Sunrise Senior Living Limited

Sunrise of Bramhall

Inspection report

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Tel: 01618209656

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 13 and 14 March 2018 and was unannounced on the first day. We last inspected the service 06 and 07 June 2017 when we rated the service as good.

This inspection was prompted by information we received from Greater Manchester Police regarding a serious incident; we are making further enquiries in relation to this incident. The provider had notified us of the incident and during the inspection we saw invites to disciplinary meetings and records of discussions about recent issues linked to this incident which had led to formal disciplinary action. This demonstrated the provider addressed any staffing issues raised in a prompt manner.

Sunrise of Bramhall provides personal and nursing care and accommodation for up to 98 older people. Sunrise of Bramhall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Two providers, Sunrise Senior Living Limited and Sunrise Operations Bramhall II Limited have dual registration for Sunrise of Bramhall. This means both providers have joint and equal responsibility for the care and support provided at this home.

The service, which is known as a 'community', is divided into two separate neighbourhoods, the 'assisted living' neighbourhood and the 'reminiscence' neighbourhood. The assisted living neighbourhood provides nursing and residential care for up to 72 older people. The reminiscence neighbourhood provides residential care and support for up to 26 older people living with dementia.

The purpose built community is located in Bramhall Stockport. Accommodation is provided over three floors and some accommodation provides single studio suites that can be shared by up to two people.

Reminiscence rooms have a similar layout to those in assisted living and are situated on the ground floor. All bedrooms are single rooms with en-suite facilities and extensive car parking adjoins the building. At the time of this inspection 69 people were living in the assisted living community, 24 people in the reminiscence community.

At the time of inspection there was a manager in post, however they had not yet formally registered with CQC. 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.

Regular audits were carried out in a number of areas.

People living at Sunrise of Bramhall told us they felt safe and said staff were kind and caring. Staff we spoke with told us they had completed training in safeguarding and were able to describe the different types of

abuse that could occur.

There were policies and procedures to guide staff about how to safeguard people from the risk of abuse or harm. Staff had access to a wide range of policies and procedures regarding all aspects of the service.

Staff received appropriate induction, training, supervision and appraisal and there was a staff training matrix in place. Staff told us they had sufficient induction and training and this enabled them to feel confident when supporting people.

We saw there were individualised risk assessments in place to identify specific areas of concern. The care plans were person-centred and covered essential elements of people's needs and preferences. Staff sought consent from people before providing support. People's health needs were managed effectively and there was evidence of professional's involvement.

Equipment used by the home was maintained and serviced at regular intervals. The home was clean throughout and there were no malodours. The environment was suitable for people's needs.

There was evidence of robust and safe recruitment procedures.

Accidents and incidents were recorded and audited monthly to identify any trends or re-occurrences. The home had been responsive in referring people to other services when there were concerns about their health.

People told us the food at the home was good. There was a seasonal menu in use and this was displayed. People's nutritional needs were monitored and met.

People told us staff treated them well and respected their privacy and dignity. We observed positive interactions between staff and people who used the service.

When people had undertaken an activity this was recorded in their care file information and there was a range of activities available for people to choose from.

The service aimed to embed equality and human rights though good person-centred care planning and people were provided with a range of useful information about the home and other supporting organisations.

The service was supported by other relevant professionals when providing end of life care. Several relatives had commended the home for the quality of its end of life care provision.

There was a complaints policy and procedure in place. This clearly explained the process people could follow if they were unhappy with any aspects of their care. There was a service user guide and statement of purpose in place.

Formal feedback from people who used the service and their relatives was sought and there were regular meetings with them.

The service worked in partnership with other professionals and agencies in order to meet people's care needs.

There was an up to date certificate of registration with CQC and insurance certificates on display as required. We saw the last CQC report was also displayed in the premises as per legal requirements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were managed safely.

People told us they felt safe living at the home.

There were safe procedures for the recruitment of staff and sufficient numbers of staff on duty.

