Sunrise Operations Sevenoaks Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Sunrise Operations Sevenoaks Limited provides accommodation, nursing and personal care for up to 102 older people. There were 79 people living at the home during our inspection. People cared for were mainly older people. People had a range of care and treatment needs, including stroke, heart conditions, breathing difficulties, diabetes and arthritis. Some people needed support with all of their personal care, eating and drinking and mobility needs. Some of the people were living with dementia. There were also people who lived independent lives, using their own transport, who came and went as they chose.

Sunrise is a large building with accommodation provided over three floors. There were communal areas on each floor, as well as large reception areas on the ground floor. The third floor, known as the 'Reminiscence Neighbourhood' was designed to accommodate people who were living with dementia. The ground and first floors were known as the 'Assisted Living Neighbourhood.' Although some people on these floors were independent and active, others were living with dementia and physical care and treatment needs.

The service had not had a registered manager since December 2014. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection in October a manager was in post and in the process of registering. However they subsequently went on long term leave, so they were not in a position to make the improvements to the care needed following the previous inspection. At the time of this inspection, a temporary manager had been in post for seven weeks. They reported they would be applying to register with CQC to become the manager.

The service was last inspected on 12, 13 and 14 October 2015. At that inspection, the home was rated as inadequate. This was because we identified breaches in the HSCA Regulations, and also the home had not sustained improvements from the previous inspection on 13 and 14 April 2015. At the inspection of 12, 13 and 14 October 2015, we identified eight breaches in the HSCA Regulations 2014. These were in relation to person-centred care, ensuring people's privacy and dignity and ensuring people consented to care and treatment. The provider was also not ensuring people received safe care and treatment, safeguarding people from risk of abuse and ensuring that people received the nutrition and hydration they needed. Additionally, the provider was not ensuring good governance of the home and appropriate staffing levels or that staff had appropriate skills for their roles.

At this inspection, we found the provider had not yet made improvements in a range of areas. These included ensuring people's nutritional needs were met and staff complied in full with the Mental Capacity Act 2005 (MCA). Ensuring they had clear and accurate records to ensure staff unfamiliar with people knew how to meet their individual care and treatment needs. People's assessments and care plans were not up to date and did not reflect a wide range of areas relating to their care and treatment. Whilst some staff were able to describe the care people needed others were not. Junior and agency staff did not have access to these care plans and relied on inaccurate brief information sheets, these did not outline the way they should

be caring for people.
The acting manager had made considerable improvements in the last seven weeks and had a plan to improve further but not all their actions were in place to provide safe, effective and responsive care to people.

People commented on the continued use of agency staff which they felt affected their continuity of care. Some staff had not been trained in meeting people's more complex needs, including using syringe drivers for pain control when someone is moving towards end of life, prevention of pressure damage and management of diabetes. We had been reassured at the previous inspection that staff had received this training. The acting manager had identified this and other areas that still required action. Although the acting manager had ensured staff were trained in areas including hygiene and infection control the provider had not taken timely action to ensure that staff had the training they needed to care safely for people and meet a breach in the regulation relating to staffing.
The acting manager had set up systems to support staff, including regular one to one staff supervision; this was not fully in practice at the time of this inspection.

People felt staffing numbers had improved. New staff were being employed. These new staff had been recruited in a safe way.

The acting manager had taken action to protect people against risk associated with medicines. The provider had appropriate arrangements in place to manage people's medicines safely. Medicines were safely stored. This was an improvement from the previous inspection.

The acting manager had improved systems to enable people to raise complaints or issues of concern. They had set up systems to improve feedback from people, their relatives and staff. People and staff said they were now more involved in developing improvements in service provision. Both people and staff said improvements had been made in key areas like cleanliness of the environment and the ordering of necessary equipment.

Staff we spoke with had a good working knowledge of how to safeguard people from risk of abuse. Staff had been trained in, and were aware of, their responsibilities under the Mental Capacity Act (2005). The acting manager had ensured the local authority had been contacted about all people who were at risk of being deprived of their liberty.

People said they enjoyed the meals. Mealtimes were social occasions and there were sufficient staff to support people during meals. People were actively supported in choosing what they ate and drank.

There was a new activities coordinator in post who was developing the service to ensure all people had the range of activities they felt they wanted, and which suited their needs.

People said they were supported by caring staff. Staff had a caring approach to people and interacted with them as individuals.

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

The overall rating for this provider remains 'Inadequate'. This means that it will remain in 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

The home's systems did not ensure people were consistently protected from risk across a range of areas, particularly relating to their medical care.

People were protected against risks associated with medicines because the provider had appropriate arrangements in place for the proper and safe management of medicines.

Staff were aware of their responsibilities for safeguarding people from risk of abuse.

There were sufficient staff and new staff were recruited in a safe way.

Is the service effective?

Inadequate

The service was not always effective.

People who needed additional support with nutrition were not supported in a consistent way. There were appropriate supports for other people with nutrition and hydration, including people who were living with dementia.

The frequent use of agency staff, and employment of new staff who were not yet familiar with people, meant they did not always receive continuity of care. Staff did not always have the appropriate training, support and skills to ensure they delivered effective care and treatment to people who had nursing needs.

