Sundial Lodge Limited

Sundial Lodge Care Home

Inspection report

Sundial Lodge
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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Sundial Lodge is a residential care home registered to provide accommodation and personal care for up to 48 older people. There were 44 people living there at the time of our inspection, a small number of whom were living with dementia.

This inspection took place on 20th and 21st April 2016 and was unannounced. We last inspected in October 2013. There were no concerns identified with the care being provided to people at that time.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
The home is arranged into self-contained apartments which include a bedroom, bathroom, dining and sitting area and kitchenette. Most of these apartments are situated within the main building with some apartments behind the main building, known as the Stables and the Mews. A lounge area is available for everyone to use. Meals are provided to people's rooms on trays by staff. People can also cook simple meals themselves as there is a kitchenette and fridge in each apartment. The home is set in gardens and is close to Torquay seafront and town centre. Two minibuses are available to ensure people can get out and about to medical appointments, supermarket and the town.

The home works well for people who are more independent and everyone we met spoke highly of the service. People and relatives all felt the care and support at Sundial Lodge was safe. However, we found a number of areas requiring improvement. Some people's health care needs had increased recently and these were not always being managed safely. For example, in relation to choking and dehydration. We also found medicines were not always managed safely in relation to how they were recorded or how they were stored. Staffing levels were not always safe because there were not enough staff available to meet the number and needs of some people living at the home at all times.

Staff did not always deliver care in line with professional guidance in relation to supporting people to eat and drink enough. Some people who were losing weight needed extra calories in their meals or snacks offered, but records did not demonstrate this was always happening. Systems for recording what people were having to eat or drink were not effective or being reliably followed.

Staff and the registered manager had knowledge of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards, however assessments and decisions had not been recorded fully or in line with legal requirements.

Information in care plans sometimes lacked detail or was incorrect, conflicting or out of date. This meant that staff did not always have clear or up to date guidance from which to work in order to meet people's needs and preferences. However, there was good verbal communication between staff about people's care

needs. All care staff attended handover meetings in the morning, afternoon and evenings where information was shared about any changes to people's health or any other important changes or appointments. The registered manager was actively working towards making care plans more person centred and involving people in this.

People and relatives expressed a high level of satisfaction with food at Sundial Lodge. One person said "there is beautiful food here" and "the food is super here". People made their meal choices a week in advance which most were happy with. Everyone received a copy of their menu choices. However, this did not suit people living with dementia. A relative said they were concerned that they regularly found evening meals left in the fridge that their family member had forgotten about. This meant staff may be unable to determine if people living with dementia were eating sufficiently. The lack of communal dining facilities at the home meant not everyone could have their preference to eat together met and this could lead to social isolation.

We have made a recommendation about setting up a system that helps assure the service that people are eating sufficiently. Since the inspection the registered manager has informed us that as well as everyone being weighed, intake charts showing how much people have eaten have been improved and implemented.

People spoke highly of the care they received. One person said "I am very happy here. I like the staff and the food". Another said "It's the best of what there is – the staff are so good" There were numerous cards and notes in the compliments book, thanking staff for their support and care. Relatives also spoke highly of the service "Staff here are wonderful, nothing is too much trouble" "Sundial Lodge is home from home".

People's right to privacy and dignity was respected in the home. One person said "It's not regimented here; you have your privacy".

Many people living at Sundial enjoyed a full and active social life. People were in and out of the home all of the time we were there; visiting friends or going out for walks. They made good use of the minibus service that took them to the shops and town and valued the support the home offered that enabled them to remain as independent as possible. However for those who were less independent there were limited activities on offer. People did not benefit from individual activity plans to promote their wellbeing. People sitting in the lounge area told us they were bored. Staff said they no longer had time to sit and talk with people. This meant not all people benefitted from meaningful activity in their lives.

The home used quality assurance processes but these had not identified the concerns we recognised through the inspection. Survey's showed a high level of satisfaction from people living at the service and families. No complaints had been received and the registered manager operated an open door policy where any concerns could be raised informally and resolved at an early stage.

Staff had a good understanding of safeguarding and how to protect people from possible harm. Safe recruitment practices were in place to ensure that staff with the right attitudes and skills were recruited. The environment was clean and well maintained and there were regular fire safety checks and testing of other equipment.

People had access to health services. GP's and other healthcare professionals were contacted where necessary to discuss people's care needs. Health professionals told us the home was good at asking for advice and support.

Staff were very happy with the level of support they received from the management team. This allowed

them to develop their learning and consider career progression. Most were involved in studying for diplomas in health and social care. Training was provided to ensure that staff had the skills needed to provide suitable care for people. However this was all currently through e-learning. The manager wanted staff to have face-to-face training too and was looking for a suitable training provider. Since the inspection we have been informed that training from an external provider is in place.

