Sunrise Operations Knowle Limited

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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**

Summary of findings

Overall summary

We carried out this inspection on 7 and 24 March 2016. The inspection was unannounced.

The service is registered to provide care for up to 131 people and offers accommodation for people who require nursing or personal care. At the time of our inspection there were 114 people living at the service. The home is divided into two units, the Assisted Living area and the Reminiscence area, for people living with dementia.

A requirement of the service's registration is that they have 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A registered manager had not been in post since October 2015.

A new manager had been in post since January 2016, and was in the process of applying for registration. We have referred to them as the 'manager' in the report. A temporary general manager was also employed managing the Reminiscence area of the home, and we have referred to them as the 'general manager' in the report.

We completed an unannounced focused inspection on 16 November 2015. This inspection was in response to concerns we received about how people's care was managed. This included people who were at risk of falling and the management of people's medicines. The inspection team visited the service and looked at two of the five questions we ask about services: is the service safe and is the service well-led. At this visit we identified a breach of regulation in relation to how the provider monitored and assessed the quality and safety of the service provided. Also a breach of regulation in relation to safe care and treatment of people in relation to the management of medicines, and in relation to staffing levels, and how staff were supported.

We visited this service again on 7 March 2016 following further concerns raised in relation to the management of medicines and the safety of the care provided. At this visit we found that some improvements had been made in the management of the service, however we continued to have concerns in relation to how people's care was provided. At times, the quality and safety of care people received remained unsatisfactory and there were not always enough staff available to support people at the times required. We sent the provider a letter outlining the areas for urgent improvements. Following this, the provider sent us an action plan detailing how they would improve.

We returned to the service on 24 March 2016 to complete our inspection and also review the management of medicines. At this visit we reviewed the action plan that the provider had sent us in March 2016. We found that improvements had been made and actions had been taken in relation to most of the areas of concern. Where action had not yet been taken, the management team were able to show us plans to address the other areas of concern. Although some further improvements were still required, the provider was no longer

in breach of the regulations in safe care and treatment of people, in relation to the management of medicines, and in relation to staffing levels. However, they were still in breach of the regulation in relation to how the provider monitored and assessed the quality and safety of the service provided, as these systems were not yet established.

At our visit on 7 March we had found people's health and social care needs were not always reviewed regularly. Care records were not always completed by staff correctly. Staff told us this was because they did not always have time to do this. Risk assessments were completed, however plans did not consistently minimise the risks associated with people's care.

Although more staff were being recruited, there was not always enough staff available to support people at the times they preferred. Staff were not always able to respond to people's needs effectively and equipment was not always available when staff required this.

However, at our second visit on 24 March, the care records we checked had been completed correctly. Risk assessments had been reviewed by staff and updated to accurately reflect the risks to people and how they should be minimised. The management team had taken further steps to employ more staff and staff told us they were now starting to feel more positive about staffing levels, as the new staff started. New equipment had been ordered to support staff in supporting people with their care.

People's nutritional needs were met and special dietary needs were catered for. However, at times staff were unaware of people's dietary needs, which had the potential to place them at risk. Following this concern being raised by us, the management team arranged further training for staff to support them in this area.

Staff had training in order to meet people's care and support needs. However, staff told us they felt they did not always benefit from computer training and that they would like further training in some areas, which the management team were now arranging.

People took part in some organised activities and trips, and told us there was plenty for them to do. It had previously been identified that activities could be further improved for people living with dementia and steps were being taken to address this.

People were treated with dignity and respect by staff when supporting them. Relatives were encouraged to be involved in supporting their family members.

People told us they liked living at the service and that most staff were kind and caring. People were cared for as individuals with their preferences and choices supported most of the time. However, people told us they did not always receive support from staff who knew them well.

People and staff were positive about the new management team and felt there had started to be some improvements at the service. The management team were beginning to make positive changes to the service people received.

Staff told us they felt supported by the new management team to carry out their roles effectively. Staff told us morale was beginning to improve at the service.

People told us they felt safe living at the service. Staff knew how to safeguard people and what to do if they suspected abuse. Checks were completed prior to staff starting work at the service to make sure they were of good character and to ensure their suitability for employment.

People were protected from harm as medicines were stored securely and systems ensured people received their medicines as prescribed.

Staff referred to other health professionals when needed, so people were supported to maintain their health and wellbeing.

Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs). Staff ensured they gained consent from people before supporting them with care.

The manager was responsive to people's feedback in developing the service, and making continued improvements, such as recruiting more staff, supporting staff further, ensuring people received care that met their needs and that this was accurately documented. Systems and checks made sure the environment was safe. People knew how to complain if they wished to, and complaints were being recorded and responded to by the management team in a timely way.

The provider had displayed their last inspection ratings, as is the legal requirement to do this.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People told us they felt safe living at Sunrise Knowle, however staff were not always available at times people needed them. Risk assessments did not consistently reflect the risks to people's health and wellbeing, to enable staff to support people safely. However, on our second visit we saw these were being reviewed and updated. Staff were confident in how to safeguard people from abuse and actions to take if they had any concerns. Medicines were stored securely and systems ensured people received their medicines as prescribed. Recruitment checks reduced the risk of unsuitable staff being employed at the home.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training to support people's care needs, however some staff felt the training they received could be improved. Staff had not received regular support with one to one meetings; however this was now being addressed by the new management team. People enjoyed their meals and were offered a choice. Special dietary needs were catered for, however some staff were not always aware of these, which placed some people at risk. The management team had arranged further training for staff around this. Staff had an understanding of MCA and DoLS and provided support to enable people to make decisions. Referrals were made to other professionals when required, to support people's needs and maintain their health and wellbeing.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us overall staff were caring in their approach. However, staff told us they did not always have time to care for people in the ways they would prefer. People were involved in decisions about the care they received and staff encouraged relatives to be involved in their family member's care. Staff supported people with dignity and respect. However, at times people did not receive care from the gender of staff they

preferred.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always completed accurately or kept up to date by staff. However, at our second visit we saw that the care records we checked had been reviewed and updated. People told us they wanted to be supported by staff who knew them well, but this did not always happen. People took part in some organised activities and they felt there was enough to keep them occupied. Activities could be further improved for people living with dementia. People knew how to raise complaints, and these had been responded to by the new management team in a timely way.