Is the service effective?

Good

The service was effective.

People's nutrition and hydration needs were met appropriately and they were given a choice of food at meal times.

Care plans included appropriate personal and health information and were up to date.

The home worked within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People who used the service and their relatives told us staff were kind and caring.

Staff attitude to people was polite and respectful and people responded well to staff interactions.

Staff respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Care plans were up to date and contained relevant information.

Care plans were person-centred, well organised and easy to follow.

Positive comments were received regarding the provision of end of life care.

Is the service well-led?

Good

The service was well-led.

Audits which were carried out regularly had not identified the concerns we found during the inspection in relation to medicines and drink thickeners.

Staff felt the home was well-led and told us the general manager supported them well.

People were asked for their views about the service and the culture of the service was focussed on the needs of people who used the service.

Sunrise of Bramhall

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.

The inspection was prompted in part by information received from Greater Manchester Police regarding a serious incident. Because of this concern the inspection was brought forward from its original scheduled date. This incident is still subject to investigation and as a result this inspection did not examine the circumstances of the incident and we are making further enquiries in relation to it. However, the information shared with CQC about the incident indicated potential concerns about the management of medicines and this inspection did examine whether there were on-going risks to people. The provider had notified us of the incident.

The inspection was unannounced and was undertaken on 13 and 14 March 2018. The inspection team consisted of two adult social care inspectors, a medicines inspector and an assistant inspector from Care Quality Commission (CQC).

Prior to the inspection we did not ask the provider to complete a Provider Information Return (PIR).

During our inspection of Sunrise of Bramhall we spoke with the director of operations, the general manager, the deputy manager, the HR manager, the nurse, administration and support staff and six members of care staff.

We looked in detail at six care plans and associated documentation, supervision and training records, six staff records including recruitment and selection records, audits and quality assurance, a variety of policies and procedures, safety and maintenance certificates. A CQC medicines inspector looked at 12 people's medicine administration records (MAR's).

We used the Short Observational Framework for Inspection (SOFI) in the reminiscence neighbourhood. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We undertook 'pathway tracking' of care records, which involves cross referencing people's care records via the home's documentation. We observed care within the home throughout the day in the lounges, dining room and communal areas.

We observed the medicines round and the breakfast and lunchtime meal. We toured the premises and garden areas and looked in various rooms. We also reviewed previous inspection reports and other information we held about the service. We used this information to inform our judgement.

Good

Is the service safe?

Our findings

A CQC medicines inspector looked at how medicines were managed in the home. We looked at storage, documentation and administration records on the assisted living and reminiscence neighbourhoods. We looked at 12 medicine administration records (MAR) in detail from the 90 people resident in the home.

Fridge temperatures had been recorded regularly, however staff had failed to inform management when the temperature had fallen below manufacturers recommended 2oC. Staff we spoke with were unsure how to reset the thermometer. The manager informed us that additional training would take place for appropriate staff and procedures tightened.

We looked at the MAR for 12 residents and found there were no gaps in records indicating that residents were receiving medicines as prescribed. Information was clear and there was evidence that stock was regularly checked. Residents' information, such as date of birth and allergy status, was seen on the monthly printed chart, however not all residents had a permanent record in their file. We saw that consideration was made for medicines that had special instructions and time sensitive medicines were given properly.

Some residents were prescribed one or more medicines to be given "when required." Additional information to help staff give the medicine safely was not always seen. These information protocols guide staff when the dosage is variable for example when administering pain-reliving medicines.

We checked the records for a resident that required a powder to thicken their drinks because they had difficulty swallowing. Staff were not recording when thickener was added to drinks accurately. Staff began to address this issue during the inspection. Residents are at risk of choking if drinks are given that are the wrong consistency.

We checked the record of a resident that received medicine from a patch applied to the skin. Staff recorded when a new patch had been applied, but the position of the patch on the body was not recorded. Patches can cause skin irritation if the position is not rotated following manufacturers guidelines.