Staff did not always act accordance with the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff were supported, including by training, to meet people's general care needs.

Is the service caring?

Requires Improvement

The service was not always caring

Systems to support people who were at the end of their lives were not consistent.

People's privacy and dignity was respected.

People were supported with their independence, including being actively assisted in making choices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People who had nursing needs did not always have consistent, responsive support.

Recreational activities were being developed, so all people would have their individual needs met.

People said the acting manager would take action if they raised complaints or concerns about their care.

Is the service well-led?

Inadequate

The service was not always well led.

The service had not had a registered manager since 2014. The acting manager had been in post for seven weeks at the time of the inspection.

The provider had not ensured it had acted to identify and act on all areas in their action plan. People's records were not always accurately maintained.

The acting manager was actively working towards improving the quality of care to people and setting up systems to receive feedback from all relevant parties. People and staff were positive about these changes.

Sunrise Operations Sevenoaks Limited

Detailed findings

Background to this inspection

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

This inspection took place on 7 and 9 March 2016. It was unannounced. The inspection was led by one inspector, who was present on both days. On the first day, this inspector was accompanied by two inspectors, on the second day by two different inspectors.

Before our inspection we reviewed the information we held about the home. This included previous inspection reports and action plans which the provider had sent us detailing how and when they would make the improvements required following the previous inspection. We looked at information from people which had been shared with us. We contacted the local authority and local clinical commissioning group, to obtain their views about the care provided. We considered the information which had been shared with us before the inspection, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with 15 people who lived at the home and observed a range of people's care, including during lunchtime meals and activities. As some people had difficulties in verbal communication, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with four people's relatives and visitors. We inspected the home, including people's bedrooms, sitting rooms, dining rooms and bathrooms. We spoke with 17 of the staff, including registered nurses, the chef, activities coordinators and junior and senior care staff. We met with the acting manager. Care staff are called Assisted Living Coordinators at Sunrise, with senior care staff being designated Assisted Living Managers.

We 'pathway tracked' eight of the people living at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed records. These included five staff training, supervision records and staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

After the inspection requested and received the provider's most recent action plan drawn up prior to the inspection, which we also considered during the inspection.

Inadequate

Is the service safe?

Our findings

People said they felt safe in the home. One person emphatically said "Oh yes, I am," when asked if they felt safe. A person told us they felt safe at night because "They call on you at least three times at night, and if awake ask you if you're ok." Staff stressed the importance of safety for people. One member of staff told us "The main thing is that residents are safe." We observed two members of staff assisting a person to move using a mechanical sling hoist. They did this in a safe way, giving the person explanations and carefully supporting them throughout the time they helped them. However, despite people having positive views about their safety, we found evidence that not all aspects of their care and treatment had been delivered safely.

At the last inspection, on 12, 13 and 14 October 2015, we found appropriate action had not always been taken to identify and reduce risks to people's safety. Also staff did not consistently follow safe practice, putting both staff and people at risk of harm and injury. At this inspection, while we found the provider had taken some action to address this shortfall, this had not yet been completed, and therefore a breach of the Regulation 12 continued.

Five of the people we reviewed had been assessed as being at risk of pressure damage. These risk assessments were kept on computer, to which junior and agency staff did not have access. This meant some of the staff did not know about people's high risk. For example, six staff who told us they knew a particular resident, however, three said they did not think, or know, if the person was at risk of pressure damage. These responses came from senior as well as more junior staff. This put the person at risk of harm as not all staff were aware of the person's degree of risk and actions they would need to take to decrease their risk.

People did have care plans about how to reduce risk of pressure damage; however five people's most recent care plans were not on their paper file in the office. People's care plans on computer were not up-to-date and also did not include relevant information on how their risk was to be reduced. For example a person who was assessed as being at high risk of pressure damage had a standard mattress on their bed, not a pressure relieving mattress to reduce their risk. There was no information on their care plan as to why the person did not need, or wish to have, a pressure relieving mattress. We asked staff why the person had not been provided with this equipment. They gave us mixed replies. One member of staff said they thought the person did have a pressure relieving mattress on their bed, others said they did not know if there was a specific reason why the person did not have, or want such a mattress on their bed. We asked the acting manager about this. They told us about the provider's policy on the use of pressure relieving equipment and said they would review the situation for this person. This lack of information from both staff and in the person's care plan meant there was a failure to assess and provide suitable equipment to ensure the person was not put at risk.

Staff, including agency, were given brief information sheets on how to meet each person's needs, Junior and agency staff were given daily assignments sheets, and registered nurses were given a different untitled information sheets. Five people's information sheets did not include instructions on what interventions they needed to reduce their risk of pressure damage. A person was assessed as being at high risk of pressure

damage and had sustained pressure wounds in the past. One member of staff said they did not know how their risk was being reduced. Another member of staff told us the person was being re-positioned every two hours. They were unaware of what they did to relieve the person's risk of pressure damage when they were sitting out of bed, which they were throughout the first day of our inspection. A third member of staff said that when they were on duty, they moved the person regularly when they were sitting in their chair and returned them to bed during the afternoon to relieve pressure. Because staff did not all report similarly about how they reduced this person's risk, the person may not have been receiving consistent care to prevent pressure damage.