Is the service well-led?

Requires Improvement

The service was not always well led.

The new management team told us they had identified areas which required improvement and actions to take; however it would take some time to implement these changes. Improvements were beginning to happen, however some concerns remained in the way people were supported with their health and care needs. People and staff told us the new managers were approachable. Staff told us they felt supported by the management team and morale was improving. Systems and checks were carried out which ensured the environment was safe.

Sunrise Operations Knowle Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 7 and 24 March 2016 and was unannounced. The inspection team consisted of four inspectors at the first visit, and two inspectors, one inspection manager and two pharmacy inspectors at the second visit.

We reviewed the information we held about the service. We looked at information received from relatives and visitors; we spoke to the local authority commissioning team who made us aware they had visited in January 2016. We reviewed the statutory notifications the manager had sent us. A statutory notification is information about an important event which the provider is required to send us by law. These may be any changes which relate to the service and can include safeguarding referrals, notifications of deaths and serious injuries.

We spoke with 14 people who lived at the service, 10 visitors and one health professional. We spoke with 35 staff including the manager, the general manager, a senior recruitment manager, a regional human resources advisor, nurses, care staff, the activities co-ordinator, housekeeping staff, kitchen staff and the Director of Operations. We looked at 14 care records, 22 medicine administration records and records of checks the management team made for their assurance that people received a quality service. We observed the way staff worked and how people at the service were supported.

Some people living at the home had a diagnosis of dementia and were unable to share their experiences of the care and support provided. We therefore spent time observing care in the lounge and communal areas. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to

help us understand the experiences of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At the time of our last inspection in November 2015, the provider was not meeting the requirements of the regulation in relation to sufficient staffing. The provider sent us an action plan outlining how they would improve.

At this inspection we found that some improvements had been made. A number of new staff had started working at the service, however as staff recruitment was on going, people had not benefited from this fully yet.

On day one of our inspection we found there was not always enough staff available to support people when they required assistance. However, on day two we found that the increase in new staff had started to have a positive impact on people and staff, who felt this was now improving. One person told us, "They have not got enough of them (staff)," and told us sometimes they had to wait to be assisted to use their commode. They went on to say, "It is better in the day, the night staff are not so good." One professional told us, "They are good care workers but there is not enough off them, they can't always observe people especially when they are busy, they can't see people walking around," They shared their concerns with us because they knew some people were at risk of falling.

Some people told us they had to wait when they pressed their call bells. They explained care staff did eventually come, but sometimes it was too late. They said they sometimes could not wait any longer, for example when they needed to use the toilet and this caused them embarrassment. One person told us, "I'm not supposed to get use the toilet on my own, but I do, because staff have not come." One staff member told us, "At mealtimes, it can impact on people who might have toileting accidents. We cannot leave someone mid-way through their meal (when we are helping a person to eat). You can't leave people, it's rude but then another person may have had an accident." Another staff member told us, "Today there is sufficient staff, when it is fully staffed, we are okay."

Other people were more positive about staffing levels. Two people told us they had never had to wait for staff and they felt safe. Another person told us there were enough staff to support them. One relative told us at the moment staffing levels were good, and said "Sometimes the agency staff are weak, but the majority of the permanent staff are excellent here."

Staff told us the skill mix of staff had been a concern before, however, the management team were now coordinating staff to get a better skill mix on every shift. One staff member told us, "It's much better now we have reduced numbers of agency staff and there are new staff on board." The general manager told us they had been using a high level of agency staff before, but this had since reduced. They went on to say, "We would like a consistency of care for people." The manager told us, "There are less agency now overall and if we do use people, it's the same people, the same agency and we have consistency."

The manager told us when they first started at the service it had been identified that they required about 1000 staff hours and they had been recruiting to this. They had recruited 800 hours in the last few weeks and

this was, "A priority." The manager told us, "We have over recruited, we are nearly full (with staff). We have concentrated on staffing, their induction and retention currently."

On day two we looked at staffing rotas for February and March 2016. We saw a member of temporary agency staff was being used only once per week, and most weeks no agency staff were required. One staff member told us, "There are loads of new starters and staffing levels have increased. It is really good and quite rare to see agency staff now." They went on to say, "Previously we raised staffing issues and nothing was done, now it has changed for the better." The general manager told us that approximately 10 new people had started working at the home that week. A senior recruitment manager told us about further initiatives they had used to recruit new staff and how this had been successful.

A dependency tool was used to assess people's needs and the levels of staff required to support these. The management team told us the deployment of staff had now been changed to provide extra staff on certain floors which were busier and also at key times of the day to support people further. During our visit we observed sufficient staff in communal areas supporting people during the day. Staffing levels were now improving and the provider had taken action to address the concerns raised by people and staff.

At the time of our last inspection in November 2015, the provider was not meeting the requirements of the regulation in relation to the management of people's medicines. We also received information about a serious incident in which a number of people had not received their medicines. The provider sent us an action plan outlining how they would improve.

At this inspection we found that improvements had been made and people's medicines were being managed safely. One person told us, "I would say with my tablets they get it 80 to 90% right." We spoke with one member of staff who told us the support for medicines management was, "Loads better," and that management were now, "Brilliant and more approachable."

We reviewed the management of medicines including the medicine administration record (MAR) charts for 22 people. Records showed which medicines had been administered and that people had received their medicines on time. All the people we looked at had photographs and their allergies recorded on their medicines records; which reduced the risk of medicines being given to the wrong person or to someone with an allergy. This was in line with current guidance.

Some people who took medicine only when required had clear protocols in place to provide staff with enough information to know when the medicine was to be given. This meant people would be given their medicine consistently and at the times they needed them. The provider told us that they were in the process of implementing this for all people.

Medicines were being stored securely for the protection of people. Controlled drugs were stored and recorded correctly, and regular checks had been carried out. Controlled drugs are medicines which require additional monitoring and storage.

Medicines that required storage in a fridge were not always stored within the recommended temperature ranges for safe medicine storage, meaning that it may no longer be safe to use. On one occasion the temperature was recorded out of range for four weeks before any action was taken. This issue was raised with the manager who told us they would they would follow this up and why there had been a delay.