Residents were encouraged to manage and administer their own medicines where appropriate. We saw records where residents had been involved in decisions and risk assessments done to ensure the residents were safe.

Shortly after the date of the inspection the provider sent us more updated information to address the concerns we identified regarding the safe management of medicines. We will check this at our next inspection.

We asked people living at Sunrise of Bramhall if they felt safe. One person said, "Oh yes, I feel absolutely safe living here; it's the way you feel with people that's important and they [the staff] appreciate you a lot." Another person told us, "I would say it's a safe place to live. Somebody always comes in and checks on me when I am in my room." A third person commented, "I've not had any concerns about safety. The staff are

trust worthy."

Staff were aware of the safeguarding and whistleblowing procedures, designed to enable them to raise any concerns in a confidential way. One staff member told us, "I would report safeguarding concerns to my manager. I would note if it was a near miss, level 2, level 3, report it verbally first then document in the residents file and tell the family and talk to the person concerned. I have done safeguarding training but can't remember when." A second said, "I would report safeguarding concerns to the manager and escalate it to operations director if necessary. I would discuss it with resident if they had capacity and their next of kin; discussions would need to be multi-disciplinary and involve the GP."

People had a variety of risk assessments in place in order to keep them safe. These included assessments for falls, skin integrity, dietary needs, communication, memory and cognition, safety within and outside the building, moving and handling, bed safety, personal hygiene and bathing, malnutrition, medication, cardiac and respiratory issues. This helped ensure guidance was in place for staff on minimising risks to people's wellbeing and safety. The risk assessments were reviewed and updated when changes occurred.

Accidents and incidents were recorded and audited monthly to identify any trends or re-occurrences. Where appropriate these contained an associated body map to identify the specific site of the injury and identified the action to be taken to reduce the potential for further re-occurrence in the future. The accident/incident file was comprehensive and included month-by-month information.

People had personal emergency evacuation plans (PEEPs) which detailed each resident, their room number and bedroom location, the identified level of risk, the type of equipment and numbers of staff needed for horizontal and vertical evacuation of the building.

We looked at the process of staff recruitment and looked at five staff personnel files and found staff were recruited safely. Files contained application forms including contact numbers, education and employment history, proof of identify and address, two references, documented interview notes and Disclosure and Barring Service (DBS) certificates. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people. This demonstrated the manager had followed safe staff recruitment practices.

We checked staffing levels to ensure there were enough on duty to safely meet people's needs. Staffing levels corresponded with the rotas we were provided with and we saw some agency staff were still being used; however the provider endeavoured to use the same agency staff members to ensure familiarity and continuity for people who used the service. When calculating staffing levels the provider assessed people's dependency levels at the point of initial assessment. This enabled the calculation of the required amount of staff needed during the morning, afternoon and night.

We found the area director and/or human resources manager held discussions with staff if an issue about their conduct arose and this was in accordance with the providers' disciplinary processes. We saw invites to disciplinary meetings and records of discussions about recent issues which had led to formal disciplinary action. We found confidential discussion documents relating to disciplinary issues were kept securely. This demonstrated the provider addressed any issues raised in a prompt and efficient way.

The premises were very clean throughout and free from mal-odours and we observed domestic staff undertaking cleaning activity in the assisted living and reminiscence communities and cleaning schedules were completed daily. Chemicals were stored safely and information on how to use hazardous chemicals (COSHH) was available to staff. Staff had access to personal protective equipment (PPE) and used this when assisting people with personal care or when undertaking domestic duties. The use of PPE helps to reduce

the potential for cross-infection.

Environmental risk assessments and audits were in place to ensure a safe environment and ensure the protection of people using the service, their visitors and staff from any injury caused by faulty or poorly maintained areas. We saw evidence that all required equipment and building maintenance checks had been undertaken within the required timescales.