Staff said there had been considerable improvements made at the home since the registered manager started two years ago. They felt that they were operating more professionally and working as a team. People, families and staff all expressed a high level of confidence in the registered manager. The registered manager told us they had worked hard to introduce changes, such as new risk assessments, a stronger team and better communication systems in the home. They had a good relationship with the provider and felt well supported. However they sometimes missed having the support of another professional from a care background. They told us that they would be resuming contact with other manager's from the local provider care forums to gain this support.

During the inspection we identified a number of concerns about the care, safety and welfare of people who lived at Sundial Lodge. We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe:

Risks to people's health, safety and wellbeing were not fully assessed or managed.

People's medicines were not always recorded or stored in a way that protected them from errors.

There were not enough staff to ensure that people always received care when they needed it.

People felt safe and secure living at the home. They were protected because staff understood signs of abuse and how to report any safeguarding concerns.

Is the service effective?

Requires Improvement

The service was not always effective:

There was ineffective monitoring and management of some people's eating and drinking.

Where people lacked capacity to make decisions, capacity assessments and decisions taken in their best interests had not been fully documented.

People spoke highly of the food at the home

People were supported to have access to health professionals including GP's and district nurses to help them have their health needs met.

Is the service caring?

Good

The service was caring:

People spoke highly of the care they received and the caring attitude of staff

Families felt welcome and could visit their relative whenever they liked

People's right to privacy and dignity was respected

People were encouraged and supported to maintain their independence

Is the service responsive?

Requires Improvement

The service was not always responsive:

Information in care plans sometimes lacked detail or was incorrect, conflicting or out of date. They did not always provide staff with sufficient guidance to support them to meet people's needs and/or preferences.

People did not benefit from individual activity plans to promote their wellbeing. There were limited activities available for people who could not leave the home independently.

The lack of communal dining facilities meant some people had to eat alone leaving them at risk of social isolation.

No formal complaints had been raised. People and relatives felt able to speak out if they did have a concerns and were confident that their concerns would be taken seriously and addressed

Is the service well-led?

Requires Improvement

The service was not always well led:

There were systems in place to monitor the quality of the service, but these had not identified the issues we found at the inspection.

Survey outcomes showed a high level of satisfaction from people and families about the care at Sundial Lodge.

People and relatives had a high level of confidence in the registered manager. Staff also spoke highly of them and confirmed they were approachable and supportive.

Sundial Lodge Care Home

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.

The inspection took place on 20 and 21st April 2016 and was unannounced. The inspection team comprised of two social care inspectors and a specialist advisor (nurse) on the first day and two social care inspectors on the second day.

As part of the inspection we reviewed the information we held about the service. We looked at previous inspection reports and other information we held about the home including notifications. Statutory notifications are changes or events that occur at the service which the provider has a legal duty to inform us about. The provider completed a Provider Information Return (PIR) before the inspection. The PIR is a form that asks the provider to give some information about the service, what the service does well and improvements they plan to make.

We looked around the premises, spent time with people in their apartments and in the lounge and observed how staff interacted with people throughout the day. We met with eight people using the service and five relatives. We observed the staff handover meeting between the morning and afternoon staff and spoke with ten staff members, including the provider and registered manager. We also looked in detail at four sets of records relating to people's individual care needs; four staff recruitment files; staff training, supervision and appraisal records and records relating to the management of the home, including quality audits. We looked at the way in which medicines were recorded, stored and administered to people. We sought feedback from health and social care professionals who regularly visited the home including community nurses and social workers and received a response from three of them. We also spoke with three visiting health professionals.

Requires Improvement

Is the service safe?

Our findings

The care at Sundial Lodge was not always safe.

People living at Sundial Lodge had a wide range of care needs. More than half of the people living at the home were independent. However, there was a group of people whose care needs had changed. They now required much more care and were completely dependent on staff to meet their physical care needs. These people were not always receiving safe care.

We looked at the records of one person who staff had identified as being at high risk of weight loss and dehydration and spoke with staff about their care. We found these risks were not being managed safely. The staff and manager could not assure themselves actions were being taken to keep this person hydrated and prevent further weight loss because records were not always completed and staff were not always following guidance. There had been two referrals to healthcare professionals about this person's weight. At the time of the first referral, a dietician had given advice that three meals and two snacks were to be offered as well as daily fortified milk drinks. Guidance stated that if food was refused, staff should "state food offered but indicate if refused". However, there were no records indicating this advice had been followed. We saw this person was often sleepy. Staff said they found it difficult to wake them, which meant a meal or drink, could be missed. Records from the previous three days showed one period of 17 hours where there was no record of any food or drink being offered. On another day there was no evidence of any drinks being offered at all and on two days less that 200ml were recorded.

Staff had recognised this person was at risk of choking due to swallowing difficulties. Advice had been sought from the speech and language therapist and dietician about managing this risk and a recommendation was made for a puree diet and 'syrup consistency' drinks which was recorded within the care records. However, we saw this person being offered a mixture of unthickened and thickened drinks, which could cause choking. When we asked one member of staff about this they were unclear about what the correct consistency was.