We saw that some people required pain relief in the form of a patch. We found clear recording templates were available to show where and when a patch was applied, but these were not always filled in. As a result,

we saw that some people had patches applied that were not in accordance with the manufacturer's instructions. This meant that people may not get the pain relief they need or suffer unnecessary side effects. We discussed this with the manager who told us they would address this.

We saw that medicines with a short expiry were dated when they were opened and disposed of when their expiry date was reached which meant they remained effective. Creams that had to be applied topically were recorded on a separate cream application chart that was kept in people's rooms. Charts showed where and how often the cream should be applied and a record was kept by the person applying the cream.

People who looked after their own medicines were provided with a lockable drawer or cupboard to store their medicines in. One person told us that their medicines were always ordered on time and that staff kept track on what the person had taken.

The number of medicines errors had significantly reduced and they were being analysed to identify common errors or patterns. This showed that that the provider was actively trying to identify where training and support for staff was needed.

There was not always enough equipment available for staff to support people at the times they required. One staff member told us, "A lot of people need a double hoist." Another staff member told us "Not having enough hoists is a problem." They told us that there were two hoists only in one area, this was not enough and had been raised with the managers. We discussed this with the manager who told us they would address this and arrange for additional equipment to be ordered. On day two we found an additional hoist had been ordered by the manager and another hoist had now been repaired so staff had increased access to specialist equipment to move people safely.

Care staff had 'pagers' that alerted them when people pressed their call bells for assistance. Staff told us, "We don't all have pagers, they often go missing." On day one of our inspection we found a pager had been left on a table in a hallway, and we gave this to the general manager. We discussed this with the manager who told us they would look into this. On day two we found that new pagers had been issued to staff, a further 19 had been ordered and nurses had been given a pager which alerted them if anyone had waited for over 10 minutes. The management team were now carrying out audits to assess times it took staff to answer calls. Staff told us this was improving.

People told us they felt safe living at the home. In relation to safety one person told us, "I think it is pretty good here." Other comments included, "Yes, I feel safe and the staff treat me well," and "I feel safe, it's a safe and secure building."

Prior to staff starting at the home, the provider checked their suitability to work with people who lived there. Staff had background checks completed and references were sought before they were able to begin work. We checked two staff files and saw these checks had been obtained. This meant as far as possible the provider checked that staff employed were of good character and suitable to work with people living at the home.

Staff understood how to safeguard people and were able to tell us about different types of abuse and what they would do if they had any concerns. Comments from staff included, "Abuse is treating residents badly; I would tell my senior straight away if I was concerned," "We have safeguarding training, we know what abuse is," and "I think people are safe, we know to report to management if we have any concerns." Staff told us they had training in relation to safeguarding, but some would like more. They said they knew who to report a concern to, but that sometimes they were not sure if something was actually 'safeguarding' or not. A

helpline was displayed for staff to call if they had concerns about abuse.

Assessments of risks associated with people's care and support needs had been documented. These included some information about possible harm and guidance for staff on what action to take to minimise identified risks. Co-ordinators were responsible for updating risk assessments as people's needs changed. We found some risk assessments had not always been updated to reflect people's current needs.

For example, one person was at risk of choking. This was reviewed in February 2015 and the person was recorded as being at 'high' risk.' Their care records said, 'Take note of my swallowing as I can encounter difficulties at times.' There was no guidance in their care records for staff to follow if the person was to choke or how to reduce the risk. The nurse told us that care staff knew to ask them for assistance if the person choked. The nurse added this information to the risk assessment at the time of our discussion, so staff would be able to provide consistent care. We asked the care staff what action they would take if the person began to choke. A senior care worker was able to tell us what they would do if the person began to choke, to keep them safe. However, as the person chose to eat breakfast and evening meals in their room, staff were not always present when they ate, which increased the risk. We discussed this with the manager who told us staff had now been made of these risks, the care records had been updated and this information would be discussed in the handover meeting. At our second visit, we found training was being arranged with a speech and language therapist for staff around risks related to choking.

On 7 March, another two care records we looked at did not give a clear understanding of people's risks, and care reviews had not been undertaken since April and May 2015. There had been some changes to people's care needs, but these had not been followed up. For example, one person had some falls and had been referred to the falls clinic. The letter from the falls clinic said, all falls risk assessments and care plans should be reviewed, and this had not been done. Another person was at risk in relation to skin damage and on their care records it did not document how staff were to care for them to reduce this risk. However, other risk assessments were in place, for example, one person had an unpredictable medical condition which meant staff had to be aware of actions to take in an emergency. We saw these documented on the person's care records and staff were aware of actions to take.

Staff told us they did not always have time to keep records updated. One staff member told us, "The documentation is suffering, you can't write chapter and verse, there is no time." Another staff member commented, "On this floor it is quite hands on care, it is difficult to try to keep up with the paperwork and give the care. I think it is getting easier. It is much better." We discussed this with the management team who told us that they were now doing some work on care records and staff were reviewing them and archiving information to make them easier for staff to understand. A full review of care records was being undertaken by a nurse who was supervising care staff and providing input around positive areas and areas for development. Staff confirmed with us they were working to improve the care records as they had been 'disorganised' and out of date in some cases.

At our second visit the management team told us a health and safety person had been reviewing risk assessments further to ensure they were accurate. We saw evidence of training being arranged for staff around assessing risks. The care records we checked had been updated to reflect the current risks to people and staff we spoke with had a good knowledge of these. This meant risks to people were being managed and reviewed more effectively so staff could support people safely.

Accidents and incidents were recorded. This information was analysed to identify any trends or patterns which may be used to prevent further reoccurrence. The manager told us, "We submit any trends every month and any actions from this we document." At our second visit we looked at the falls one person had

from January to March 2016. However, the date of falls recorded on the provider's 'falls log', their monthly falls analysis and the person's care records did not match. It was unclear how often the person had fallen. Inaccurate recording meant the person may not be supported correctly to reduce the falls. We looked at a second care record for a person who had fallen, and for them, recordings did match. We raised this with the management team who told us they would look at their records to ensure they were consistent.