The National Institute for Health and Care Excellence (NICE) has set out guidelines on prevention of pressure wounds. Staff were not following these guidelines.

One person was living with diabetes, which was managed by insulin injections. We asked staff about responding to their diabetic needs. One of the staff said they did not know the person needed insulin. A senior member of staff said they thought the person's diabetes was stable. Three members of staff told us the person's diabetes was unstable. Two of them told us different information about the person's diabetic instability and how they supported the person to maintain stability. The person's care plans were kept on computer, to which junior and agency staff did not have access. The different brief information sheets given to registered nurses, junior and agency staff did not outline how staff were to appropriately support the person when their diabetes was unstable. The person's care plan did not state the blood sugar levels the person's doctor wished them to remain within, nor actions staff were to take when they showed blood sugar levels which were outside these levels. The person had shown a high blood sugar level the day before the inspection. There was no documentation to show if this had been re-checked or other relevant actions taken by staff to appropriately respond to the person's diabetic needs and monitor their needs at that time. Therefore there was a potential that the lack of systems to check, monitor and respond to people's diabetic conditions could put their safety and welfare at risk.

During the inspection of 12, 13 and 14 October 2015 we were assured that all registered nurses were trained in prevention of pressure damage and diabetes. This training had not been effective and at this inspection people continued to be placed at risk by staff not following standard guidance on meeting the needs of people who were living with medical conditions such as pressure damage risk and diabetes.

The provider was not reducing risks to people in other areas. One person had records which showed they had experienced falls recently. Their falls risk assessment and care plans were kept on computer, to which junior and agency staff did not have access. The person's brief outline of care for junior and agency staff did not provide information about this particular risk and how to minimise it. We asked staff if they were at risk of falling. One member of staff said they did not know, two thought they were not at risk, three knew the person was at high risk. Four members of staff gave us differing information about the person's use of mobility aids and how they walked about. This was not documented on the person's care plan, to ensure a coordinated approach to preventing the person's risk of falling.

Risk management was a concern at the previous inspection and although some improvements had been made since that inspection on the 'Reminiscence Neighbourhood', people remained at risk of harm because not all staff knew how to keep everyone safe.

We discussed these findings with the acting manager, who had been in post for seven weeks when we inspected. They said they were aware of these issues and had identified such areas for action. This was because their assessment had shown the risks for people who were living with dementia was highest. The acting manager said they would next work with staff, and the provider, to ensure assessments and care

plans were fully available to staff and regularly updated. This intention to improve risk management is positive but it had not prevented the person above experiencing falls or ensured that timely action had been taken following the last inspection.

The provider did not to ensure that care and treatment was provided in a safe way to people. This was because they were not doing all that was possible to mitigate people's risk to their health and safety. This is a breach of Regulation 12 of the HSCA Regulations 2014. This is a continued breach from the inspection of 12, 13 and 14 October 2014. Additionally a breach about similar matters was identified under the previous Regulation 9 of the HSCA 2010 Regulations at the inspection of 15 December 2014. The provider had not ensured they met such regulations over time, to ensure people's safety.

At the last inspection on 12, 13 and 14 October 2015, issues were raised in relation to medicines. After the last inspection we also received a range of information about medicines errors. The provider and the acting manager had taken action to address and improve a wide range of areas relating to medicines., The provider is no longer in breach of the Regulation relating to medicines, but two minor areas still needed to be improved The plans for two people whose behaviours may be challenging were not cross referenced to the relevant medicine 'if required' protocol. A further two people had a 'just in case' medicine, but their supporting action plans were general action plans, not individualised to meet each person's specific needs in relation to their prescribed medicines.

We recommend that the service consider how they individualise information to support the care provided to people in relation to medicines.

The effectiveness of medicines was now being appropriately monitored. For example, we reviewed the records for one person who was prescribed a medicine that requires blood monitoring. These records contained relevant test results, subsequent scheduled tests and the exact dose to administer. Their care plan also contained the signs and symptoms of over and under treatment and supporting actions including seeking expert advice.

Medicines were appropriately ordered, stored securely and kept within their recommended temperature ranges. The administration of medicines was recorded via people's individual medicines administration records (MAR).

Homely remedies were available within the home. Homely remedies are medicines the public can buy to treat minor illnesses like headaches and colds. Staff had agreed a list of these remedies with a lead GP.

Information about allergies, 'when required' and variable dose medicines was held within each person's MAR. One person was self-administering their medicines following the completion of a risk enablement assessment.

At the last inspection on 12, 13 and 14 October 2015, we found there were insufficient numbers of staff deployed to meet people's needs and ensure their safety. At this inspection, people we spoke with felt this area was improving. A person told us that staff "Always come" when they used their call bell. We saw there were enough staff on duty to respond to people when they needed, including at busy periods like mealtimes.

