Le Flamboyant Limited

Sunrise Care Home

Inspection report

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

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2012 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 2012, and to pilot a new inspection process being introduced by the Care Quality Commission which looks at the overall quality of the service.

The inspection was unannounced.

Our last inspection of this service was on the 4 November 2013. We found that the standards we checked had all been met.

Sunrise care home is a care home that provides care and support for up to 20 older people, some of who are living with dementia. At the time of the inspection, there were 19 people living in Sunrise care home.

There was a registered manager in place. A registered manager is a person who has registered with the CQC to

Summary of findings

manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The registered manager was absent on the day of our inspection.

Staff did not always engage effectively with people who had dementia and people were not always given adequate choice about what to eat, drink or where to reside within the service. This meant that some people were not treated with respect. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and you can see what action we have told the provider to take at the back of the full version of this report.

Some relatives felt that their loved ones required more stimulation to enhance their quality of life. Similar comments had been received from a healthcare professional and the local authority prior to our inspection, particularly in relation to people who had dementia. During our observations throughout the day, we saw that some people spent a lot of time sitting in the same chairs either asleep or gazing around the room. The provider had not ensured that people living with dementia had adequate stimulation or support to help them maintain their hobbies or interests to enhance their wellbeing. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and you can see what action we have told the provider to take at the back of the full version of this report.

The staff had a good knowledge of what care they needed to provide to meet people's basic personal care needs. However, the provider had not made sure that they had received adequate training in dementia to give them the knowledge and skills required to care for people who were living with this condition effectively. Staff had not received training in other important subjects such as infection control and health and safety although we were advised after the inspection, that plans were in place for this training to be completed. The provider was not following their own policy regarding how often staff should receive supervision from their manager. This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and you can see what action we have told the provider to take at the back of the full version of this report.

Staff did not understand the principles of the Mental Capacity Act (2005) even though they had received training in the subject. This meant that we were not assured that people who lacked capacity to make decisions for themselves had their rights fully protected.

The service was meeting the requirements of the Deprivation of Liberty safeguards (DoLS) which meant that authorisation had been sought from a specialist independent body before depriving someone of their liberty.

Relatives told us that they felt their loved ones were safe and were in the main, happy about the care that was being received. There were enough staff to keep people safe and their medication was given to them correctly. People were protected from the risk of abuse and their care needs had been assessed. People had access to specialist advice when they needed it to keep them healthy and they received adequate nutrition.

The staff were happy working at the service and told us that the management team and the provider were supportive, that they listened to them and that changes in care practice were implemented where concerns had been raised. The provider monitored the quality of the service provided. However, we saw that staff concentrated on meeting people's physical needs rather than taking the time to engage with them on a personal level. Staff engaged with people who could communicate with them on occasions during the inspection, but we saw little interaction with people who were living with dementia and/or who had communication difficulties.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe. Staff demonstrated a poor knowledge of the Mental Capacity Act (2005) and were not following its principles. However, there were enough staff to keep people safe, people's medication was given to them safely and steps had been taken to protect people from the risk of abuse.

The service had applied to the relevant authorities before depriving someone of their liberty. This meant that the service was meeting the requirements of the Deprivation of Liberty (DoLS) safeguards.

Requires Improvement

Is the service effective?

The service was not consistently effective. Staff had not received sufficient training to give them the knowledge and skills to provide support to people living with dementia. Most staff had not received training in other important subjects such as infection control or health and safety.

People had access to specialist healthcare advice when they needed it to help them stay healthy and they received adequate nutrition to meet their needs.

Requires Improvement

Is the service caring?

The service was not consistently caring. Staff did not engage with some people who were living with dementia on a regular basis. These people were not offered a choice about what to eat or drink, or where to spend their time during the day.This showed that these people were not always treated with respect.

People who were able to provide us with their feedback told us that they were involved in planning their care.

Is the service responsive?

The service was not consistently responsive. Some people had access to activities that they enjoyed. However, some people living with dementia were not being supported to maintain their hobbies or interests to promote their well-being.

People's care needs had been assessed and in the main, were being met.

People were confident to raise concerns with the management and the staff if they had any.

Requires Improvement

Is the service well-led?