Personal emergency evacuation plans were available for people living at the service. These detailed care needs so people could be assisted effectively and safely in an emergency. One staff member told us, "(In an emergency) everyone goes downstairs on the ground floor, we wear different coloured jackets, and we know what to do. The teams check each room in twos." Fire alarm tests and fire drills were recently completed to practise dealing with an emergency situation.

Some emergency records did not identify some people's needs and staff were unsure how to support some people. We raised this with the manager who said this would now be discussed with staff. At our second visit we saw that a 'Resident evacuation plan' had now been produced for staff with guidance in moving people from communal areas. Emergency evacuation plans we checked had been reviewed and were now up to date.

The management maintained health and safety procedures at the home and had systems to protect people from harm. Checks were completed to ensure the buildings and equipment were safe to use. Certificates for water temperatures, legionella testing, gas and other services had been completed and were up to date. The environment appeared safe and well maintained.

Requires Improvement

Is the service effective?

Our findings

Most people told us staff had the skills and knowledge to care for them effectively. One visitor told us, "On the whole, the care is pretty good." However, one person told us, "Everything is okay, the day staff are better than night staff." Another person told us, "Night and agency are not as good, not trained very well, they don't know us."

Staff were supported during an induction period at the home. This included shadowing (working alongside) a senior staff member. The manager told us, "We make sure training is done for all new starters, they complete e-learning (on the computer)." A handbook of the provider's policies and procedures was provided to staff. One nurse who had been there for a short time told us they had considered leaving at first, as there was little induction and few permanent nurses to support them. However, they felt it was improving with the introduction of new management and more staff recruitment.

On day two of our inspection an induction 'champion' had been appointed to support staff further. The director of operations told us, "Before we had got no structure in place to support new people, people left." We saw an induction plan for temporary staff had now been developed. One staff member told us, "I think it is fantastic. New starters get very good support, they get two week's 'shadowing,' which I didn't get." One new staff member told us about when they first started work, "I observed how shifts work, see what goes on. I then shadowed lead carers. I have had the training I need, but I can have more training if I need. I felt relaxed."

Staff received training relevant to the health and social care needs of the people who lived at the home, however had mixed views about this. One staff member told us, "The training is not good at all," and told us they did not feel this equipped them to carry out their role effectively. However, another staff member told us, "It's okay, it's no problem for me." Some staff told us the online learning was not effective for them and told us there should be more 'practical' classroom based training for new staff. One staff member told us, "I struggle with computers, so I don't really enjoy having to do training. The training needs to be more classroom based and face to face rather than e-learning." We saw 50% of the training completed was on the computer. At our second visit we discussed this with the director of operations. They told us online training was being improved to make this better for staff.

Training was arranged for areas such as moving people, falls prevention and fire training. We observed staff moving people safely using a hoist. A training schedule was completed detailing when this was next due. The Care Certificate was completed for some staff. The Care Certificate sets the standard for the skills, knowledge, values and behaviours expected from staff within a care environment.

Some staff told us some training was effective, such as the dementia training. One staff member told us, "The trainer helped us understand why people with dementia get frustrated doing some things." Another staff member told us when they first started working at the home they had felt concerned around the staff understanding of dementia care, but things were now improving. Further dementia care training had been arranged. Another staff member told us some people had 'challenging behaviours' and the training helped

them understand how people might feel, not to rush people, and to explain what was happening.

Some staff told us they had just completed the first aid training. One staff member told us about an incident when a person was unwell and an agency nurse was on duty, "They didn't know what they were doing." We asked staff what they would do, for example, if someone was choking. One staff member told us, "All the seniors and nurses have had first aid training. We know what to look for," and were able to explain this to us. However, another staff member told us they did not feel confident with first aid and would like further training.

On day two of our inspection we saw that further first aid training had been arranged for 30 staff in March 2016. The manager told us that prior to booking temporary nursing staff now, they checked to make sure they had completed first aid training. In the assisted living area, two staff were on duty that had completed first aid training. Further training was arranged in March 2016 with a dietician to ensure staff were aware how to support people with special dietary needs, diabetes and people at risk of choking. The manager told us they were arranging for a staff member to become a 'champion' in the areas of nutrition and hydration so they were able to support staff further. Staff confirmed that this support was being arranged.

Staff had not received regular management support with one to one meetings or appraisals. One staff member told us, "I haven't had an appraisal or supervision for a long time." Another staff member told us they had not had a one to one meeting or appraisal in two years. Staff told us they thought this was because the managers had more important priorities, but would ask for supervision support if they needed it. The general manager told us this had been identified as an issue and was now being addressed. Group 'supervision' meetings were being held. Lead care staff were going to be responsible for one to one meetings in the future, and training was being arranged so they were able to do this effectively. The general manager told us, "This area needs some work. It should be done every six to eight weeks but it is very poor at the moment."

On day two of our inspection we saw training had been arranged in April 2016 for senior staff and nurses to be able to supervise other staff. One staff member told us, "Things have definitely improved. Although I have not had supervision I am confident I can speak to the managers, voice my opinions and I know that things are being done now."

A 'handover' meeting was held as each shift commenced, where information was passed onto staff about any changes to people's health or well-being. Lead care staff were involved in these meetings and passed relevant information to other staff. Staff told us communication had been a problem in the past due to lack of permanent staff, however this was improving. However, on day two of our inspection, one staff member told us about a person who had redness and sore skin around their groin area and staff had to apply a prescribed cream. We checked the handover information and no information about this was recorded. We spoke with the nurse about this, and they told us this should be documented on the handover information. Poor recording posed a risk that information about the people's care would not be communicated by staff and people would not be supported correctly.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA and whether any conditions

on authorisations to deprive a person of their liberty were being met. The rights of people who were unable to make important decisions about their health or wellbeing were protected. Mental capacity assessments were in care plans and were decision specific. One person's care record stated, 'I can make my own decisions, I have a good memory.' Another person had a diagnosis of dementia and it was documented on their care record they were able to make daily choices. We saw advanced decisions for people to refuse treatment and refuse hospital admission, and these were completed correctly. Consent was sought from people when providing them with care and documented, such as when photographs were taken.

Staff had an understanding of the principles of the Act and how this affected their practice. We saw documented on one person's care record that sometimes they refused to have a medicated cream applied and that they had the capacity to make this decision.