We raised our concerns to the manager in relation to this person and they took immediate actions to improve this by updating records and giving staff clear guidance about the correct consistency for thickened fluids. Since our inspection this person has moved to alternative accommodation as the registered manager and provider have assessed that Sundial Lodge can no longer meet their needs.

Another person was losing weight over time. A referral had been made to the dietician in June 2015 who had advised the person be weighed weekly and they should have a high calorie diet and snacks. Staff were also advised to monitor the amount of food the person ate. However, records had not been completed in relation to this. Records showed this person was being weighed monthly and not weekly and they were continuing to lose weight. Staff were not keeping records of how much food this person was eating or if they were offering snacks. A food supplement powder had been prescribed to be given daily to the person, which medication records noted was for "kitchen use". The kitchen records did not show this and there was no records that the supplement was being given correctly or of any record of the need for a high calorie diet.

Staff told us that a food chart had been used in the past but that they had stopped using it because this person frequently chose to eat their meals later in the day or could make their own snacks and it was therefore difficult to monitor what had been taken. The lack of actions and monitoring placed this person at possible risk.

We discussed our concerns about supporting people to eat and drink sufficiently with the registered manager. When we returned on the second day, changes had been implemented and improvements made to systems and staff practice. A new, more effective tool had been designed to record and calculate food and drinks taken by each person staff considered at risk. The registered manager had raised awareness of these with staff who were using the new tool confidently.

We looked at how risks were managed in relation to protecting people's skin. Staff were using a recognised tool to complete assessments and were weighing people regularly. This meant they were able to recognise when someone may be at risk of skin damage. Steps were being taken to manage this risk. For example, by introducing pressure relieving equipment such as cushions or a mattress. However, when we looked at whether staff were following the prescribed instructions in relation to the use of creams for protecting people's skin, we found records did not always accurately detail if creams had been applied for six people. Systems for recording skin care were not clear. Some people had charts kept with the daily records, others did not. This made it difficult for staff to know what and where to record and could contribute to a risk of skin care not being provided safely.

We saw staff give people their medicines and staff were confident everyone was receiving their medicines as prescribed. However, we found that staff were not always completing records to show that medicines had been administered or that prescribed creams had been applied, as they should do. We saw four people's medication was not signed for on their medication administration record at the time it was given. We looked at medication administration charts for everyone living at the home and found that twelve people's medication had not been signed for as administered according to their prescriptions. Recording that medicines have been given is important to prevent misunderstanding and possible errors.

People told us they could choose to manage their own medication if they wanted and they had locked cupboards in their rooms to store medicines in. One person told us that they liked to have this choice and independence and felt reassured that staff would be there to help if needed. Homely remedies that could be given to people without prescription were available. Where people were prescribed 'as required' medication we saw that people were asked if they needed this. There were plans with the medication administration records that gave guidance to staff about when such medicines should be used. For instance one person sometimes had hip pain and we saw staff asking about how this was feeling and whether they needed the pain relief. For people who could not verbally express how they were, we saw that there was a clear description of behaviours that staff should look for to guide whether to give the medication. Staff were able to describe what these behaviours were and we saw that there was no over-use of calming medications.

The registered manager or deputy managers on duty administered medicines and staff said they felt confident and competent to do this and completed regular on-line training.

The process for disposal of medicine was clear within the home's medicine policy. However, this process was not always being followed. Some medicines requiring disposal had been left in an unlocked office. The manager explained medicines for disposal would normally be stored in a locked office, and this was an oversight.

These were a breaches of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014

We brought these issues to the manager's attention at the time of the inspection and immediate changes were made to improve practice for administration of medication and store returned medication safely in a locked office.

We looked at staffing levels and found people were not always safe because there were not enough staff available for the number and needs of people living at the home. At the time of our inspection there were 44 people living at the home. Staff rotas showed there were usually 5 care staff working from 8 am until 2 pm, then 3 care staff from 2pm until 8pm and 2 waking night staff from 8 pm until 8 am. There was also the registered manager and additional staff for housekeeping, maintenance and cooking. We asked the manager about how decisions were made about the levels of staffing needed to meet people's care needs. We were told there was no dependency tool currently being used (a dependency tool is a system for determining how many care staff are needed in relation the number of people who lived in the home and their changing dependency needs). We discussed this with the registered manager who said they would introduce a system once a suitable dependency tool had been identified.

People told us that staff usually responded promptly during the day if they called for assistance, but that was "not always the case at night as staff are obviously very busy". Relatives said that the design of the home, with some apartments outside of the main building, was such that staff found it difficult to get to people quickly. However, they said "You can always find someone if you look".