Good

Is the service effective?

Our findings

We asked people who used the service if they felt staff had the correct skills and knowledge to provide effective care. One person said, "Sometimes staff come quickly when I press the buzzer, other times they take ages, once they never came. It can take 30 minutes sometimes but sometimes they arrive immediately." Another person told us, "Staff are very competent; in fact they have just reminded me to wear my wrist tag."

We looked at logs of nurse call-bell response times which were generated electronically and found the majority of calls were answered by staff immediately, however some calls had taken longer to be answered. In response the provider had purchased 10 additional telephones with escalation pagers for staff which were in place at the time of the inspection. In addition we found many people had chosen to wear a personal alert pendant on their person which was used to alert staff if an incident occurred where other equipment such as a passive infrared sensor (PIR sensor) was not in the vicinity. This helped people call for assistance immediately and staff to respond promptly.

The relative of a person who had previously used the service was very complimentary and said, "My wife passed away here and the care here was excellent and we got to know all of the staff exceptionally well. The standard of care was first class. I work here as a volunteer now because I wanted to give something back because I was so appreciative of the care that was provided."

We looked at staff training and saw there was a staff training matrix in place. We saw staff had access to a range of training including manual handling, infection control, health and safety, bed rails, falls prevention, fire safety, COSHH, dementia, safeguarding, MCA/DoLS and equality and diversity. Staff we spoke with confirmed they had completed this training which we also verified by looking at historical training records held by the service.

Staff were required to undertake a probationary period before being offered a permanent position, which included observed practical assessments before confirmation in their role. Staff were also required to familiarise themselves with the people using the service by reading care plans and spending time in their company. If a new staff member had not previously worked in social care, their induction was aligned with the requirements of the care certificate. One domestic staff member said, "During my induction I met all the team, read the policies and procedures, did COSHH training and a week of shadowing. I felt confident at the end and received praise." A second told us, "My induction covered areas such as fire, moving and handling and safeguarding. I was also able to shadow other staff and had my competency assessed. It gave me a good insight into working at the home." Another member of staff added, "A full induction was provided. I completed a few shadow shifts as well so that I got a feel for the job."

We found newly recruited care workers were required to undertake a 12 week programme of induction during which time their work was observed and monitored. New staff 'shadowed' other more experienced members of staff prior to working independently. Staff were given an employee handbook which included information about policies and procedures and the organisation's expectations of employees.

We found staff received supervision every eight to twelve weeks. We looked at the staff supervision file and saw each supervision record was different which demonstrated the registered manager tailored the supervision to the individual staff member's needs. Each supervision identified different areas to be addressed and where issues were identified by staff there was advice about how to address them from the manager. Annual appraisals were undertaken for each staff member and these discussed strengths, weaknesses and achievements, and had action plans which were all documented. One staff member told us, "Supervisions are every eight to twelve weeks and we have annual appraisals." A second, more recently recruited staff member said, "I don't know about supervision yet, I'm on a probation period; they sign off the modules in the probation record as we do them."

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).

There were appropriate records maintained relating to people who were currently subject to DoLS. There were appropriate mental capacity assessments in place which outlined the issues and concerns. Timely applications for DoLS had been made when the indication was this was required and we saw these were up to date and reviewed regularly.

We saw no evidence that people were being deprived of their liberty without authorisation. Applications for DoLS authorisations had been made and in some cases authorised (although others were still awaiting a decision). Those applications we saw had been completed correctly and set out the reasons for the application. The outcome of applications had been notified to CQC, as required under the regulations. A tracker file was kept with information for each person which allowed the service to adequately monitor any applications and their outcomes.