One staff member told us they had training about mental capacity and completed an assessment to test their knowledge. They told us, "If people have dementia and don't have capacity, we have to decide for them whether they are comfortable." We asked another staff member what they would do, for example, if a person had continence needs, refused to have a shower and they did not have capacity to make this decision. They told us that they would try to encourage the person, if they continued to refuse, to suggest doing something else for a while to distract them, or see if other staff could get them to agree. However, ultimately they would have to try to assist them in their 'best interests' because of the potential for health problems.

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). At the time of our visit 29 people had a DoLS authorisation and other applications had been submitted. The manager was aware of the circumstances when a DoLS authorisation may be required and other people were waiting for DoLS assessments. They told us, "Everyone in the reminiscence area has a DoLS application."

People had a choice around their meals and were positive about the food provided. One person told us, "The food is good." Another person told us, "Yes, I think the food is nice, but can be a bit repetitive." Other comments included, "There is plenty of choice," and "I can get a drink or something to eat whenever I fancy it." One relative told us, "The food is excellent." Menus were located in dining rooms and in the passenger lifts. A 'bistro' area meant people could access snacks or drinks 24 hours a day. Staff told us they could meet any cultural needs and anyone on a specific diet, the dietician would liaise with the head chef to offer advice. We saw people were supported to eat and drink when they required this.

People and staff told us poor staffing could impact on the meal time experience. One person told us, "Breakfast time is often hectic in the dining room, sometimes just one person is serving food, we often have to wait for a cup of tea." One staff member told us they did try to make sure they had time to support people with food and fluids, but if there were not enough staff, this could be challenging. Another staff member said when they were fully staffed, people got the food and fluids they need, but when short staffed this was not always the case.

Some people had additional dietary needs in relation to their health. We spoke to the deputy chef and saw a notice board contained photographs of all residents and identified those at risk who required special diets. One person had diabetes and told us, "I keep having to tell staff I am diabetic, they don't know." We asked six staff, and four staff knew this. The nurse amended their care record to reflect this at the time of discussion. We asked the kitchen staff and they told us they were aware the person had diabetes and prepared their meals accordingly. The management team told us they would not expect all staff to know

everyone's dietary needs and staff were responsible for the allocated people they knew.

For another person, we saw a tool to assess their risks around malnutrition had been completed, but this was not dated so we were unclear whether this was up to date. They had been assessed as being at 'high risk' of malnutrition and their care record stated 'Offer high calorie foods and snacks between meals.' We looked at their recorded weight and saw it was stable. We asked care staff and they told us that the person had a good appetite, they did not feel the person was at risk and that the record was not accurate. Inaccurate recording meant that the person was being supported incorrectly and could pose a risk to their health.

People were supported to access health professionals when required. A GP visited the service twice a week. We saw documented on care records, referrals to speech and language therapy and dieticians. Comments included, "I've seen the GP this morning," and, "The doctor pops in to check that I am okay every week," and, "If I feel unwell I see the nurse or a doctor is called." People told us they saw a doctor when they needed to. Records showed that health professionals were involved in people's care and staff made these referrals when required.

Requires Improvement

Is the service caring?

Our findings

People were positive about the staff at Sunrise Knowle and felt they were caring. People told us, "The carers are lovely," "They are dedicated staff," and "They do everything they can, they are very helpful." One relative told us, "The permanent carers work very hard and are great, overall we are happy." However, some people commented that they did not feel the night staff were always as caring. People told us they felt there were less staff at night, they did not appear as well trained or patient, and did not know people. We raised this with the management team who told us they were aware that some further work was required with staff at night and this was being addressed currently.

Staff treated people with dignity and respect. People told us, "They [care staff] always knock the door before they enter," and "It is my private space, they [staff] know that." We observed, when moving one person, staff made sure people's clothing was checked to ensure their dignity was maintained, and a blanket was put on a chair to make this comfortable when the person moved into it. Another person was given a soft toy to hold onto when hoisted, to ease any distress and we saw this reassured them. However, we saw one example when a person's dignity was not maintained. For example, we saw one person having their toenails cut in a communal area. We asked a staff member about this and they told us this was the usual practice. We raised this with the management team who told us they would discuss this with staff.

We found inconsistencies in how people's care was provided to them in a personalised way that met their wishes. For example, people could furnish their rooms with personal possessions and we saw rooms were organised how people wanted them. However, some people told us they preferred female care staff and they said they did not always get this. We asked some staff how they made sure people received care from staff of the gender they preferred. They told us the previous weekend, three male agency staff worked in one area, and the majority of the people in that area were female and preferred assistance from female staff. A staff member told us, "It was as though anyone from the agency was bought in, it was a desperate situation." The manager told us this would not usually be the case, and in this instance there had been a problem with the rota where they had to change staff at the last minute.

On the action plan we received after day one of our inspection, following the concerns we raised, it stated people's preferences in relation to gender of care staff would be documented on the 'handover' meeting sheets. When we returned on day two of our inspection we checked handover sheets and found people's personal choice was still not documented. One staff member told us about one person, "[Person] prefers female carers. We know what they need." We saw that this information was on care plans where people had expressed their preference. We asked a male member of staff, out of the six people they cared for that day, who preferred male or female carers. They did not know and told us, "I have assisted with their personal care. No one has told me what they prefer." In the care records we saw two of the people preferred female care staff. We asked the staff member about this, they told us, "There has not been time to read care plans. I have not done it. You don't have time. There were 32 residents, yesterday and there were only five staff." We raised this information with the management team who assured us this would be addressed.

Staff gave us mixed views about their experiences of working at the home. Some staff we spoke with told us

they enjoyed working at the home. They told us, "They (people) are like my family here," "I treat people how I'd like to be treated or how I would treat my own mom or dad," and "I make sure that I am patient and give people plenty of time when I am helping them," and "I enjoy working here, everyone is friendly and people are looked after well."

However, some staff told us due to staffing levels they could not always give people the care they would like to. One staff member told us, "I think things are getting missed and we don't always follow family wishes about their relatives care (because we are so busy.)" Another staff member told us, "I do love the job and the residents, (but we are so busy), the manager's know we will do the care for people anyway." Staff told us they knew how to provide good quality care, "Listening to people and being patient," and "Having time to sit and talk with people and being respectful and approachable."