There was a safe and effective recruitment procedure which ensured prospective staff were fully checked to ensure that they were safe to work with people. All registered nurses had their current registration with the Nursing and Midwifery Council (NMC) verified. All staff recruitment files were kept in an orderly manner by an

administrator who monitored each prospective members of staff's progress through the home's recruitment process.

At the last inspection on 12, 13 and 14 October 2015, we found people were not protected from abuse or improper care as systems did not operate effectively to recognise and prevent abuse. The provider and the acting manager had taken action to address this area. All staff we spoke with, at all levels, said they had been trained in safeguarding people from abuse. This was confirmed by the home's training records. To find out about staff awareness of risks of abuse to people, we used different scenarios which might indicate a person was at risk of being abused. Staff showed a good practical understanding of their responsibilities and of the actions they needed to take. They said they would always report any concerns, no matter how small and that they were confident the acting manager would take the correct action to ensure people were safeguarded. The provider and acting manager had taken action therefore the breach in the Regulation had been met.

At the last inspection, on 12, 13 and 14 October 2015, issues were raised in relation to hygiene and cleanliness. People said this had been addressed. For example a person described the home as "Very good, very clean." As this was a busy home, with some people who needed support with meeting all of their care needs, at the start of the day there were some areas which needed cleaning. By the time we returned after people had been supported to get up, such areas had been fully cleaned. Difficult to reach areas like the backs and undersides of bath hoists were clean. Peoples' wheelchairs were clean, including the chassis and wheels.

Inadequate

Is the service effective?

Our findings

People told us they received an effective service from the home. One person commented on the new staff and how for "The new ones, staff work with them, teach them." A person told us about the effective healthcare support and said they were "Able to access health care services as needed". Many people commented on their enjoyment of the food provided. One person told us the food was "Very good, good variety," another person described the "Pretty good menu." A person told us they had a small appetite and the staff "Go to a lot of trouble" in supporting them to eat. We asked a frail person who was eating in their room if they had liked their meal, they smiled and responded enthusiastically "Oh yes, thank you." However despite people's positive views on how effective the care was and how much they enjoyed the food, we found evidence the provider was not always providing consistently effective care to people.

At the last inspection on 12, 13 and 14 October 2015, we found people did not have their nutrition and hydration needs effectively met. At this inspection we found the acting manager had made some improvements in this area. Although the acting manager had taken action to address a range of areas, they and the provider still needed to address some areas in relation to people's nutrition, particularly for people who were frail.

A person whose condition was deteriorating due to their ill-health was being given full support from a member of staff to enable them eat their lunch. The person's food intake chart for the days before the inspection showed they were eating only small amounts. The person's care plan dated 8 October 2015 described this person as not requiring any assistance with eating and drinking. Their monthly review dated 9 February 2016 stated they were not at nutritional risk. It had not been reviewed since the person's condition changed. The brief information given to junior and agency staff also did not document about how the person currently needed support to eat.

We met with a different person who chose to eat in their own room. At lunchtime, we saw they ate only approximately half of their soup and none of their main course or dessert. The person's daily notes documented that they had eaten in their room, with no information on the limited amount of food they had eaten. We asked staff who said they knew the person about their normal eating habits. We received a variety of replies, these included two members of staff who said they did not know about their eating habits. It also included two members of staff who said the person had a very small appetite and it could be difficult to get them to eat, and they preferred sweet tasting food and drinks. The person's dietary risk assessment and care plan were kept on computer, so were not available to junior and agency staff. The person's care plan was dated seven months before the inspection. It stated the person preferred small portions, but nothing else about the person's preferences or strategies for supporting them in eating. The person's review and dietary risk assessment was dated 25 February 2016. Their risk assessment stated they had some risk due to their 'reduced appetite'. However their review only stated the person was independent with dining and did not document any information about their appetite and the difficulty staff reported on getting them to eat.

As information was not up to date and not all staff were aware of people's different needs, there was a risk

that staff would not know how to recognise if all people were receiving the nutritional support they needed.

The provider did not ensure all people's nutritional needs were met. This is a breach of Regulation 14 of the HSCA Regulations 2014. This is a continued breach from the inspection of 12, 13 and 14 October 2014. Additionally the provider had been recommended to take relevant action to support people's nutritional risk at the inspection on 15 December 2015 and while these recommendations had been addressed by the inspection of 13 and 14 April 2015 actions had not been sustained over time.

We asked the acting manager about these people's nutritional needs and risks. They said they had identified issues relating to a need for increased emphasis on supporting people with their nutrition and hydration. They had started a training programme for all staff, which agency staff also participated in. A group supervision session was taking place about the management of nutrition and hydration on the first day the inspection. The acting manager also reported they had started their programme to make improvements in people's nutrition and hydration on the 'Reminiscence Neighbourhood' of the home, due to the increased vulnerability of the people living there. Despite these assurances this is a continued failure by the provider to take action to ensure effective nutritional care was provided people prior to the acting manager starting in post.