We found care staff had received training in MCA/DoLS and further training was planned. The staff we spoke with were able to explain why people may be deprived of their liberty. One member of staff said, "MCA is about supporting people who lack capacity; it's there to protect them. [Staff name] does mental capacity assessments. DoLS is for when people can't leave the premises alone and for covert medications and this is assessed and authorised by Stockport local authority. If someone not on a DoLS wanted to leave I would encourage them to stay but couldn't actually stop them from leaving." A second commented, "In a care setting if people lack capacity to make their own decisions we are responsible for doing DoLS applications and assessments. We assume everyone has capacity and it is decision specific; assessments are done by nurses for nursing residents and the GP does them for residential residents."

We looked at the dining experience and saw staff supported people with patience and consideration, holding conversations with people as they supported them at mealtimes, although the majority of people were able to eat independently. The meal times were not rushed and people had plenty of time to eat their meal at their own pace. Dining tables were pleasantly laid with cloths, napkins, cutlery, condiments and flowers.

There was information on food allergens and eating and drinking guidelines for each person if they required

a specialist or modified diet or thickened fluids. There was a food hygiene policy and we saw that staff had completed training in food hygiene.

There was an extensive and varied menu on display in the dining area and a separate breakfast menu was also available. A dedicated bistro café was situated near the entrance of the building.

Dedicated staff, called the dining services team, were employed to ensure the mealtime experience was a positive experience for all people.

We were provided with examples of a pureed and soft diet version of the lunchtime meal. We found very little difference between the physical appearance of the specialist diet type meals and the normal meal which ensured they remained appealing to the people who required them. One person said, "I find the food to be ok. I always seem to eat it so I think that tells you something." A second person said, "No problem with the food. I am helped down to the dining room and there is always a nice variety available."

We found people's nutritional needs were monitored and met and their weights were regularly monitored and action taken if staff were concerned about any significant weight loss.

The environment was suitable for people's physical needs. There were hand rails in corridors, grab rails in toilets and bathrooms, pressure relieving items and sufficient moving and handling equipment. There was some signage for bathrooms/toilets, the dining room and other areas of the building, which would assist people living with a dementia to better orientate around the environment.

There were picturesque and well-maintained garden areas that were accessible from both the assisted living and reminiscence communities. The reminiscence community garden had additional security features to ensure people did not wander off away from the premises unauthorised. There were walkways and stopping-off points in the gardens along with several informational notice boards about plants, trees and wildlife.

People were able to personalise their bedrooms with individual items such as family photographs, bedding and personal objects and there was adequate space and seating in each bedroom for visitors to use and spend private time with their relative.

People's health needs were managed effectively and there was evidence of professional involvement, for example GPs, podiatrists, district nurses, Speech and Language Therapy (SaLT), dietetic advice, chiropodists or opticians where appropriate. This demonstrated people had access to health care professionals when required. Staff recorded in each person's care file when they had been visited and treated by health care professionals.

The previous inspection report was on display in the home along with a range of other useful information for people who may be considering a placement in the home. Each person was provided with a 'resident handbook and information guide' which included information about the service and staff and how to make a complaint. A Statement of Purpose was also made available to people which is a legally required document that includes a standard set of information about a provider's service.

Good

Is the service caring?

Our findings

We asked people who used the service and their relatives if they felt staff were kind and caring. The responses we received were positive and people told us they were very happy with the care being provided. One person said "Everything is great here; I've just had my nails done and I like to sit in this quiet lounge and watch what is going on outside. It's a happy place if you want it to be and we are very happy here. It's how the staff treat you that's important and they treat you very well here." Another person who was sat alongside this person said, "We're very happy here."

People had a range of care plans in place called Individual Service Plans (ISP's) which identified the type of individual support each person required, such as mobilising around the home and we saw people's independence was promoted.

We spoke with five members of care staff who had a good understanding of people's identified needs and described how people preferred their care and support to be given. One staff member told us, "We find out about any changes to care plans during the daily handover meeting and we also read daily logs when we come on duty." A second staff member said, "I do get time to read care plans but I am regularly office based; if there are significant changes they are mentioned at handover." A third told us, "Person-centred care is tailored to the individual person and we work with families to ensure we achieve this."

