at the accident and incident records and people's individual care records. The records showed safeguarding concerns were being identified, acted on and reported to the relevant agencies. The deputy manager kept a record of all safeguarding referrals which helped them to monitor safeguarding concerns and look for possible trends or patterns.

The home employed a maintenance person. We spoke with the maintenance person and reviewed their records, which demonstrated that regular checks were conducted on the facilities and equipment, to ensure they were safe for the intended use. This included fire safety systems, call bells, water temperatures and electrical equipment. Gas, water and other appliances were also regularly serviced. Risk assessments were

in place for the premises, environment and use of equipment to ensure risks were kept to a minimum.

We noted that there was a communal kitchen based within the reminiscence unit. Staff informed us that the kitchen was used fully for meal and drink preparation, as well as the storage of food. We saw that people within the unit had access to the kitchen at all times throughout the day and night. Kitchen equipment such as a kettle, toaster and cooking hot plate were easily accessible to all. We asked whether a risk assessment had been carried out with regards to those people with dementia who may need supervision when using such equipment or accessing food/drink, to maintain their safety. There were no risk assessments in place for individual's relating to potential risks that access to the kitchen may present. Indeed, staff confirmed that whilst staff were present for the majority of the time to offer supervision, there may be times especially during the night when the area was not always supervised. The registered manager told us that the ethos of the home was to include all people and encourage independence, however he assured us that they were in the process of reviewing this area and were awaiting guidance from a dementia expert within their organisation. We recommend that the provider carries out a full risk assessment of the kitchen area and ensures that any actions highlighted as a result of this are implemented.

The home was clean, very well decorated and maintained to a high standard. The home was also free from odours. There were a number of housekeepers visible around the home and they told us that cleaning schedules were in place. We observed staff wearing personal protective equipment, such as gloves and aprons when appropriate, to help reduce the risk and help the prevention of infection.

Requires Improvement

Is the service effective?

Our findings

We asked people living at Sunrise of Mobberley whether they found the care and support to be effective. Most people spoken with told us that they were supported by staff who were skilled and knowledgeable. People told us "I am happy with the care that is being provided.", "The staff are great, they are well trained. And "The staff are excellent."

Staff were knowledgeable about the needs of people and how to care for them effectively. For example during our observations we saw that a person had a staff member spending time with him, providing support and guidance, the person appeared to be enjoying the interaction. The staff member was aware of the person's likes and dislikes and they discussed one of his favourite sports, this enabled to staff member to provide effective support.

Staff told us that they received an induction and on-going training. Training records confirmed that staff had received training which included subjects such as, Mental Capacity Act 2005, Deprivation of Liberty safeguards, infection control, food safety and health and safety. The registered manager reviewed the training statistics on a daily basis within the manager's daily "huddle" meeting. We were told that the amount of e-learning training that had been completed changed on a daily basis but that 86% - 90% of this mandatory training had been completed by staff. Training was provided through e-learning, but the registered manager told us that bespoke training could also be arranged. We noted that staff were encouraged to develop their skills and a number of staff had signed up to complete national vocational qualifications (NVQ) in care. However, as discussed within the safe section of this report, there were gaps in the number of staff who had completed the required medication administration training.

New staff followed an induction programme in line with the Care Certificate. This is awarded to staff who completed a learning programme designed to enable them to provide safe and compassionate care to people. A number of staff had completed the Care Certificate. The records inspected showed that staff completed a 12 weeks induction programme which was followed by an appraisal. The induction included a day one checklist and spent time working alongside more experienced team members.

Staff we spoke with told us that they received supervision meetings with members of the management team, although the frequency of these meetings was variable. We asked to see records which demonstrated how often people had received one to one supervision. We found that some staff had received supervision, but some staff had not received supervision as frequently as required by the company's policy and records indicated that some staff were overdue. We were told that this was partly due to the long term leave of a member of the management team. We asked for information which could provide an overview of the amount of supervision that staff members had received over the past few months, but this was not available. There was a tracca which indicated when staff's supervisions or appraisals were next due. The deputy manager told us that they had an action plan in place to address this, as they had already identified that nursing staff required clinical supervision and advised us that the appraisals of all staff were being planned. There had been one full staff team meeting at the home since the registered manager came into post in October 2015.