We observed staff supporting people with kindness, warmth and affection. For example, we saw staff take their time with people, and there were some caring gestures such as a staff member rubbing one person's arm, and making sure that food was wiped away from a person's mouth while they were eating. We heard staff explaining to people when they were going to do something such as walking them to the dining room or taking them to the toilet. One person looked uncomfortable sat in a chair at the dining table, and we saw a staff member ask them if they wanted to move and helped them to do this.

Staff encouraged people to make daily decisions for example, where they would like to eat their meals and if they wanted to join in with activities. Many people wanted to join a scrabble activity and staff took some people to the activity room. In the Reminiscence area, we observed less verbal communication between staff and people. We spoke with some staff about this and they told us they were being further trained and supported in how they could engage more with people living with dementia.

Relatives were encouraged to be involved in their family member's care and there were no restrictions on visiting times. If people were very unwell, family members were able to stay over at the home to be close by. People told us that their family and friends were always made to feel welcome when they visited. For example, they went to the bistro for a coffee or have coffee bought to them in their rooms if they preferred. We saw some visitors at the home during the day and there were different areas they could go to spend time alone with their relatives. One person told us their son had been invited for lunch the previous day, as it was mother's day. Both of them had enjoyed the lunch and the time they spent together. The person told us they had been given flowers by the staff and that this, "Was a kind gesture." Staff recognised it was important for people to keep important relationships, so supported some people to use 'Skype' (an internet based tool to communicate visually) on the computer to keep contact with relatives who lived a distance away.

The manager told us no one at the home currently used the services of an advocate, however this was available to support people if required. An advocate is a person who supports people to express their wishes and weigh up the options available to them, to enable them to make a decision.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with had mixed views about how their care and support needs were met by staff. One person told us, "I am quite happy here." Another person told us, "Staff work very hard and they need to be appreciated." However, some people told us staff did not always know them well enough to support their care needs. One person told us, "You keep getting different faces." People told us they wanted staff who knew them and who they were familiar with. Comments included, "More staff that know me would make things so much better." People told us this made them frustrated and they felt more confident being supported by familiar permanent members of staff. Another person told us, "Once you get used to one member of staff it is better."

Prior to admission to the home, people were assessed to ensure the home could meet their care needs. This involved a director of community relations meeting the person and their relatives. Senior staff then assessed the person's level of care needs which the management team then reviewed, to see how they could support them at the home.

Care plans sampled contained minimal information about people. Records included specific health conditions; for example for one person who had seizures. People's care needs were reassessed monthly or if people's needs changed by the co-ordinator in each area. We saw people's care reviews were kept up to date. Care plans contained historical information about people's care needs, so it was not always clear when reading the care plans if this information was current. This posed a risk that people would not be supported correctly with their current needs, and the out of date information could be used by staff.

Some care records seen contained relevant information about people and were 'person centred'. One person's record said, 'I can wash my own face and comb my own hair' and the person told us this was correct and it was important for them to, "Be looking their best." The care plan stated they liked a glass of wine or a gin with meals. They told us, "I have a care plan; it tells the nurses all about me." The person and their family had been involved in completing information about what they liked and disliked and this was reflected in their record.

Staff did not always follow guidance around completion of daily care charts. On day one of our inspection a person's care chart stated their skin was to be checked daily, however we saw the charts for this person had not been completed at all for the previous day. Another person also had risks in relation to their skin, and required 'repositioning' every two hours in the day and four hours at night. We checked their care records and on 6 March 2016, staff had recorded they repositioned them at 4am and then again at 3pm. We asked staff about this and one staff member told us, "It is not recorded, but probably would have been done." Poor recording by staff posed a risk that the person's health was not being monitored correctly and this could deteriorate further. Another staff member told us, "We are so stretched we cannot do the daily records, you only have one pair of hands." Some other daily charts we saw were completed correctly. We asked the manager about the charts and they told us, "This has been identified, but I don't feel we have moved as far forward (as I would like)." They had already arranged for staff to review all care records and charts and were aware these were not always being completed currently.

On day two of our inspection the general manager told us, "You are not necessarily going to go around and find great notes." One nurse we spoke with told us, "We need to get care staff to do notes better and on time." However, the Director of Operations told us, "They should be a lot better," and a lot of work had been done in this area. They explained they had prioritised people with higher level care needs such as risk of falls or skin problems. We looked at three charts and records for people with high level care needs and found they were up to date and had been completed by staff. The management team recognised further improvements were required to make sure everyone's care plan and associated records supported their individual needs.

The manager told us had started to audit records of daily care charts and a charts 'champion' was being arranged who was a staff member responsible for ensuring staff completed charts. One staff member told us, "The managers give us lots of guidance. They tell us to take our time and do it (work) properly. They tell staff if you have assisted someone, fill in the records as you go along." They went on to say, "I think things are improving. The new managers are fantastic, we get so much support from them." They went on to say the importance of keeping good care records had been discussed in staff meetings.

For people living with dementia, staff were not always aware how to support them effectively. A regional dementia lead had been in post four weeks to work with staff. They had carried out some observations, and had identified further improvements were needed in this area. In the reminiscence area, there were tables displaying objects of interest, for example a table with travel books and related objects for people to look at and touch. Memory boxes had been completed by families for people who wanted this, and were displayed outside people's bedrooms. These contained photos, personal mementos and important information about people's lives and histories. One staff member told us "It's important we speak to families to get as much background as possible," as they enabled staff to understand more about the person they cared for. One person had previously been a dog trainer and their box contained items including a dog whistle. Their relative told us, "This is a brilliant idea." They felt this helped the person settle in and prompted staff to make conversation in relation the person's individual interests.

In the Assisted Living area, people told us there was enough for them to do to keep them occupied. Comments from people included, "We get a weekly activities timetable; there are plenty of things to do," and "There are lots of activities you can join in and there is always something going on." One person told us, "I sometimes go out on day trips." Other people had chosen to visit a garden centre and a local pub. One staff member told us, "I love my role, I don't like to call things 'activities,' it's about daily living, what would people do at home they like."