We observed positive examples where effective action had been taken to ensure people's nutrition and hydration were met. We observed mealtimes on both the 'Reminiscence Neighbourhood' and in the main dining room. On the 'Reminiscence Neighbourhood', we observed staff engaging with a person who appeared to prefer walking for much of the mealtime. Staff gently encouraged the person to sit and have some food so that their nutritional needs were met. Staff showed people the plated-up meal choices, describing what was on the plate and supporting people in making a decision about what they ate. People were also given a menu when they wanted one, so they could read and decide what they wanted to eat, at the time of the meal. These systems particularly supported people who were living with memory loss with their nutrition.

Where people needed full support to eat, staff sat with them, supporting them and engaging them in conversation, making the meal a social occasion. People were not rushed. Staff made sure people had swallowed a mouthful, before checking with them if they were ready for the next one. Where people could not open their mouths wide, staff used small spoons to support them with eating. Where people lost concentration during the meal, staff gently encouraged them to eat, reminding them of what was happening and that their meal might become cold.

At the last inspection on 12, 13 and 14 October 2015, we found there were insufficient numbers of suitably skilled and competent staff deployed to meet people's needs and ensure their safety. Staff also did not always have the appropriate knowledge, support, training and supervision to ensure they delivered care and treatment to people safely and effectively. The provider's action plan had identified specific areas, including the use of agency staff and training for staff in safe moving and handling and infection control, but did not identify and address all areas relating to the breach. The acting manager reported they had assessed that this was a key issue. They had set up systems to ensure all staff were trained and supervised in their roles, however this was not fully in place or embedded at the time of the inspection.

People told us they were concerned about the high usage of agency staff. A person told us there were "Not enough staff, so we have agency." One person's relative commented on the "Constant change of staff" and they were concerned about the number of staff who did not know their relative. The use of agency staff who did not know people well had been raised by people as a concern during the last inspection. The provider reported in their action plan on steps they were taking to recruit more permanent staff. However, they did

not report on actions they were taking to ensure people received effective care and treatment while they were still continuing to use agency staff.

The acting manager said they were aware of the issues of high numbers of agency staff, and new staff were gradually being employed. They said newly recruited staff were being taken on slowly. They said this was partly because of lack of regular staff to 'buddy' or support and supervise newly employed staff and also to ensure new staff were fully aware of their role. They said as much as possible the same agency staff were booked, so they got to know both people, and the home's systems. The high use of agency and new staff meant people did not always have consistent or effective care because staff did not know about and were not provided with relevant information about people's care and treatment needs. Additionally senior staff were inconsistent in their knowledge about effectively meeting people's needs. They would therefore not be able to direct agency and new staff in how to meet people's care and treatment needs.

For example we saw a person who had a history of unstable diabetes, who was also living with dementia, had a large chocolate bar on their bed side table, where they could reach it with ease. We asked a senior member of staff about the chocolate bar. They said they did not know about it and said they did not think the person should have it readily available to them, and they would look in to it. By the second day of the inspection, the chocolate bar was in the same place. We asked another senior member of staff about the person. They said they did not know about the chocolate bar, but they did know the person's family brought such treats for the person, they had been asked to let staff know when they did this, so staff could monitor the person's intake, to support their diabetic stability. None of this information was documented on the person's care plan or brief information, to ensure junior and agency staff were aware of what to do when the person's family did this and ensure the person received effective care for their diabetes.

A different person had a small dressing on their upper left arm. We looked in their records, but there was no documentation about this dressing. We asked staff about it, only one of the six staff we spoke with knew about the dressing, when it had been put on and why the person needed it. They did not know the condition of any wound under the dressing. The person was frail and had a history of tissue damage. As there is the potential for small wounds to deteriorate rapidly for some frail people, the lack of knowledge and information about this person meant they were at risk of receiving ineffective care.

None of the staff we met with reported they had been recently trained in prevention of pressure damage, although several of the people in the home had pressure wounds, and other people were assessed as being at high risk of their development. At the inspection of 12, 13 and 14 October 2015 we were informed that all registered nurses had been or would shortly be trained in prevention of pressure damage. Despite this, two senior staff were unaware of the NICE guidelines (2014) on the prevention of pressure wounds. We talked with a member of staff about a person who was feeling very unwell at times. The member of staff was not aware that the person's periodic high blood sugar levels might be factor in making them feel unwell. They said they had not been trained in supporting people who were living with diabetes, so did not know about how they could be affected by an unstable diabetic condition. The provider had not identified these deficits in the action plan which they sent to us before the inspection. The acting manager said they had identified that staff needed up-dating and training in a range of clinical areas and showed us their plans for progressing this.

The provider did not ensure they always had suitably skilled and competent staff deployed to meet people's needs and ensure their safety. Staff also did not always have the appropriate knowledge, support and training to ensure they delivered care and treatment to people safely and effectively. This is a breach of Regulation 18 of the HSCA Regulations 2014. This is a continued breach from the inspection of 12, 13 and 14 October 2014.

The acting manager had addressed a range of other areas in relation to training and supervising of staff. We talked to two newly employed members of staff. One member of staff described the "Very good induction," which they said was "So much better" than their previous employer. Staff were enthusiastic about both the training they had received and were booked to attend. An activities coordinator said they were booked on to a conference which would focus on activity and engagement. Senior staff understood their role in supervising more junior staff in their role. A senior member of staff said they knew working in care was stressful and they must not "Knock back" a junior member of staff. They stressed the importance of discussion when supporting a more junior member of staff in the development of their role.