The service was not consistently well-led. The provider had not made sure that staff had sufficient knowledge and skills to always meet people's individual needs or enhance their wellbeing.

Requires Improvement

Summary of findings

Staff were happy working for the service and told us they were listened to. The quality of the service provided was monitored regularly so that improvements could be made.

Sunrise Care Home

Detailed findings

Background to this inspection

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

The inspection team consisted of an inspector and an expert by experience. An expert by experience has personal experience of using or caring for someone who uses this type of care service. Our expert had expertise in services for older people with dementia.

Prior to our inspection we reviewed historical data we held about the service. This included any notifications that had been sent to us by the provider. A notification is information about important events which the service is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was received by the deadline given. We also spoke to the local authority safeguarding team, quality monitoring team and the community nursing team.

On the day we visited, we spoke with four people who lived at the service, five relatives, four care staff and the deputy manager. Most of the people who lived at the service had a diagnosed dementia and some were therefore not able to provide us with their feedback.

We observed how care and support was provided to people. To do this, we used the Short Observational Framework for Inspection (SOFI) as well as general observation. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at four people's care records, ten people's medication records, eight staff records relating to recruitment, supervision and training, the daily menus and records relating to how the service monitored the quality of the care it provided.

Following the inspection, we asked the registered manager to send us a copy of a document detailing how they worked out their staffing levels, the overall training record for all staff working at the service and some policies and procedures.

Is the service safe?

Our findings

It was clear from our observations throughout the day and our conversations with staff that they did not understand the requirements of the Mental Capacity Act (MCA) (2005). The MCA is legislation that is in place to protect the rights of people who are unable to make decisions for themselves. Some people who they engaged with were assumed to lack capacity to make decisions and were therefore not always asked for their consent before care was delivered. For example, we did not see staff asking people for their consent when placing tabards over them to protect their clothing when supporting them with their eating and drinking. One staff member turned the television off that some people were watching and put the music on. The majority of people who lived at the service were in the lounge at the time and no one was asked if they were happy with this.

People who lacked capacity were not always supported to make decisions. For example, we asked a member of staff how people made the decision about what they wanted to eat. They told us "They cannot tell us so we just give it to them." When we asked if alternative methods were used to help people make a decision such as pictures of the meals or showing the choice of meals on offer, the staff member said, "No, but that is a good idea." Staff told us that they had received training in the MCA (2005) and training records confirmed this but staff did not understand how to apply the principles of the Act in practice. Staff were also not able to demonstrate to us that they had an understanding of the Deprivation of Liberty safeguards (DoLS). This meant that we could not be sure that people who lacked capacity to make their own decisions had their rights protected.

Although staff lacked knowledge surrounding the MCA and DoLS, we found that the service was meeting the requirements for DoLS. The deputy manager told us that the registered manager had reviewed people's care following a recent court judgement regarding the application of DoLS. Three urgent applications had been made to the local authority for authorisation to deprive these people of their liberty in their best interests to keep them safe. We spoke to the local authority who confirmed that they had received these. The service had therefore taken the appropriate action by requesting an authorisation under DoLS.

Two relatives that we spoke with told us that they were happy with the care provided and that they felt their relative was safe. One relative told us, "I am happy that (my relative) is well cared for here and is safe." Another said, "It's not posh but it is homely." One person who lived at the service said, "It is nice here, there are no arguments."

The majority of care staff we spoke with demonstrated that they would take the correct steps to protect someone who lived at the service from the risk of abuse. They were able to tell us the different types of abuse that they would look out for and who they would report any concerns to so that they could be investigated.

Risks to people's safety had been assessed by the service. Records of these assessments had been made. These had been personalised to each individual and covered areas such as moving and handling, nutrition, pressure care and falls. Each assessment had clear instructions for staff to follow to ensure that people remained safe. One person told us that people were checked on regularly during the night to 'make sure that they were ok.'

We observed that there were enough staff to assist people when they needed it. For example for personal care and to eat at lunchtime. All staff told us that there were enough staff to keep people safe. The registered manager told us after the inspection that when staff were unwell or could not complete their shift, that other staff would work extra hours to cover this to make sure that there were enough staff to meet people's needs. If necessary, agency staff would be used if other staff could not work.