A number of staff told us that they did not always feel supported by senior management. Staff told us that they felt unsettled due to previous changes in management and the turnover of staff. The current registered manager and deputy manager had been working at the home for a few months and told us that there were a number of areas that they were looking to improve and had an action plan in place. There was a specific management structure in place within the organisation, whereby there were different departments, each with a manager who was responsible for the day to day running of the department. A number of staff told us that they felt that that staff morale was low because there had been a number of changes in staffing and that they felt undervalued. Staff told us that they felt supported by their immediate line manager but felt separate from the registered manager and that they had little face to face contact with him. One person told us that senior managers were not very accessible and would not feel comfortable to raise any concerns directly with them. The registered manager provided details of incentives and support that had been provided to staff over recent weeks and told us that they had planned a barbecue for all staff to attend to show their appreciation.

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. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw that the deputy manager had recently focused on DoLS to ensure that appropriate applications were made for the people who required them. Some assessments had been undertaken of people's capacity to make decisions and the management team were aware of their responsibilities with regard to DoLS. Where people had been deprived of their liberty the registered manager had made appropriate applications to the local authority for a DoLS authorisation. There were seven people with a current DoLS authorisation in place and 24 where application had been made to the supervisory body (local authority). The main focus had been on people living within the reminiscence unit. However, further assessments were required for some of the people living within the assisted living unit. The deputy manager had developed a matrix to ensure that information about DoLS applications and authorisations were appropriately recorded, this should ensure that any renewal applications were highlighted and applied for in a timely manner.

The staff we spoke with had different levels of knowledge and understanding of the MCA and DoLS. The training matrix we saw showed nearly 80% of the staff were up to date with MCA and DoLS training. Staff were able to tell us how they supported people to make their own day to day decisions when caring for them and what they would do if a person refused support. However not all of the staff we spoke with knew which people were subject to a DoLS authorisation or how this may impact on the support that they required.

Staff we spoke with appeared to understand the importance of consent and people told us that staff sought their consent before carrying out any care support. Staff commented that this was included as part of their induction. However within the care records we saw that information was inconsistent to evidence that people had consented to the care and treatment described. Where people potentially lacked capacity to consent there was no evidence in some cases to demonstrate that the appropriate process to make decisions of their behalf had been followed. For example we saw in one person's plan that it had been recorded that the person was unable to make decisions, however we could not see that an assessment had been completed to reach this conclusion. We also saw that a person had been assessed as needing a sensor mat to enable staff to monitor them closely. There was no information recorded to indicate whether the

person had consented to this, or if the person lacked capacity to consent whether a best interest decision had been made to reach this decision. This meant that their rights may not have been protected.

Some people told us that they were involved in care planning and that staff consulted with them about their care needs. A relative told us that she had recently been involved in a review of her relative's care plan. However, another relative told us that they had been unhappy because they had not been involved in their relative's reviews since they had moved to the home. We saw records of meetings that were held with people and their families to discuss the person's care needs and support required. We saw in some circumstances that the MCA had been followed correctly and saw an example where the appropriate processes had been followed to administer a person's medication covertly in their best interests.

People were supported to eat and drink enough and to maintain a balanced diet. People we spoke with were very complimentary about the food provided at Sunrise. The home employed a chef who also managed a team of catering staff. We spoke with the chef who told us that the company provided a four week menu and all meals were nutritionally balanced, being prepared from fresh ingredients. There was some flexibility to the menu choices and the chef sought the views of people about the food provision via a monthly meeting. People were also able to make comments about the food in a comments book. Choices were available for breakfast, lunch and dinner, alternative options were available if people did not like any of the choices on offer.

We observed a lunchtime meal. The majority of people ate their meals in one of the two dining rooms. The assisted living dining room had a restaurant feel, the atmosphere was calm and relaxed. We saw that people we offered wine with their meal should they choose. We sampled the food which was appetising and well presented. People told us that they were enjoying the food. One person said "The food is fantastic, the choice is amazing, I've put weight on since being here."

The chef told us that a photo card was produced for all of the people living at the home, which contained information about the person's specific nutritional needs, including their likes and dislikes. The chef had undertaken training and was knowledgeable about people's nutritional requirements. He was aware of people who were at risk of weight loss and told us that they provided fortified diets and milky drinks to people requiring additional calories. The home had been awarded five stars in their latest food safety inspection, which meant that their food hygiene standards were very good.