Staff told us that people's needs had changed recently and they now needed more help, but staffing had not increased in line with this. They said they could not meet people's needs promptly because they were too thinly stretched. Also, they were unable to monitor people who were sitting in the lounge as they had so many tasks to complete elsewhere in the home. There said they did not have time to spend quality time with people: "the bells are ringing constantly. There is no time to do the little extras anymore". We were told that the night staff were under particular pressure in the mornings in the period between 6 am and 8 am, before the day staff arrived. In this period they were required to undertake a wide range of tasks including giving medication, assisting people with personal care and getting up, and distributing the morning paper deliveries to people. Staff were also under increased pressure in the evenings between 8pm and 10 pm when people were getting ready for bed and drinks and snacks were being delivered to rooms. They said they had regularly asked for more staffing at night, but there had been no changes. The registered manager told us they had made efforts to create an extra shift to respond to this, but had not been able to find staff to fill it.

Staff had recognised that some people were at risk being in their apartment alone during the day and so brought them down to the lounge in the mornings so that they could have closer monitoring and support. However, there were not enough staff to provide this and there were periods throughout the day with no staffing present in the lounge. At these times people who were more independent tried to help others who were less able. Some people needed help, but were not capable of calling for staff. One person who had dementia, wanted to go to the toilet but did not know where it was. Another person living at the service took them to the toilet as no staff were present to help. Later we saw a hot drink left in front of the same person. After a few minutes they started making unhappy anxious noises and said "I can't do it, I can't do it" "Too hot!" Other people living in the service provided reassurance and said "leave it to cool", but this person remained distressed. No staff were present in the lounge area to reassure or assist this person as they were occupied with tasks in other areas of the home.

We observed one person, who had dementia and was at risk of falling, wake up and try to stand up. Other

people sitting in the lounge area attempted to provide reassurance and told them to sit back down. They went to help and spent time encouraging the person to sit back down, which they did. However, later the same day we learnt that this person had fallen from their chair when trying to stand. There was an alarmed mat in front of the chair, but staff were not close enough to respond in time to prevent the fall happening. There was not sufficient staffing to monitor this person's safety and falls risk. The accident records showed they had fallen regularly in the lounge area over the past two months.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We raised our concerns with the manager about this person's safety. They took immediate action to arrange a specialist seating assessment to be completed by an occupational therapist which was completed on the second day of the inspection. An extra member of agency staff was put in place to work in the lounge area to monitor safety and encourage food and drinks to be taken.

We asked people if they felt safe living at Sundial Lodge. Most people living at Sundial Lodge were able to communicate their needs and wishes and they told us they felt very safe living at the home. One person said "I love it here; I feel really safe and secure. I am really happy". We saw that people responded warmly to the staff and registered manager and this indicated they felt safe and comfortable with them.

Relatives told us that they felt their loved ones were safe and well looked after. If they had any concerns, they felt confident that they could speak openly with the manager of staff and their concerns would be listened to, taken seriously and addressed.

We looked at home's safeguarding of vulnerable adults policy and safeguarding records and talked with the registered manager and staff about how they protected people from possible harm. A safeguarding concern had been raised in the past 12 months and appropriate action had been taken in response to this incident, including contacting the local authority safeguarding team. Outcomes had been recorded and CQC had been notified. Staff told us they received annual online training about how to safeguard people and were knowledgeable about how to recognise signs of abuse. They knew who they should contact to raise a safeguarding concern and what to do if the registered manager was not at the home. This showed they were competent and knew how to protect people from harm. Staff understood their responsibility to safeguard people and work alongside other professionals, such as the Local Authority Safeguarding Team. They were also aware of whistle-blowing procedures, whereby they could report any concerns 'in good faith' to an external agency such as CQC without repercussions.

Safe staff recruitment procedures were in place. Staff files showed the relevant checks had been completed to ensure staff employed were suitable to work with vulnerable people. This included a disclosure and barring service check (police record check). Proof of identity and references were obtained.

People were kept safe by a clean environment. All areas we visited were clean and tidy. The building was well maintained. There were three members of staff responsible for maintenance on site during the inspection and they confirmed they undertook repairs and redecoration as needed. Records supported this.

Equipment was maintained in safe working order and weekly checks had been carried out in relation to the safety of fire. There were regular fire drills. Each person had a personal evacuation plan in case they needed to vacate the home in an emergency.

There were gas and electrical safety certificates and evidence of legionella testing and of regular testing of

hot water temperatures throughout the home. People were protected by the prevention and control of infection with gloves, aprons and bags and hand washing facilities available in apartments where needed. Staff we spoke with were able to describe good infection control practice such as hand washing and other protective measures. Cleaning fluids were stored safely in a locked area with health and safety guidance clearly displayed for staff.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective.