We attended the morning handover meeting which was called the 'morning huddle' which was attended by 11 staff members. Discussions included new admissions, people's medical situation, people's birthdays, call-bell response times and any medical appointments. Individual resident concerns were also discussed; for example one person was concerned about their pet cat and in response staff decided to phone the cattery for an update on the cat's welfare.

We found people and their relatives were involved in developing their care plans. We saw people were provided with information about the service. There were notice boards to indicate which activities were on offer each day. There was information about likes, dislikes and preferences in care files for how care should be carried out which demonstrated people and their relatives had been involved in decisions about planning their care and support.

We found staff had developed a good rapport and understanding of the people living in both the assisted living and reminiscence communities. Staff were friendly towards people and treated them with courtesy and respect. We observed staff interacted with people well and engaged them in conversations relevant to them. For example we observed one staff member explaining to one person about their relative, as the person had become confused about them. The staff member was patient and took their time when speaking with the person, repeating the information several times in a quiet and gentle tone until the person understood what they were saying. This reassured the person concerned who then went on to have breakfast. We saw many other instances when staff greeted people as they got up in the morning, enquired about their welfare and then confirmed with them if they were having breakfast.

Our observations of people throughout the inspection, both in the assisted living and reminiscence community's demonstrated people were happy living at Sunrise of Bramhall and we saw lots of laughter and chatter between people and staff at all times of the day.

Information on how to access advocacy services was posted in the building; this information would be useful for people who did not have any relatives to ensure they had someone they could turn to for independent advice and support when needed. An advocate is a person who represents people independently of any government body; advocates are able to assist people in ways such as writing letters for them, acting on their behalf at meetings and/or accessing information.

We looked to see how the provider promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights though good person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they needed to lead fulfilling lives, which met their individual needs. For example if people had been referred to the home who required an alternative diet the service had responded appropriately.

We found there were appropriate policies in place which covered areas such as equality and diversity, confidentiality, privacy and dignity.

We found people's care files were held in an office where they were accessible but secure and staff records were also held securely in lockable cupboards. Medication administration records were stored in the lockable treatment room. Any computers were password protected to aid security.

A wellness service was available at the home and operated an open door policy Monday to Friday for people who wished to seek advice about their wellbeing. Monthly nurse led wellness checks were carried out to assist in the early detection of any health issues. Where health issues were identified the person was referred to their GP and notes were recorded in their individual support plan.

The home's 'philosophy of care' was clearly stated in their statement of purpose, a copy of which was given to all people who used the service. The philosophy was based on the following principles: celebrating individuality; preserving dignity; enabling freedom of choice; nurturing the spirit; involving the people who used the service and their family and friends; encouraging independence. We observed staff acting out these principles and they provided care and support to people.

Good

Is the service responsive?

Our findings

People we spoke with said they felt staff were responsive to their needs. One person said, "Whenever I need them they are there for me. They are always asking me if there is anything I need." A second person told us, "I have been very well looked after since living here. Nothing seems to be too much trouble."

We saw examples of where the home were responsive to people's care needs and requirements. For example, where people required specialist equipment because they were at risk of developing pressure sores, we saw this was provided for them. A second person required a crash mat because they were at risk of hurting themselves if they fell from bed and we observed this to be in place during the inspection. We read the care plan of a third person which stated they enjoyed listening to [singer name] music and we observed this happening with music playing closely to where this person was seated. This helped us determine that people were receiving care in line with their assessed needs and personal preferences.

Prior to people moving into Sunrise of Bramhall, an assessment of their care needs was carried out. The assessment covered mobility, eating and drinking, communication, capacity, skin integrity and moving and handling. Each person also had their own personal care plan which detailed their care needs and the kind of support they required from staff. If people's care needs had changed, we noted these were updated to reflect things that were different. This meant staff could have access to important information about people's care requirements.