Staff were knowledgeable about people's nutritional needs. A carer who we spoke with was able to explain about the people who required specialist diet such as a pureed diet and who required thickened fluids. We saw that people had regular access to drinks and people who remained in their rooms/apartments had drinks available to them. The reminiscence unit coordinator had worked with staff to improve the dining experience for people. People were supported with eating and drinking where necessary and it was very positive to see that staff were also seated with people eating their own lunches. This enabled staff to spend time talking with people and to encourage people with their meals where necessary.

We saw records to confirm that people had received care from the optician, chiropodist, dietician and their doctor. The nursing staff told us that the home had links with a local GP who carried out a weekly round on Mondays. People were still able to register with their own GP should they wish to. We spoke with a visiting health professional who told us that they now had some planned meetings with the registered manager to promote good communication and joint working. People were supported and encouraged to have regular health checks and were accompanied by staff or family members to hospital appointments. One person commented "If you're off colour they pull all the stops out."

We looked around the home and found the environment to be conducive to the needs of the people who lived there. The majority of people lived in apartments which contained a kitchenette, bathroom and sitting area. The apartments were bright and decorated to a very high standard. People had been encouraged to bring in personal items from home and many rooms were personalised with people's own furniture and pictures. Some people had telephones in their apartments. Outside of the building people had access to a beautifully maintained garden, we saw during our visit that some people were seated outside, enjoying the sunshine.

People's needs and preferences were taken into account with regards to the design and decoration of the home. Thought had been given to the decorations with the reminiscence unit, which had been specially designed for people with dementia. For example we saw that there were tactile pictures, memory boxes and some doors were painted in specific colours so that the toilets could be identified more easily. The unit had areas where people could be occupied, such as a desk with a type writer and a work bench. There was also a pool table available for people to use should they choose.

Good

Is the service caring?

Our findings

People told us that they were happy with the care that they received and told us that staff treated them with kindness and compassion. We saw examples where staff responded to people in a supportive and caring manner. People commented "The girls (staff) are wonderful" and "staff are very caring, they are great." Another person commented that "The carers are all very nice."

The home had received a number of compliments from people who had lived at the home. We saw that one relative had written to thank staff for treating their relative with "Affection, kindness and compassion."

The reception/entrance was a large open area with a grand piano and coffee bistro. We found that people tended to gather in this area and were able to help themselves to drinks and snacks throughout the day. We saw that fruit and homemade flapjacks were available. The atmosphere felt welcoming and relaxed. People were able to meet with friends and relatives in this area, as well as generally socialising with other people who lived at the home.

We spent time talking to people and observed interactions between staff and people during our inspection. Staff supported people in a kind and caring manner. We saw that staff had built relationships and had good rapport with the people who lived at the home. One person told us "They have a lovely way of dealing with me and have been very supportive through my grief." We heard staff chatting with people in a friendly and respectful manner, for example one member of staff complimented a person as he entered the room and told him how "smart" he looked. People spoken with told us that the regular staff were compassionate and considerate of their needs. During our observations, we saw that a person living with dementia had become anxious, we observed staff taking time on four separate occasions to communicate with this person and helped to provide reassurance, this was done in a caring and tactile manner.

However, some people spoken with told us that whilst staff treated them very well, they were concerned about the lack of time that the carers were sometimes able to give to them. We have focused on this area within the safe section of this report.

We saw that people were supported and involved in planning and making decisions about their care. Staff had a good knowledge about how to provide care, people were given choices and staff were aware of people's personal preferences. We saw in people's care records that information was held around people's likes, such as whether people preferred to have a bath or a shower. People's care records also contained a "This is me" document, which provided detailed background about people's life histories' including things that were important to them. This enabled staff to have a good understanding of the person when providing care and support to them.

We found that there was an emphasis on supporting people to maintain as much independence and control as possible. For example one person told us that they were supported to use their skills to organise some of the activities for people. We also saw that there was a laundry available for people to use should they wish to do their own laundry. Relatives and visitors told us they were able to visit the home at any time.