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 decisions 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 checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005 as some people living at the home had conditions that affected their ability to make decisions about their care and treatment, such as dementia. We also checked whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us that two DoLs applications had been made to the local authority, and another was in progress. However, there were no authorisations in place yet. This was clearly recorded in people's files. The registered manager had knowledge of the DoLS. For example, they knew that a MCA assessment and DoLS application would be needed in relation to the introduction of a specialist chair for one person that potentially restricted their movement. They also knew about recent case law and sought advice from the local authority DoLS team. However, documentation in relation to mental capacity act assessments and best interest decision making had not been fully completed and there were key aspects of information missing. Although the service was acting in accordance with the MCA, this was not always fully documented, and it was not always clear that assessment of capacity to make a decision was specific to the decision to be made at that time, as it should be.

This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014

Approximately half of staff had completed MCA training and there were plans for others to complete this. Those we spoke with understood the principles of the MCA. They were able to tell us how they supported people to make individual decisions on a day to day basis. For example choosing what to wear, how to spend their day and what to eat. They told us how they would seek consent from people by talking with them, visually showing people different options and observing body language. They were able to demonstrate how support should be given. One staff member said "Even if people have dementia, they can still make choices and decisions about lots of things. People have rights as individuals and we must respect those".

People living at the service expressed a high level of satisfaction with the quality of food available. One person said "There is beautiful food here. I used to cook myself, but it's just as good here". Another told us "the food is super; a starter, main and pudding and lots of choice. We get a leaflet every week to choose from". Meals were home cooked and nutritious and incorporated a range of seasonal vegetables and fresh fruit. For example, on one day of our inspection people were enjoying homemade soup, followed by roast

beef or bean burgers, and fruit pavlova or strawberry mousse. Meals smelt appetising and were well presented. In the evenings there was a lighter meal available. For example, savoury pastries and sandwiches. Snacks were also available through the day and at bedtime.

Meals were delivered to people's rooms on trays. Sometimes people kept their meals in the fridge until they were ready to eat them. A relative said they were concerned that they regularly found evening meals in the fridge that their family member had forgotten about. This meant staff may be unable to determine if people living with dementia were eating sufficiently.

We recommend that the service considers setting up a system that helps assure them that people are eating sufficiently.

People's feedback about food choices was sought through resident meetings and their menu suggestions were implemented. There were no restrictions to food budget and people could record their own preferred meal choices on the menu planner if they wanted something different. Kitchen staff told us they were always happy to prepare alternatives and did so regularly. The kitchen area was clean and well maintained with the highest food hygiene rating of 5. All food in the fridges and freezers was clearly labelled to ensure freshness.

People were supported by an experienced and established staff group. Relatives said this stability gave them confidence that their relative's needs were well understood. When staff first came to work at the home, they undertook a comprehensive 12 week period of induction. This included reading care plans and working alongside more experienced staff to get to know people and about their care and support needs. All new staff had to undergo a probation period and had their competencies assessed. This ensured they had the right skills and attitudes to work in care before they were given a permanent contract of employment.

All care staff had completed diplomas in health and social care. Some had completed their level 4 or were currently studying for it. They told us that they felt well supported by the registered manager who encouraged their individual progression and development. One said "I've learnt so much here. I get supervision and loads of support". Staff received regular one to one supervision with a more senior member of staff. All staff had an annual appraisal where they had an opportunity to discuss their practice and identify any further training and support needs.
The provider had recently introduced the care certificate, which is a more detailed training programme and qualification for newly recruited staff. Training was currently being provided via eLearning. Staff undertook regular update training such as fire safety, health and safety, safeguarding, moving and handling and infection control. The registered manager recognised that this may not be the most effective way of learning for all staff in all areas and was actively looking for a training consultant to provide face to face training for staff.

People had access to healthcare services for ongoing healthcare support. They were seen regularly by their local GP, and had regular health appointments such as with the dentist, optician, district nurse and chiropodist. People were accompanied to medical appointments if they wished to be and transport was provided to ensure people could attend with ease.

Communication systems within the home were good. The use of walkie-talkie's enabled staff to call for help to a specific area of the home if they needed it. There were daily staff handover meetings in the morning, afternoon and evening where information was shared about any changes to people's health or any other important changes or appointments. The registered manager was approachable at all times and we saw staff seeking guidance and receiving calm, considered responses throughout the inspection.

Where any health concerns were identified, visiting health care professionals confirmed staff at the home sought advice appropriately. A relative told us that if their relative was unwell, staff called a doctor and rang them straightaway to let them know. Visiting health professionals gave us positive feedback about the standards of care provided and about the knowledge and skills of staff. One said "All staff are very caring and considerate to the patient I was looking after, always happy to help, liaised information appropriately and seemed very 'on the ball'". Another said "they seem to know their nursing capabilities and always call us appropriately" We saw that visiting professionals were required to write in people's notes following their visit. This meant that information regarding any changes in people's care needs or treatment could be clearly passed on to staff at handovers.