At the previous inspection on 12, 13 and 14 October 2015, we found staff did not always understand or act in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The acting manager had identified this as an important area for action, however a few areas still needed to be addressed.

Two people's records showed they could be administered medicines covertly when necessary. These people did not have a capacity assessment in relation to administering their medicines covertly. Their records did include notes from a best interest meeting and specialist pharmaceutical advice to ensure the medicines remained active whist administered covertly. A member of staff told us in detail about a different person's capacity about a particular area of their care, however there were no records of their mental capacity having been assessed on the person's file. Because assessment of these people's capacity was not evident from their records before a decision being made in their best interests, it had not been determined if they may have been able to make the decision, if given information in a way which was approachable for them. This meant the best interest decisions which had been made had not been carried out under the principals of the MCA.

Staff did not always act in accordance with the requirements of the Mental Capacity Act 2005 This is a breach of Regulation 11 of the HSCA Regulations 2014. This is a continued breach from the inspection of 12, 13 and 14 October 2014.

All staff reported they had, or were planning to receive training on MCA and DoLS. Comments about this training were mixed. A member of staff told us the training had been on line and "Wasn't that helpful," however when we spoke with them they had a satisfactory understanding of the general principals of the MCA. A person who used bed rails had a clear assessment about their use and their preference to use them. A registered nurse had a very detailed knowledge and understanding of their responsibilities under the MCA and in relation to DoLS. The acting manager had made sure all relevant applications had been made to the local authority where people were at risk of being deprived of their liberty. They were awaiting a response to their applications at the time of the inspection.

People said their healthcare needs were met. A person told us "The doctor comes on a Tuesday and I can see them if want to." A member of staff told us about supporting a person with an appointment to attend a local healthcare clinic two days after our inspection. A registered nurse told us about their telephone contact with the local tissue viability nurse about a person's ongoing wound and the advice they had been given on the use of a wound dressing, which they were following. A different person's records showed they had been seen by the speech and language therapist about a swallowing difficulty and their advice was being followed.

Requires Improvement

Is the service caring?

Our findings

We received mixed comments about the caring nature of the home. One person described agency staff as "Lazy." A person's relative told us agency staff "Don't give a lot of choice." We fed back comments about agency staff to the acting manager during this inspection. We did not see evidence of agency staff working in an uncaring way. People were complimentary about permanent staff. One person described staff as "Very willing," another as "Very tolerant," and a person said "Care staff very good, very clean " A person said they were "Happy" in the home and another person said "I have everything I need here." Despite these positive comments, we found the provider had not ensured people's needs were responded to in a caring way, including at the end of their lives.

Staff told us about a person whose condition was deteriorating. They had recently been seen by staff from the local hospice, as they were reaching the end of their life. We asked staff about the management of this person's pain. A senior member of staff told us it was difficult to find out if the person was experiencing pain, as they could no longer communicate verbally. This member of staff did not know of any other ways of communicating with the person or assessing their pain. Two members of staff told us in detail how they found out if the person was experiencing pain. However both staff reported different ways of doing this. We looked at the person's records. Their most recent records were only kept on the computer, so junior and agency staff did not have access to them. When we looked at the person's computer records, they had not been reviewed and up-dated since the person began to develop needs in relation to end of life care. The brief information given to agency and junior staff did not include any reference to how staff were to support the person with their current needs. This meant there was no coordinated approach in supporting this person at the end of their life. There was therefore a risk that the person would not receive the support they needed at this time, because staff did not have information on how to appropriately meet their individual needs, particularly with pain relief. This is particularly relevant as another person at the end of their life had not experienced the care and support with pain control that they deserved. This was confirmed by the local authority safeguarding team. Therefore, although the acting manager had recognised that changes were needed in staff training and the delivery of care this had not resulted in lessons learnt as a result of the previous case.

People were not fully supported by staff who respected them, their wishes and preferences. A person's relative told us that because their relative was very particular about their appearance, they had opted to wash the person's clothes themselves. They said not all staff were aware of this, so items had been sent to the laundry and they were concerned that the person's individual preferences had not been respected. A person who was living with dementia had a care plan which documented they liked to listen to music. However they had none playing in their room during our inspection and staff did not know why this was. This lack of staff knowledge about people's individual needs meant this person's choices may not have been met.

The provider was not ensuring all people received person-centred care. This was because they were not ensuring that people's care was appropriate, met their needs and reflected their preferences. This is a breach of Regulation 9 of the HSCA Regulations 2014.

We observed a kindly, caring approach from the staff in other areas. A person who appeared to be confused asked repeatedly "Where are we going" as a member of staff supported them in going to lunch. The member of staff was respectful and kindly, reminding them on each occasion of where they were going and why. We heard a domestic worker talking to a person who remained in their room. They were enjoying a lively conversation, with jokes and laughter on both sides. A person on the 'Reminiscence Neighbourhood' was looking for their cardigan and trying to open a range of different doors. The member of staff who supported them was cheerful and polite, orientating them to where they were and how to find their room so they could put their cardigan on.