We saw that staff treated people with dignity and respect. Staff knocked on people's doors before they went into people's rooms and apartments. One person told us "I am treated with dignity." Staff told us that issues around respect and dignity are discussed as part of the induction process.

We found that people's confidentiality was maintained. Care records and personal information was kept securely and in a lockable cabinet in the office.

Good

Is the service responsive?

Our findings

People told us that the service was responsive. We saw that people enjoyed living at Sunrise and people received a personalised service. Comments included "I can't complain it's great." And "I haven't regretted choosing to live here."

We reviewed people's records and saw that they had "Individualised service plans" in place. The care plans that we inspected contained assessment documents which had been completed before the person came to the home to make sure that their needs could be met. The plans of care outlined people's abilities, identified needs, risks and action required by staff. Records had been kept under regular review. People and their relatives had been involved in the assessment process.

We found that the plans reflected how people would like to receive their care, including their individual preferences. The information was detailed, although we found that that some care plans were more detailed than others. Information about people's preference were included for example it was recorded in one person's plan, "Please turn on the shower and provide me with three towels." Another plan indicated that the person "Benefitted from one to one care to ease their anxieties". People told us that they were supported in a way that they wanted to be supported. Their choices were respected and we saw for examples where people were able to come to the dining room for breakfast at a time that suited them. One person told us that they preferred to have a bath rather than a shower and the staff supported them with a bath twice weekly.

Staff told us about the importance of respecting people's choices. Staff told us that "People are given a choice, they say a time that they would like to get up, but sometimes it's hard to get to them on time." People were supported to follow their interests and maintain their independence. One person told us that they enjoyed painting. They were encouraged by staff to use their skills by spending time with other people within the home to help and guide them to paint.

We spoke with the nursing staff who were knowledgeable about the support that people needed, including those people who required dressings, Blood glucose monitoring(BM) or weight monitoring. The unit coordinator told us that they took preventative measures to prevent people from developing pressure ulcers and there were currently no people living at the home who had developed a pressure ulcer.

Staff maintained records of the support that people received each day. Any changes or updates were shared at a shift handover. We saw that some people had records in place to enable staff to record when support had been carried out. We reviewed four people's positioning charts and saw that staff recorded the time that they had supported the person to change their position to help in the prevention of skin damage. However, we saw that there were some gaps in the recording of these positional changes, which meant that it was not possible to evidence that all care had been provided as required. The unit coordinator told us that on occasions staff did not always remember to record that support had been provided and assured us that this was an area that they were monitoring.

An activities programme was on display in the main entrance, which demonstrated that a full and varied range of activities were available to people. For example activities included yoga classes, ten pin bowling, scrabble, poetry and flower arranging. Trips out were also organised and we saw that trips had been planned for this month to Ness Botanic Gardens and Knowsley Safari Park. The home had access to their own transport and employed a driver to enable people to go out on a regular basis. People spoke positively about the activities going on within the home. One person told us "Exercises with laughter is a wonderful hour" and "They have plenty going on, it's great." We saw during the inspection that representatives from Macclesfield Town football team were visiting the home to support people to take part in ball sports activities.

We spoke with one of the activities co-ordinators who told us that they were part of a team who supported people with activities. She told us that they had been working on developing the activities planner and were also in the process of recruiting volunteers to support people. People were asked for suggestions about the types of activities that they would like to take part in via a suggestions form or meeting. New activities were being trialled and they were developing a new plan for the reminiscence unit. People's spiritual needs were supported through a monthly church service and Holy Communion service taking place within the home. We saw that people were also supported on a one to one basis, for example people who preferred to stay in the rooms or were in bed were supported with activities such as reading the newspaper. We observed that staff supported someone from the reminiscence unit to go out for a walk around the garden. The home had access to a newspaper called the Daily Sparkle which had information about that day in history and provided a helpful talking point for people, especially within the reminiscence unit.

People said that they felt able to raise any concerns with staff. They told us that they could speak to the managers if they had any complaints. One person commented "If you want to complain you can." The provider had a complaints procedure in place, which was on display in the entrance area of the home. We saw that the manager had a system for logging any complaints, there was a folder in place which was organised and recorded the details of complaints. The service had received five complaints since October 2015 and there was a record of how the complaints had been dealt with, as well as details of any further actions that were taken.