Recruitment records showed that the provider had carried out a number of checks on staff before they were employed. These included checking their identification, health, conduct during previous employment and that they were safe to work with older adults. However, not all gaps in some staffs employment history had been explored to help the provider judge whether the staff member was of good character.

We found that the arrangements for the management of medicines were safe. They were stored safely and effectively, for the protection of people who lived at the service.

Arrangements were in place to record when medicines were received, given to people and disposed of. The

Is the service safe?

records kept regarding the administration of medication were in good order, provided an account of medicines used and demonstrated that people were given their medicines as was intended by the person who had prescribed them.

We observed one member of staff giving out medication at lunchtime. This was done correctly and in line with current guidance which is in place to make sure that people are given their medication safely.

Where people were prescribed their medicines on a "when required" basis, for example, for pain relief, we found detailed guidance for staff on the circumstances these medicines were to be used. The provider could therefore be assured that people would be given medicines to meet their needs.

Is the service effective?

Our findings

All of the staff we spoke with told us that they had received training in a number of different subjects to help them meet the needs of the people who lived at the service. However, one member of staff told us that they felt that they needed to update their knowledge and most of them said they required training in understanding dementia to give them the skills to care for people with this condition. When asked, one member of staff told us, "I don't know much about dementia." Two of the relatives we spoke with told us that they did not think that all the staff were experienced enough to work with people who were living with dementia as they did not observe staff interacting with their relative regularly.

The eight staff training records we looked at had recorded that only one staff member had received training in dementia in 2012. This meant that the provider had not made sure that staff had sufficient training to give them the skills to care for people with dementia effectively. Other training that had not been received by the majority of staff included infection control, first aid and health and safety. Following the inspection, the registered manager advised us that staff had been booked to receive training in dementia, infection control and health and safety in August 2014 and first aid by the end of October 2014. However, as six of the eight staff had worked for the service for more than six months, this did not follow the national guidance from Skills for Care that states all staff should receive appropriate training within 12 weeks of commencing employment.

All of the staff at the service had the opportunity to complete nationally recognised qualifications in adult social care. Most of the staff we spoke with told us that they had regular supervision meetings with their manager although one staff member could not recall their last meeting. We checked their file and saw that this was in August 2013. In one other staff members file, there was no documentary evidence to show that they had received any formal supervision since starting work for the service in February 2014. The provider's supervision and appraisal policy said that staff were to receive formal supervision every two months. This demonstrated that the provider was not implementing their own policy regarding staff supervision for all staff. The lack of appropriate training and supervision of staff meant that there was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

The people we spoke with had mixed views regarding the food. One person told us that they didn't like the food much and that there wasn't much of a choice. Another person however said, "The food is nice."

A menu was displayed in the service that showed there were a choice of meals on offer. The provider had asked people about their preferences regarding food which were documented within their care records. People who required soft diets were also provided with these.

During the lunchtime period, people who required support to eat their meals were provided with this. People's risk of malnutrition had been assessed and we saw that where people had lost weight and the provider was concerned, that they had referred them to the GP who in turn requested specialist advice from a dietician. However, these people's food and fluid intake was not being recorded to enable the provider to monitor that it was sufficient for their needs. We mentioned this to the deputy manager who immediately put food and fluid charts in place. Staff were able to confirm to us which people were receiving extra food to help them to maintain their weight.

All of the people we spoke with told us that they were able to see healthcare professionals when they needed to. One person said, "I do see the doctor when I need to." Another person told us that they received assistance to attend regular appointments at the local hospital. Records confirmed people were seen by the GP and that other specialists such as chiropodists, district nurses and community psychiatric nurses when needed. Relatives told us that staff contacted them if they were concerned about their family member and if they had needed to go into hospital.

Is the service caring?

Our findings

During the inspection we observed the care that three people who had dementia received in the morning. We did not see staff interact with these people unless they were performing a task such as providing them with a drink.