People's dignity was respected. A person said they had found being supported by a member of staff to have a bath difficult at first, but they appreciated the discreet way staff always supported them, so they now felt comfortable when they had a bath. One person who was eating lunch had difficulty in stopping the food from spilling out round their mouth. The member of staff assisting them politely asked them on each occasion this happened if they could wipe the food away, which maintained the person's dignity, and appearance. A relative told us they knew it was an apparently small area, but they appreciated the way the service had ensured their relative had enough hangers to enable them to hang up all their clothes properly. Another person had very recently needed to start being moved using a mechanical hoist and sling. The slings used for the person had already been marked with their name to ensure they were used only for them.

People's independence and involvement was supported. One person had an appointment with an external healthcare agency. They said they would prefer to do this on their own and not be escorted by a member of staff. Staff did not put the person under any pressure to change their mind and prevent their independence. A person told us they were working with an activities coordinator to develop a newsletter, as this was what they wanted to do. A different person told us they were regularly involved in interviewing prospective staff and they appreciated their involvement with this. The activities coordinator told us about a person who particularly enjoyed listening to jazz music. The person had been supported in setting up their own small group, and other people were now joining it to share their enjoyment.

The systems in the home supported people's dignity. We met with one of the laundry workers. They had effective systems to ensure all people had their own clothes named for them. They were aware of the effect on people of any misplacement of their clothes in the laundry and clearly worked hard to ensure they identified the owners of any un-named clothes. For this size of home, we saw there were only a very small amount of un-named clothes. The home environment supported people's dignity. All people had entrance areas to their rooms where there was a kitchenette, and a small sitting area, making each person's own room more private. If people wished, they could bring in items of their own, so many people's rooms reflected their individual likes and preferences.

People said the acting manager supported the caring approach of the home. One member of staff told us the acting manager "Gets to know the clients and understands them." We saw one of the agency staff standing up to support a person who was sitting and needed full assistance with eating. We went and told the acting manager about this. They took prompt action to ensure the agency worker was aware that supporting a person to eat in that way did not support their dignity.

Staff we spoke with showed a caring attitude towards people. At staff shift handover, staff discussed a person who had a visual disability who was also living with dementia. They talked together about how both these conditions affected the person's daily life and the strategies they needed to take to support the person in the light of their individual needs. During shift handover staff also showed an awareness of people's past and family lives and how to support them as individuals. This included discussing how they could support a person's spouse while a person's condition was changing. They understood how much each person meant

to the other and discussed how they could foster the two people's relationship during this period. A person had a first language which was not English. They were provided with one to one support at regular intervals by a member of staff who could speak their language, to ensure their preferences were known about and met.

Requires Improvement

Is the service responsive?

Our findings

People said the staff were usually responsive to their needs apart from the previous concerns reported on regarding agency staff not always knowing their individual needs. One person who was fully able to tell us about their experiences was concerned about others who were less able to do so. They told us, "I worry about people with dementia a bit about continuity of care, where so many agency and new staff are involved with looking after them." A member of staff said they knew they needed to "Make plans a little more person centred." Other people were more positive about the responsiveness of the service. We were told they "Have meetings to discuss any changes, always ask for anything." Another person said they "Can speak with nurses" about their needs.

The staff did not always meet people's needs in a responsive way, particularly where people had nursing needs. A person whose records stated they were living with dementia, had daily records which showed they had a specific continence aid applied by staff at night. The person's records also showed they tended to remove the aid at times. There was no assessment of the frequency of when they did this or of reasons why they might be removing the aid. The person's care plan had no information on how this aid was to be correctly applied to ensure their comfort and the aid's correct functioning. None of the day staff, including a senior member of staff, knew if the night staff, who applied the aid, had been trained in how to safely and correctly apply the aid. There were no records to show if staff had been trained in this. We asked senior staff if there had been an assessment of whether this aid met the person's current continence needs. They said there had not been such an assessment to ensure it met their current needs.

We found another example where staff were not always aware of how to respond appropriately when caring for someone with breathing difficulties. Staff gave different descriptions of the person and what care they needed. The care plan was not made available to all staff and this did not accurately record the person's health or ways that staff should care for them to respond to their needs.

The provider had identified issues relating to ensuring people's care profiles were up to date to ensure people's needs were met, including their medical needs. They stated this would be addressed by 29 February 2016. However they had not taken action by this time to address these issues. We discussed with the acting manager about these and other examples of where the service was not appropriately responding to people's needs in an effective way, particularly where people had nursing needs. We outlined that the current systems did not ensure people's medical needs were met and risk to them of changes in their medical condition reduced. The acting manager said they were aware of the risk and were planning to develop systems in the future to ensure people's medical needs were effectively responded to.

The provider was not ensuring people's care and treatment was appropriate and met their needs. They were also not carrying out full assessments of people's needs for care and treatment. This is a breach of Regulation 9 of the HSCA Regulations 2014.