One person enjoyed gardening and had a flower bed in the garden which they tended in the summer months with support from staff. They had requested this when they moved in and had picked which bed. They also had a bird feeder outside their bedroom window, staff filled it up with bird seed and they enjoyed seeing the birds every day. We saw another person choose a DVD and watched it on the television. They told us, "Staff know what I like, after lunch I like to watch a film. I really enjoy films."

We saw activities planned such as an ancestry workshop and a poetry group. On the day of our visit a Shetland pony visited the service and we saw people enjoyed this visit. One person told us they really liked animals and on seeing the pony told us, "It was magical." A hair salon was open three days a week with different hairdressers, so people had a choice of who they used. There were regular church services and bible studies, and staff told us they could support people of other faiths also.

In the Reminiscence area we did not see such a high level of activities and people sat with the television on. One staff member told us "We put the music on and sit and talk with people, do hand massages, but there

are not many other activities." The general manager told us they had identified this area needed to improve, so that activities were more suited to people's needs. We saw people playing skittles and there were two entertainers on different floors singing. We saw staff sitting and talking with people.

The activities co-ordinator also had the occasional responsibility of being the 'on call' duty manager. They were responsible for the activities with nine other staff and several volunteers. They told us they were trying to establish more activities in the Reminiscence area and had been devising a "getting to know you" record, so they could tailor activities to people's preferences. They told us staff tried to do one to one sessions, have "tea and chat" sessions, hand massages and there was an area set up like a bar, where people could play dominoes and sit with family. Staff also took people to the Bistro area of the home, so they could socialise further. They were going to liaise with the provider's dementia specialist to get some advice for other appropriate activities.

People were aware of how to make a complaint if they wished to and we saw responses had been provided. One person told us, "I haven't needed to complain, but I would do if I was unhappy." Another person told us, "I feel confident to speak out if I have a problem." One person told us they were given a booklet with the complaints procedure in. Complaints information was provided to each person living at the home and we saw these on care records. The general manager told us, "When I came here I had 10 complaints to address and these were mostly historical." These had been around areas such as the management of the home, quality of the care, staffing, financial issues and poor communication. We saw responses had been given to all these complaints.

Requires Improvement

Is the service well-led?

Our findings

At the time of our last inspection in November 2015 the provider was not meeting the requirements of the regulation in relation to good governance. Effective systems to assess, monitor and mitigate risks related to people's health, safety and welfare were not in place.

The provider sent us an action plan outlining how they would improve. At this inspection we found that some improvements had been made, however the systems were not yet established.

On day one of the inspection we found that although there had been some initial improvements made by the new management team, there continued to be concerns in several areas that we had previously identified. Additionally, we were not able to see evidence that people's care plans and risk assessments had been reviewed, and staff had been receiving regular one to one support, as detailed in the provider's action plan.

We found that care records and charts were not being accurately completed by care staff which posed a risk to people of not receiving the correct care or treatment they required. Risk assessments had not always been updated, so we could not be sure staff knew the risks to people and had taken steps to minimise these. Some new staff had been recruited, however staffing levels continued to impact on people and staff. Care was not always provided at times people required, and this impacted on people's dignity. Some people received care from staff who did not always know them well. People were not always given a choice about the staff who supported them. Equipment was not always available when staff required this. Staff received some online training, however staff told us they felt this did not always give them the correct skills and knowledge to support people safely and effectively.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Immediately following day one of our inspection, we wrote to the provider and outlined the areas for urgent improvement. Following this, the provider sent us an action plan detailing how they would improve.

On day two of our inspection we saw some action had been taken, such as care records were now updated for people with higher level care needs. Staff continued to be positive about the changes the new management team had implemented and felt more supported in their roles. New staff had started work at the service and told us they were confident in supporting people. New equipment had been ordered. Although further improvements were still required, we were able to see the urgent concerns we had raised, had and were being addressed by the management team.

The management team consisted of two managers, two deputy managers, two co-ordinators and a management support team for services such as maintenance, housekeeping and activities. There had been some significant change in the management team over recent months, when the registered manager and two deputy managers had left the service. The new manager was a permanent member of staff who

intended to apply for registration with us. The general manager was a temporary manager who intended to work at the service for around nine months. One deputy manager was new in post. There were two areas of the home, Reminiscence (where people had a diagnosis of dementia) and Assisted Living and both were managed by a co-ordinator. One co-ordinator had recently been appointed and was due to start in the Reminiscence area. The role of the co-ordinators was the day to day supervision of staff, updating care records, completion of staff rotas, supervision meetings and ensuring the standards were being met.

Due to inconsistent management, the home had not been well led in recent months. The general manager told us, "We have tried to be honest with people and explained that we know they have heard this before, but they have to trust us," and that improvements were now being made. They went on to say, "This will not come to fruition for another month or two. We would like to be open and honest. This is my seventh week at the home now." They told us they had been focusing on the Reminiscence area because this was the area of the home where most concerns about care had been raised. The manager told us they walked around the entire home three or four times a day so they could identify any issues as they arose. The general manager told us, "Our biggest priority is recruitment, we are trying to recruit a core group of positive staff." The director of operations told us, "The management structure before was not working and we aware the service is vulnerable at the moment," however they were taking steps to address this now.

We spoke with people and staff about the management of the home. Comments included, "The manager is approachable, smiley. We need someone like them, strong and determined," "I have met the new manager, they mean business," and "The manager is open, they are trying to sort out the problems, I put my trust in them." People told us they knew who the new managers were. One person told us, "I've met them both, I introduced myself." One relative said they had known the general manager before, and this person had 'sorted things out' then, and they had confidence that they would do so again. One health professional told us, "I have met [Managers] and they seem very approachable, you could speak to them if you wanted." Although people and staff felt that the home was starting to improve, it was felt this would take some time due to the number of improvements that were needed.

Staff told us they felt the management team were approachable and they were starting to see some positive changes. They told us, "Team work is improving, this is good for everyone." Other staff told us they had faith in the managers who were trying to recruit more staff to make things easier for staff and people. Other staff comments included, "I hope they can learn from the past, I wouldn't recommend this home for my family member if I'm honest at the moment," and "It's nice to have our own general manager now (in Reminiscence) we were treated differently before, but it's better now."