Person centred reviews were held as necessary if the person experienced any health changes. Where issues were identified such as changes to the person's care these were noted and follow up actions were recorded. We asked staff about their understanding of person centred care, one staff member said, "Person centred care is ensuring care is tailored to that person; we work with families to ensure we achieve this."

People living at the home had a wide range of activities to choose from and participate in. We saw there were a wide range of activities available to choose from which included visits to places of interest, a knitting circle, talking newspapers, skittles/tenpin bowling, baking and live entertainment. The home also had access to a mini bus so that people could be transported to any activities within the local community.

During the inspection we observed people singing along to various songs being played on the piano and a planned choir/concert event also took place with nearly 40 people in attendance in the upstairs part of the building. Computers were also available in the home, with access to Wi-Fi, enabling people to keep in contact with family and friends and we also saw people using their own personal mobile phones. Activities were organised by an activities coordinator who consulted people about their preferences during residents meetings before completing the activities programme.

We saw the reminiscence community was designed specifically to support people living with dementia. People were able to freely walk around the community access the secure enclosed garden areas which we observed one person to do frequently. Specific facilities were provided such as a reflection/ quiet room with mood lighting which could help people to gain a better understanding of the environment and improve their

mood and behaviour.

People were well-presented and we observed staff holding conversations with people throughout the inspection. We saw one person living in the reminiscence neighbourhood liked to read a specific newspaper and we saw this was provided and ready for the person to read when they got up in the morning. A volunteer who knew this person also confirmed this newspaper was always provided and that the person was always immaculately dressed in accordance with their personal preferences; we observed this was the case.

Records of people's involvement were kept in care plans, detailing any activities they had taken part in. A concierge service was available in the main reception of the home seven days a week between the hours of 8am and 8pm. A bistro area which served hot and cold beverages/ snacks was open 24 hours a day and also provided daily newspapers and a fortnightly shop was opened for small personal items to be purchased. We observed this area being well used during the inspection by people who used the service and their visiting relatives.

A complaints policy and procedure was in place which allowed people to express if they were dissatisfied with any aspect of the service they received. The policy allowed complaints to be escalated to the local government ombudsman if the complainant remained dissatisfied with the outcome. We looked at the log of complaints maintained and saw an appropriate response had been made to the complainant. People we spoke with told us they knew how to make a complaint if they had any concerns and guidance telling people how to make a complaint was displayed in the community vestibule and foyer.

We asked relatives if they knew how to complain and one relative said, "[Person name] has raised many complaints with management; they always listen and respond. He once complained about waiting too long in the dining room and it was rectified quickly."

An end of life policy was in place which documented the service followed the Gold Standards Framework for end of life (EOL) care. The deputy manager told us the service was currently working towards accreditation under the Six Steps to Success programme. The deputy manager told us that nobody using the service required end of life care at the time of the inspection, however if a person was nearing end of life the relevant palliative care professionals would be involved including the District Nurses and the person's GP. In addition to this an appropriate individual support plan would be implemented. A nurse commented, "End of life care for residential people is done by district nurses, and nurses do it for the nursing residents."

Good

Is the service well-led?

Our findings

At the time of our inspection there was no registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, they are Registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The previous registered manager left the service in January 2018; however the provider had put in place immediate alternative management arrangements. At the time of the inspection this manager was in the process of registering with CQC. Evidence seen during the inspection such as systems to identify where quality or safety was being compromised were being fully utilised, and feedback from the staff team, residents and relatives on management support was consistently positive.

Staff we spoke with told us management were always present and visible in the assisted living and reminiscence communities and said management supported them well. Our observations throughout the inspection supported this view and we saw all the management team were permanently involved in supporting and advising staff and people who used the service.

It was clear that the managers we spoke with, including the operations director, had a very good understanding of each person who used the service without the need to refer to care planning information. One person told us, "I was a little cold sitting near the large window where I like to look out into the garden so I told [operations director name] and he put his coat on and went out and got a new heater which was lovely." There was a vibrant atmosphere in all areas of the building, staff were well-presented and accommodated our requests throughout the inspection.