Good

Is the service caring?

Our findings

The service was caring

People spoke highly of the care they received. One person said "I am very happy here. I like the staff and the food". Another said "It's the best of what there is – the staff are so good" There were numerous cards and notes in the compliments book, thanking staff for their support and care. Relatives also spoke highly of the service "Staff here are wonderful, nothing is too much trouble" "Sundial Lodge is home from home".

Relatives confirmed they were always made to feel welcome and that visiting was unrestricted. There were frequent visitors throughout the day and staff greeted them warmly and respectfully. They all told us that staff knew their relative as an individual and that staff made them feel special, for instance by giving cards and flowers on birthdays. One relative said "They go over and above here".

The registered manager told us she took pride from the good relationships she had established with people and families. She wanted people to have an enjoyable older age living at Sundial Lodge "I want people to feel happy, not to feel they have no prospects because they are elderly"

People told us there were resident meetings where they could discuss any concerns and make suggestions about care at the home, for example, in relation to food, activities or outings. People's religious beliefs were supported, and there was a regular communion service at the home as well as transport provided for visits to the church.

People had developed strong friendships within the home and these were supported by staff. For instance two people who had become friends were encouraged to go out and have short walks together. One person said "We giggle a lot, me and my friend. We like to go out walking. I met her here".

Staff listened to people and talked to people in a way they understood. For example, one person was not able to communicate well verbally. Staff knew this person well and understood them. They spoke kindly and were laughing together.

The environment was comfortable and homely with books, ornaments and pictures in the communal areas. Staff used people's preferred names. There was a warm and welcoming atmosphere in the home and the interactions we saw between people and staff were positive and kind. For example, one staff member was assisting someone put in their earrings and said "there you go; you look beautiful" Another said "I like your necklace, its beautiful" "But do you like my shoes?" "Yes I like them too!" Staff brought the telephone handset to people in the lounge so that they could take calls and keep in touch with friends and family. There was also a post box in the foyer with daily collections for letters. One person had brought their cat with them when they moved into the home and staff were fully supportive of this.

People said their right to privacy and dignity was respected in the home. For example, staff knocked on doors and waited for a response before entering. They were careful to not use people's names over the

walkie-talkie system used for communicating within the home. One person had a discreet note on their apartment door to alert visitors of the need to discuss with staff before entering due to a potentially contagious illness. One person said "It's not regimented here; you have your privacy". However, we noted that pressure on staffing could lead to people's right to privacy and dignity being compromised. For example, one person who was sat in the lounge area needed to have a dressing changed by the district nurse. Staff initially proposed completing this in the public lounge area because there were not enough staff available to support them to go back to their room. The nurse said this was inappropriate and asked if a screen was available to increase privacy in the lounge area, but there was not. The situation was resolved by the nurse agreeing to return later when staff would be available and staffing was later increased. The registered manager talked to staff immediately to ensure this did not reoccur.

Laundry was completed individually so there was no chance of people's clothing becoming mixed up. One relative said "The laundry service is excellent. Everyone's washing is done individually. There is no need to put tags on it".

People were encouraged to maintain their independence and to maintain an active life. A regular minibus service took people shopping to a local supermarket. People could make simple meals in their own apartment if they wished and groceries were provided for this. The registered manager told us "We want people to lead an independent life as long as it is safe to do so. That's what it's about. At Sundial, we really are about supporting people to live as independently as possible".

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive.

The registered manager had started making people's care plans more person centred with the introduction of 'my plan' which gave a brief overview of people's care needs. People's views about their care needs had been sought in writing these. There were also 'tick box' assessments which briefly indicated their needs in a range of areas such as personal care, diet, mobility, continence and mental health. For example, with reference to personal care, people's needs were described as 'totally independent', 'independent with prompts', 'requires assistance' and so on. However, the person's preferred manner of support or how they should be assisted was not described in any detail to guide staff.

People did not always have a care record that accurately reflected their care and treatment needs. For example, one person who was described as being fully independent with toileting needs was disorientated and unable to find their way to the toilet without assistance. Staff told us this person who was living with dementia was becoming increasingly agitated and distressed. Their care plan said "I have been diagnosed with vascular dementia and this causes me to have visual hallucinations and thoughts which I believe to be real". There was no care plan in place that described to staff how to respond to this person's anxiety and distress. Reviews had been completed regularly and advice from mental health services sought, but the main care plan for mental health had not been updated for over eleven months. We asked staff how they responded to this person's anxiety and distress. They said they would try to calm and reassure them, but they had no clear strategy for how to do this and said they used their "common sense".

People selected their choice of meal from a leaflet that gave menu options for the forthcoming week and everyone received a copy of their menu choices. They were able to write in their own preferences if there was not an option they liked. Kitchen staff said they were happy to provide alternatives and we saw examples of this where people had made individual choices that were different from the main menu. This system suited some people, but did not suit people with dementia who had forgotten what they had chosen.