Some staff and people expressed concerns that the new managers would not stay. Comments included, "It will be better as long as these people stay," and "This is my biggest concern (if they stay), the managers seem very good, there is a big presence of the floor and the vibes are good." One relative told us, "Leadership changes hands frequently. It seems to be a new manager every two years. I have felt able to take concerns to the manager, then they leave. We've not had much continuity with management over the years." The manager told us, "We are aware there has not been a consistent management team for people, this has not been sustained."

One nurse told us they felt systems needed to be more organised with nurses having more control. They wanted care reorganised so it was clear who required nursing care and who required residential care, as it currently felt 'disorganised and chaotic' at times. They told us, "The new managers are aware of our concerns and we need to all communicate and follow things through, and if we make changes, these need to be audited." One health professional told us, "There is a lot of pressure on the nurses, I have seen good staff leave, they need to value the staff more, they work hard."

Staff told us monthly meetings were now held with the management team in each area of the home and a combined general staff meeting known as a 'Town Hall Meeting' was also held monthly. One staff member told us, "Our opinion is now being valued." Other staff told us, "At the last team meeting we felt able to speak out about our rotas," and "I feel motivated now as managers are listening to us." The general manager told, "Historically issues had not been raised by staff as they did not feel anything would be done." We saw there had been a staff meeting in January and February 2016. Staff had been thanked by the management team and issues such as communication, staffing and better organisation had been discussed. In another meeting in February 2016, it has been discussed that staff were to ensure that care records were kept up to date.

A team member 'forum' meeting was also being held to give staff a further opportunity to raise any issues or concerns. One staff member told us, "You can join the staff forum if you have any concerns; there is a representative off each floor."

On the day of our second visit we were made aware that senior managers had met with staff to invite them to discuss any concerns with them directly at staff listening groups. A staff helpline had been set up so staff could raise any concerns they had directly to the provider.

Staff morale had been low at the home and staff told us this was improving. One staff member told us, "Morale is getting better, but we feel the pressure is on for us to do a good job," and "The change of so many managers affected staff morale and now we need to work as a team." The general manager told us they were trying to address this currently and this would take some time. However they told us, "There is a core group of staff who are really positive," and they were working with them to implement the changes, but acknowledged this remained an area for improvement. They went on to say, "Hopefully morale has changed. I feel morale is better, sickness is better and staff better. Staff seem more positive, they are able to come in and talk with us." Staff were now more involved in areas such as completing the staff rota, which had not happened previously. Managers had been giving staff incentives and rewards to thank them for covering extra hours and their flexibility. One staff member told us, "If it had not been for [the manager and general manager], I would have left."

People told us that meetings were held and gave them opportunities to feedback about the home. They told us, "We have meetings, I can have my say," and "If something goes wrong, it gets fixed." Person told us they had attended a meeting and staffing had been discussed, "I have been told to expect real improvements in staffing by May this year." People and relatives were not being asked for their views about the service currently with any feedback surveys, however the manager told us this was something they intended to do in the coming months.

A meeting involving people's relatives had been held in the Reminiscence area in February 2016 and 25 people attended. We saw feedback which said, "Staff are hardworking and committed, they are overworked and there are poor levels of staffing." Plans were in place to elect three or four of these people to a 'steering group' to be involved in plans and changes. On day two of our inspection, we saw this steering group meeting had now taken place in March 2016. The general manager told us that people had felt before there had been an 'us and them' attitude between both areas of the home. Examples were given that getting hot drinks was more difficult for visitors in the Reminiscence area. They told us, "We have been dealing with a lot of historical complaints. Communication was poor before. I think the general feeling is it is improving." The manager told us that monthly meetings were also now being planned in the evenings to be more accessible for some people and visitors. We saw a meeting had also been held in March where people were able to discuss further issues such as staffing and management.

Some people told us about other issues at the home that they felt needed addressing, such as their bins not being emptied often and towels not changed. Also some linen was old and frayed. One person told us, "My bin has not been emptied for three days, my towels were not changed for several days." However, they told us this had improved over the last few months. We raised this with the management team who told us they were aware there had been some concerns raised and they were addressing these. They had been short staffed in the housekeeping team due to unplanned absences. One housekeeping staff member told us they had tried to order new towels and linen previously and had been told, "We will see what we can do," but nothing had been done. However, the new management team had ordered the required linen now.

Weekly governance meetings were being held with senior staff looking at different areas of people's care, such as dietary needs. Monthly manager's audits and six monthly audits were planned. The manager told us, "After each audit we check what had been done, what we are going to do and create an action plan." They told us they were also working with other agencies, such as the community falls team to support people better. The manager told us, "We know this is early days." A head's of department meeting took place each morning to communicate any issues within the home.

The management team had produced an action plan to address the issues raised on day one of our inspection, which included timescales to address this by. For example, staff supervision and appraisal concerns were to be addressed by the deputy manager by the end of July 2016. The manager told us they would send us a fortnightly report updating us of the actions taken and improvements they had made. We received the first report following our visit on 24 March 2016.

The general manager told us about other challenges they faced. Currently people with different levels of needs were mixed on floors and there had been some discussion with people and their relatives about possibly changing this. Plans were in place to identify staff champions in areas such as infection control, medicines and moving and handling. Work was being done around identifying further skills staff had to utilise these, and further training required. For example in relation to 'end of life' care and long term conditions. They were also arranging for some further on call nursing support to be provided.

The manager was able to tell us which statutory notifications they were required to send to us in line with their legal obligations. This meant we could effectively monitor any changes or issues with the home. For example, serious injuries or allegations of abuse. They understood the importance of us receiving these promptly and of being able to monitor the information about the home. However, we found we had not received the required notifications from them in relation to a serious medicine error involving a number of people, and they told us this would now be done. We received this prior to day two of our inspection. Following this medicine error in February 2016, there had been a visit from the local authority to follow up concerns in relation to 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 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) Systems and processes to monitor and improve the quality and safety of services provided, and to manage risks related to the health, safety and welfare of people, were not established. This included records not always being sufficiently detailed and accurate to support safe and appropriate care.