Regular "resident's council meetings" were also held on a monthly basis. These were attended by people living at the home, their relatives and staff. We saw from the minutes of these meetings that people were able to raise and discuss any concerns or ideas for improvements with the management team. Although some people commented that they were not sure that issues raised at these meetings were always addressed.

Good

Is the service well-led?

Our findings

There was a management structure in place. The registered manager had been in post since October 2015 and had registered with the Care Quality Commission (CQC) in January 2016. The registered manager explained that since coming into post there had been a number of areas which had been identified for further improvement. He understood his responsibilities and was supported by a wider team of staff. He was available throughout the inspection as were his colleagues from the provider management team. They engaged well with the inspection process. We found that many tasks were delegated to the deputy manager or the unit coordinators and we were directed to these members of staff to gather the majority of the information required. We found that they were able to provide all the necessary documentation and information requested for the inspection, in an organised manner.

The registered manager worked closely with the deputy and other senior staff and held a daily meeting with them. Staff said this was a useful way to communicate with each other about relevant matters and gather updates. During the inspection we observed one of these meetings and saw that this enabled senior staff to communicate well. However we found that other members of the staff team did not always feel that there was good communication. Some staff told us that they did not have a lot of contact with the senior managers. One member of staff told us that they had never spoken with the registered manager directly and felt unclear about the roles and responsibilities of the different members of the management team.

Staff spoken with told us that they felt unsupported and gave examples when they would like more visible support such as when there were staffing issues. We discussed this with the registered manager, who explained that the management staff had clear roles and responsibilities and acknowledged that the rest of the staff may need clearer guidance about this. One of the management team had recently returned to work after a period of absence and staff told us that they felt this would have a positive impact on the home. The registered manager confirmed that the home should now benefit from the stability of a complete management team and the recruitment of new staff.

Some staff told us that they were "A good team" and one person told us "I enjoy working here." People told us that there had been a recent power cut and that the team "had worked together" to provide support to people during this time.

Some meetings had taken place with staff. For example there had been a meeting held on the reminiscence unit and a meeting held to discuss medication. However we found that there had only been one full team meeting since the registered manager had been in place. The registered manager informed us that a meeting had been arranged for December but that none of the staff had attended this meeting. There were plans to arrange more frequent and regular staff meetings

People living at the home knew who the registered manager was and chatted with him around the home. However one person told us that they didn't know who the manager was and another person said that the care staff and management seemed to be "separate". People were aware that meetings were held and that they could attend to provide feedback about the service should they choose. We saw that feedback was

sought from people living at the home and staff through a "your voice counts" survey. A recent survey had been carried out and the results were awaited.

We saw that the management team were working alongside other organisations such as the local authority and clinical commissioning group to promote good practice. The management team had worked with the local authority quality assurance and contracts team to take actions to address particular aspects of the care provision The registered manager told us that they had focused upon the recruitment of new staff and were working to reduce and remove the need to use agency staff.

There were arrangements in place to regularly assess and monitor the quality of the service. We saw that the deputy manager completed monthly audit checks and kept robust records of these checks. Some of these base line audits included medication, care records and other "hot topics" such as the environment, DoLS, training, medication and care plans. The audits had highlighted where some improvements were required and the deputy manager told us that these had been effective in driving improvements forward. Examples such as new cleaning schedules had been implemented. A comprehensive action plan was in place which provided timescales and indicated which person was responsible, with details of when the action had been completed.

A monthly quality indicators audit was also completed by the deputy and unit coordinators, this looked at areas such as skin damage, weight loss, infections, accidents and incidents, compliments and complaints that had occurred over that previous month. The deputy manager told us that a governance meeting was held each month where information from these audits was analysed and any further actions identified as a result.

We saw that the provider also carried out regular audits and the regional manager visited once per quarter to complete a full audit. The deputy told us that the regional manager was supportive and would undertake extra audits as required. We found that the service ensured that the quality of the care was monitored and actions to make improvements were being implemented. However in the case of medicines, whilst audits had effectively highlighted a number of medication errors, a positive outcome had not yet been achieved, as staff training remained incomplete. We saw that an action plan had been implemented.

Our records demonstrated that the registered manager notified CQC of significant events appropriately, as legally required to do so.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not always deployed sufficient numbers of suitably qualified, competent, skilled and experienced staff.