There is no permanent communal dining room at Sundial Lodge. We spoke with the provider about the lack of communal dining facilities in the home and he explained that his model of care was not to have communal area, but for people to have their own separate apartments with dining facilities. For people sitting in the lounge area, lunch seemed a highlight in their day. They were eagerly anticipating their meal and discussing it and wanted to eat together. Staff put up a folding table and chairs which seated a maximum of six people. We saw that some people were not able to sit down at the table. Staff said they hated turning people away, but they were only allowed to put up one table. They did guide one person to sit separately at a low table, but they were not part of the main group. They said it was "a shame, as people laugh and joke sitting together at the table" This meant some people could not have their preference met to eat together or to enjoy the sociable lunchtime occasion, leading to a risk of social isolation. The temporary nature of these facilities also meant they were not comfortable. One person said to another "I do find these chairs hard, don't you?" Since the inspection the provider has told us they are planning to convert a ground

floor room into a dining room.

People's interests were not necessarily reflected in their care records. For example, one person told us they loved craft and embroidery but there was no mention of this in their care records. Another said their relative said "she used to adore classical music", but in their records there was nothing at all recorded for current and past interests. The registered manager was aware of this issue and was in the process of gathering more information from people and their relatives to update records and staff knowledge.

During our inspection we looked at how people were supported to follow their interests and take part in social activities. People did not benefit from individual activity plans to promote their wellbeing. This was not an issue for the majority of people living at the home because they were more independent and could pursue their own interests. However, for those who were less independent, such as the people sat in the lounge area, we saw little meaningful activity and people sat quietly for most of the day. One person who was sat in the lounge area said "It's too quiet here" and "I don't get hungry sitting here doing nothing all day". Another said "It's all good here; my only complaint is that people in the lounge don't get any stimulation. They just sit there. Nobody makes any conversation. It's a shame, but that's how it is". Some relatives felt that the service overestimated their loved one's level of independence and that they needed more prompting or assistance than staff realised due to their memory problems. This related particularly to reminding them about planned activities, so they didn't miss them.

Staff said that there was nobody employed specifically to focus on activities and they didn't have the time to organise this themselves. They said they used to have more time to spend talking with people, but this had not been possible recently since people's care needs had increased. On the first day of our inspection one person was encouraged by a member of staff to play the piano before lunch, but there was little going on until the television was turned on in the mid-afternoon. One person sat for the most part of the day with a cushion on their lap that they fiddled with. On the second day, holy communion took place and the lounge was busy for this period. There was a member of staff allocated to the lounge area and conversation was more animated. It was also the Queens 90th Birthday and one person commented "You'd have thought they'd have put something on". There were some organised activities which were advertised on a poster in the foyer. There were six planned for April, including flower arranging, piano playing and singing. People told us how much they enjoyed these activities when they occurred. However, for the majority of days in the month, there was nothing organised. People were able to contribute suggestions about future activities at the regular resident meetings.

These are breaches of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014

We looked at how people contributed to the assessment and planning of their care. People said they had been involved in sharing information about themselves when they first moved to the home and that they could read their care plan anytime if they wanted. Relatives told us they were regularly contacted to keep them informed about any changes in their relative's health. They felt information sharing and involvement was good at the home. The registered manager said relatives and people living in the service were involved in an annual review or more frequently if needs changed. They were actively working with staff towards improving levels of personalisation within the service. For instance in relation to holding better information about people's likes and dislikes. Everyone had recently been involved in updating this information and work was ongoing in this area. This was contributing to improving care plans. However, care plans were not signed by people or their representatives. The registered manager told us they would ensure people's involvement was more clearly evidenced in the future.

People were encouraged and supported to maintain relationships that mattered to them. Family and

visitors felt welcome and were encouraged to visit and be involved in the home. Relatives and friends could join people for celebrations such as birthdays and the fireworks display. People's rooms were personalised with things that were meaningful. For example they were encouraged to bring family photographs, pictures and ornaments that were precious to them.

The service had a complaints policy and process which was posted in areas of the home and available to people and their relatives. There had been no formal complaints raised. The registered manager felt this was because they were approachable and any concerns were dealt with quickly before they grew into bigger issues. People and their relatives confirmed that this was the case. They said any concerns they had would be listened to, taken seriously and responded to quickly by the registered manager or provider. People also told us that they could bring up any concerns through the monthly residents meeting. We saw that these were regularly used to discuss ideas for activities and feedback about the quality of food and the service more generally. Where people were not able to attend the meeting, the registered manager discussed the minutes with people individually to collect their views. They were also in the process of setting up a regular opportunity for relatives to meet and share their views about the service and put forward any concerns or ideas.

An annual survey was completed that gathered the views of everyone living at the service as well as their relatives, staff and visiting professionals. Suggestions from this had been put into action, such as the introduction of a light snack being offered at bedtime.