People were not always given a choice about what to eat or drink or where to spend their time during the day. We observed staff give people cups of tea without asking them if that was what they wanted. Biscuits were given but no choice was offered. We observed lunch being served in the dining room and saw that everyone was given the same type of juice. We did not see staff giving people who lived with dementia a choice about whether they wanted to go outside, move around the service or go to their rooms. We asked one staff member if people had a choice of whether to have a bath or shower. They told us that they always gave people baths because, "It is easier just to stick them in the bath as there is more room."

During the afternoon, one person was seen calling out to try to attract someone's attention. Some staff walked past the person and did not acknowledge them. However, one staff member did eventually go and speak to the person which alleviated their distress. We heard one person say, "I want to go home." The staff member replied, "No you don't." The person then said, "Take me home." The staff member replied, "When I go." There was no attempt made by the staff member to distract the person or to engage them in an activity to alleviate their distress. This meant that some people were not always treated with respect. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

One relative we spoke to told us how the staff had helped their relative return to the home from hospital after the ambulance service would not bring them home. They said, "They are really good, they will do anything to help." However, another relative told us how they were concerned that staff did not spend any time with their family member. They said, "They don't seem to take the time to just sit and talk to people and be with them."

A few staff did engage with people in a kind way. Some people were seen laughing with staff and enjoying themselves. We saw one staff member discreetly ask someone if they wanted to use the toilet so that their dignity was maintained. When people used the bathroom facilities, the door was always shut to protect people's privacy. We saw that staff knocked on people's doors before entering into their bedrooms to make sure that they were happy for them to go in before entering.

The four care records we looked at contained information relating to the individual person's life history, needs, likes, dislikes and preferences. The staff we spoke with were able to tell us about people's individual basic care needs such as what personal care they required, what they liked to eat and when they liked to go to bed. However, when asked, they could not demonstrate that they had a good understanding of the person's social and emotional needs such as their past history or their interests and hobbies. This is important for people who live with a dementia so that staff can engage in meaningful conversations with them and enhance their wellbeing.

The people that were able to provide us with their feedback told us that they understood the care they received and were involved in making decisions about their care. Where people were unable to make their own decisions, we saw that their next of kin had been consulted. The care records we looked at had been signed by either the person or their relative to show that they agreed to the care. One relative told us that they were involved in reviewing their family members care once a year. The deputy manager told us that meetings were held with the people who lived at the service and their relatives to gain their views on the care received. This was confirmed by two people that we spoke with who confirmed that they were able to feedback any comments they had regarding their care.

Is the service responsive?

Our findings

Prior to our inspection, both the local authority and a health care professional who visited the service had told us they were concerned that people living with dementia were not being supported to maintain their hobbies and interests. During the inspection two relatives also told us that they felt their family members could not take part in the regular activities that were on offer and that they did not receive alternative, adequate stimulation to enable them to have a good quality of life.

During the inspection, we saw that some people participated in playing a version of snakes and ladders that was played on the floor. People appeared to enjoy this. One person told us, "I enjoy myself most of the time." However, another person told us that there was not much for them to do and that therefore, they spent a lot of their time asleep.

We observed that some people were not asked if they wanted to participate in the snakes and ladders game or any other activities during the day. These people spent most of their time sitting in the same chair during the day either asleep or gazing around the room. We checked three of these people's care records and saw that they had been diagnosed with dementia. We looked at what hobbies or social activities were recorded that they enjoyed. It was noted within one person's care record that they enjoyed gardening, singing, reading and chatting to people. This person also had a specific need in respect of religion. Although records showed that this person attended a monthly church service that was held within the home, we did not see that they had engaged in any other of the activities that they enjoyed within the last ten days, apart from on one day where it was noted that they had 'chatted to staff' and another when they 'looked at a magazine'. We asked a member of staff how they had helped this person continue their interest in gardening. They told us that the person could no longer garden as they had arthritis but they did not offer any other solutions such as taking the person outside into the garden to see the flowers or to assist them with potting plants. Another person was noted as enjoying football but there was no evidence that this had been explored further.