One staff member said, "The team is well supported by management; [manager name and deputy manager name] are approachable and they have asked my opinion on care plans. The deputy manager is a registered mental nurse (RMN). They have a vacancy for a nursing co-ordinator and there are often days when there are 2 RGN's on duty." A second staff member commented, "[Manager name] is always fair and pleasant, supportive and checks on me in a friendly way and I can make suggestions to her; I have made suggestions and she said yes."

In order to ensure the views of people who used the service were adequately captured, the organisation had established two 'resident ambassadors' who were people currently living at the service. Their photograph and role designation were clearly identified on a notice board for all to see and contact if people so wished. The resident ambassadors attended meetings with management and discussed issues that were important to them and on behalf of the wider resident group.

A list of meetings with people who used the service was on view and we saw meetings took place every month throughout the year; these were attended by managers and other staff such as the activities coordinator and the dining services coordinator. We looked at notes from the most recent meetings and saw discussions included the meal time experience, general care, activities, housekeeping, visitors, agency

staffing. Minutes of each meeting were provided to people who did not attend the meetings.

The operations director told us people who used the service were also involved in the recruitment of new staff which demonstrated the importance the service placed on understanding and capturing the views of people living at Sunrise of Bramhall, and valuing their contributions in respect of the staff who supported them.

Additional feedback about staff performance was also captured through the provision of an initiative called 'heart and soul awards.' This provided the opportunity for people who used the service and the staff group to nominate a staff member for an award. One comment from a person who used the service cited, '[Staff name] the residents wanted to say a huge thank you for all you do – great work.' A comment from a staff member read, 'Always smiling and making our residents smile. So enthusiastic even when a shift may be hard.' Recognising and valuing the work of colleagues is important to team building and team morale and we observed all staff and managers demonstrated a positive and happy demeanour towards people throughout the inspection.

We looked at the audits the general manager and provider had undertaken of key areas of care and record keeping. Audits included infection control, nurse call-bells, health and safety, care plans and care files, DoLS, daily walk-around of the premises, staffing levels, cleanliness and resident's appearance, safeguarding, medicines, accidents/incidents, the meal time experience and complaints. Regular management meetings were held and any issues arising from the audits were discussed at these meetings which demonstrated an open culture of information sharing within the home.

A 'community development plan' had been established for the assisted living and reminiscence communities in addition to a separate development plan for housekeeping, dining, the deputy manager and general manager. Each plan identified the date of the required action arising, the department responsible, details of the actual issue, the action to be taken, who was responsible, the timescale for completion, the current percentage completed and the latest update. The development plans were extensive and colour coded to identify the stage of completion, for example green indicated fully completed, amber indicated in-progress and red indicated not achieved within the originally identified timescale. We found over 93% of items identified that required action had been achieved or were on target to be achieved within the identified timescale.

There was an up to date certificate of registration with CQC and insurance certificates on display as required. We saw the last CQC report was also displayed in the premises and on the provider website as required. The website also provided a wide range of information that would be useful to people considering residence at the home and/or their relatives.

We found the management team reflected on past issues raised regarding the delivery of care and support to people and used this information to improve practice; for example one learning outcome had identified the need for staff to record unexplained bruising accurately, to bring accident reports to the daily morning 'huddle' meeting, to ensure body maps were completed, to ensure effective communication within the home and with CQC and the local safeguarding authority. As a result additional coaching had been provided to staff members.

The service had a business continuity plan that was up to date and included details of the actions to be taken in the event of an unexpected event such as the loss of utilities supplies, fire, loss of IT/telecoms, an infectious outbreak or flood. This meant that in the event of an unforeseen disruption to the service there were robust plans in place to provide continuity of support people using the service in a safe and co-

ordinated way.