Requires Improvement

Is the service well-led?

Our findings

Sundial Lodge is a service that has enjoyed a good reputation and has always been inspected positively by CQC in the past. For some people it continued to meet their needs. However for others, who needed higher levels of physical care, the systems were not in place that ensured their care needs were met and that risks were managed and mitigated. Although the dependency levels of some people living at the service had changed, the service had not adapted to meet these. For example, there were not enough staff to meet people's changing care needs. This had not been recognised or acted upon by the service, despite concerns being raised by staff. There was no dependency tool in place to help review and determine appropriate staffing levels. The service was not following robust systems so that staff and managers could assure themselves that people were getting enough to eat or drink. Some records were inaccurate and did not reflect people's current care needs or give staff clear guidance about how to meet people's care needs. There was no effective system in place to review and identify this.

Quality assurance systems were in place. However, they were not always effective as they had not identified the risks and issues we found during our inspection. For example, the home's policy was that medicines were managed safely and as prescribed. However, this had not been followed. There was a system for auditing of medication. Previous audits identified an ongoing issue of medications not being signed for correctly. Although this issue had been identified, there had been no action taken to remedy it and the omissions in recording continued at the time of our inspection. This meant that over a long period of time medication recording had not been carried out correctly in line with the home's medication policy. Accident trend analysis was not effective. Records showed one person had fallen regularly in the lounge area over the past two months. However, this did not prompt actions in relation to the individual who was repeatedly falling.

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

There registered manager at the service was well respected and liked by people, relatives and staff. They coped calmly at times of pressure. For example, when electrical engineers called unexpectedly during the inspection and wanted to switch power off, they declined due to the potential impact on people living at the service. They rearranged the appointment to allow time for planning and communicating with people. They also responded quickly and effectively to the concerns raised during the inspection. For instance, by redesigning charts to make recording of food and drinks more effective and by accessing urgent occupational therapy input for one person and new equipment. This showed strong leadership skills and willingness to work in partnership to improve the service for people.

All staff said the registered manager had made significant improvements to the service and was supportive of their development and ideas. One said "everyone here has a say". They also spoke highly of the provider: "The managers here are approachable. I can pick up the phone and they'll be there for you. They stick by you and support you through things" and "He's a great employer – nothing is too much trouble". They said they felt valued and that they were working better as a team since the registered manager joined.

There was an open door policy which we saw in action with staff seeking guidance and communicating easily with the registered manager. The registered manager and provider were supportive of their staff team and valued their hard work. They expressed this by supporting staff's training and career development and by awarding an 'employee of the year' award. They recognised that good staff morale led to a stable staff group and this was an important factor for people living in the home. The service had recently been granted the investors in people award. This is a recognised standard for best practice in managing people.

There were annual reviews of quality and satisfaction completed by people, relatives and visiting professionals. These showed a high level of satisfaction. For example in the 2015 survey 62% of people felt staff respect for their privacy and dignity was "excellent" and 38% said it was "good". Responses had been collated and analysed and an action plan produced. Changes, for example in relation to food choices, had been actioned. The 2016 survey results were being analysed at the time of our inspection.

The registered manager told us they had faced significant challenges since they started in the role two years ago. This included introducing more comprehensive records for people and motivating and bringing the staff team together. They had introduced positive changes to make the residents meetings more inclusive and hear everyone's views and were working towards setting up relatives meetings too. They had also set up more effective communication systems within the home with the use of the 'walkie- talkie's' which staff loved. They were keen to provide a good service and committed to making the required improvements. They said the provider was excellent and always supportive, but did not have a background in care. They recognised that they had become isolated from the support of other managers working in the care sector. They told us they intended to resume their contact with the local provider forums in order to gain support and share good practice. They also accessed resources to learn about current best practice from the CQC and local authority website.

The registered manager had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

We spoke with the provider and registered manager about the vision and values of the service. They told us the home has always been focused on supporting people to live their lives as independently as possible with good resources to help them do this. This included the minibuses which took people to the shops and medical appointments, and self-contained apartments where people could make their own drinks and light meals if they wished. They acknowledged that whilst this model was positive for many people, it may not be realistic for those who were completely dependent on staff to meet their physical care needs or needed intensive care at the at the end of their lives. The provider told us they would be considering whether they provided end of life care in the future and would involve people in discussion about this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care that met their needs or reflected their personal preferences. Regulation 9 (1) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Action had not been taken to assess people's mental capacity and record best interest decisions in line with the requirements of the Mental Capacity Act 2005, and Code of Practice. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Action had not always been taken to fully assess risks to the health and safety of people receiving care or to mitigate those risks. Staff had not managed medicines safely. Regulation 12 (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes were not in place to ensure action was taken to assess,

monitor and manage risk. Regulation 17 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's care needs at all times.Regulation 18 (1)