There was little stimulation for people living with dementia to enhance their wellbeing. No activities such as reminiscence were available for people to take part in. There were no items around the service to help facilitate engagement with people such as soft toys, memorabilia or textiles. This meant that the service was not providing enough meaningful activities or stimulation for people living with dementia to promote their well-being. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

The care records that we checked demonstrated that the service had conducted a full assessment of people's individual care needs. Guidance was in place for staff on how to support people with their identified needs such as personal care, communication, skin and agitation. Three people's care records indicated that they required interventions to make sure that they were protected from the risks of developing pressure ulcers. Pressure ulcers are a type of injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. We saw that these people were receiving these interventions. For example, pressure relieving equipment such as cushions and mattresses were being used to reduce the risk of them acquiring a pressure ulcer. People also had their position changed frequently when they were in bed at night. However, we saw these people sitting in the same position for long periods during the day. The deputy manager told us that one person had only been supported to move twice during our inspection (eight hours) to use the toilet. This meant that the service was not doing all it could to reduce the risk of these people acquiring a pressure ulcer.

Information was kept in a separate folder regarding people's current medication, medical history and allergies that could be given to the ambulance service if they needed to go into hospital. This was so that the ambulance and hospital staff would have sufficient information to be able to treat them in a timely manner.

We asked people if they were confident to raise any concerns or complaints if they were unhappy about the care they received. People told us that they did not have any complaints, although one person added that were not confident that any issues they raised would be dealt with. This indicated that this person felt that they were not always listened to.

Any complaints received were recorded in a book. However, the deputy manager told us that they had not received any formal written complaints within the last 12 months. Staff we spoke with knew how to respond to complaints if they arose.

Is the service well-led?

Our findings

We saw that staff concentrated on meeting people's physical needs rather than taking the time to engage with them on a personal level. Staff did not demonstrate that they had a good knowledge of the people they cared for. They did not always support people living with dementia to make choices about their care or provide them with support to maintain their hobbies or interests to promote their well-being.

Staff had not been provided with the appropriate training to enable them to give effective care to people who lived with dementia. There were no systems in place to ensure that the training that staff had received was understood. For example, staff had received training in the Mental Capacity Act (2005) but could not demonstrate their knowledge of the subject and were not applying the principles in practice. Also, one staff member was unable to show us that they understood their responsibilities with regards to reducing the risk of abuse to adults although they had received training in this subject. This meant that the provider could not be assured that staff had the necessary skills to meet all people's care and wellbeing needs. It is acknowledged that the provider has now planned following this inspection, for the staff to receive training in dementia.

All of the staff we spoke with told us that they felt supported by the management team and that they felt able to raise any issues or concerns that they had. They said that they were confident that these would be acted on and explained and that they had regular meetings to discuss these concerns. They told us that morale was good amongst the staff but that the main issue was the high turnover of staff at the service. The deputy manager explained that this was due to a number of other care homes being situated within the local area. They told us that the provider was aware of this issue and was working to retain the current staff members so that people could have care from staff who knew them well.

Relatives we spoke with told us that they knew who the manager was and that they were approachable. One relative told us, "The manager is very nice, very approachable." Another relative said, "If you have a problem, (the deputy manager) is the one to see."

We asked the deputy manager how they learnt from incidents. They told us that they analysed all incidents monthly to see if any patterns were evident. We saw documentary evidence to show that this occurred. The service also carried out a number of other audits that covered areas such as cleanliness and care records to ensure that the service was clean and that the care records were up to date.

Feedback from people and their relatives had been sought to find out what they thought about the care they received. We saw a sample of these questionnaires that had been completed in May and June 2014. In the main, the responses were positive with comments such as, 'They (the staff) do a wonderful job with a lot of kindness and patience', 'My wife is happy' and 'I feel that the home is very well run and friendly." Areas identified for improvement were regarding the lack of stimulation for some people with comments such as, 'Some kind of communal stimulation would be good although not sure if (my relative) would join in', 'More entertainment i.e. singing' and 'Reminiscence for residents.' The deputy manager told us that an action plan from this survey would be completed shortly so that they could put in place any improvements that were needed.

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services There were a lack of meaningful activities for people with dementia to participate in to promote their wellbeing. Regulation 9 (1) (b) (i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People who used the service were not always asked for their consent or given adequate choice about their daily care. Regulation 17 (1) (b), (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Staff were not provided with adequate training or supervision to ensure that they had the skills and knowledge to provide people with safe and effective care. Regulation 23 (1) (a).