People gave us mixed comments about the activities provided. One person said there was "Not enough in-house entertainment could use a bit more." This was not echoed by other people. One person described the

"Wonderful entertainment, which I like."

Some people chose to remain in their rooms most of the time. These people were unable or did not choose to be involved in larger group activities. Two of these people did not have any activities provided during the inspection. We asked the activities coordinator, who was newly in post, about this. They said they had started by establishing a person-centred activities programme and were working on a balanced itinerary for people. They said they were "Keeping daily notes of what worked well for people and what people would prefer more of," to further develop the service. Areas they had started working on included a bingo session which had proved to be "Very popular." They said they had made it a visual experience, using large cards and large red counters and prizes. They had started other activities and they said people had found the painting groups "Therapeutic." They had also started developing a befriending service for people, using volunteers. They said they were pleased activities were now "Starting to grow." They were aware of the needs of people who did not come out into the communal areas and, now activities programmes were underway, they were planning on developing other ways to meet such people's needs.

The facilities included the 'bistro' café on the ground floor and a range of different larger and smaller sitting rooms, which provided different venues for activities across the home. A person commented on the "Very nice garden," and a person told us about the "Minibus which goes out on trips." In the Dementia Neighbourhood, the use of signs helped people find areas such as their own room and the toilets. There was a domestic, homely atmosphere in the sitting areas on the Dementia Neighbourhood. People were relaxed, sitting and chatting comfortably together in small groups in these areas.

At the last inspection on 12, 13 and 14 October 2015, we found although the complaints system was available to some people and relatives, relatives we spoke with then did not have confidence that the complaints system was being used as an opportunity to improve or learn lessons. It was also not accessible to all people who were living with dementia.

The acting manager stressed the importance of listening to relatives, they said some relatives had told them they felt ignored in the past. They said "I'd rather know" if people's relatives had concerns. They said they did feel relatives felt more ready to speak to them than in the past. A person's relative described the acting manager as "Very approachable."

A person told us they could speak with the "Acting manager" about any concerns. Another person said about the acting manager "Oh yes she'd sort" if they had complaints or concerns, they then added "And she reports back on it." Another person said there was "Always someone to speak to" if they had concerns, but that they had "Not really had any problems."

We looked at the complaints log. The acting manager had developed a revised log since they came in post. This documented both formal, written complaints and informal concerns from people. The records showed what the issues were, the investigation and the outcomes, as well as points learned. A senior member of staff told us if they had issues raised with them, they tried to resolve them informally. As some issues had been resolved locally by staff, the acting manager was not aware of them and had not been able to ensure the person had been effectively responded to in all cases. They said they were working with senior staff as they were aware some staff did not yet fully understand the importance of logging all issues brought up with them. The provider had made the improvements necessary to meet the breach of regulations; however there were minor improvements still to make to ensure they became embedded with staff.

Inadequate

Is the service well-led?

Our findings

People told us they wanted continuity of leadership, from the same manager. They were positive about the acting manager's leadership and were concerned she might not be remaining in post because previous managers had not done so. A person described the acting manager as "Particularly good," another person told us "She's knocking this place into shape," and another "I would recommend it now." A person said they were "Quite content" in the home and another that it was "A great place to be."

Such comments were echoed by staff. One member of staff told us the home had been "Very chaotic," in the past, but this was not the case now because the acting manager was making improvements. Another member of staff said "I think it's all improving since we had the new manager." Another member of staff described the acting manager as "The most sensible, most practical manager I've ever met."

Despite positive comments from people and staff, we found there were areas of leadership which continued to breach the regulations.

The home did not currently have a registered manager, and had not done so since 2014. The provider had appointed different managers since 2014 but they had not been registered with us. The acting manager had been in post for seven weeks at the time of the inspection. A senior manager from the provider was working in the home as a care manager to support them in some areas.

At previous inspections, including on 12, 13 and 14 October 2015, we found although there were some quality monitoring systems in place, these were not always being used effectively or consistently to improve the care people received were sustained. At this inspection, we found the provider did not always consistently ensure all actions identified in its action plans were addressed. This stated that people's care profiles were being reviewed and that by 29 February 2016, 'All care plans have been reviewed and updated to ensure that they accurately reflect the resident needs.' The provider had not identified that this had not taken place for all people. For example two of the people who we reviewed in detail were diabetics. They had risk assessments which stated they were at high risk of pressure damage. Where a person is at high risk of pressure damage and is a diabetic, there is an increased risk of damage to their lower limbs, particularly their heels. These people's care plans and reviews gave no instructions on how staff were to reduce this risk to the person, either when they were in bed or when they sat out of bed. A different person had been seen by external healthcare professionals during February 2016, in relation to their bowel management needs. Their care plan had not been reviewed or revised to reflect how staff were to support this person with these needs, to ensure their comfort and hygiene.

In their action plan the provider stated the assignment sheets given to agency and junior care workers 'are reviewed on a weekly basis' and this would take place by 29 February 2016. The provider had not identified their action place had not been met. For example we asked four people about how a person moved and they each gave us a different response. The person did not use an aid and used furniture to move about their room, that they used two sticks to move, that they used one stick to move, and that they used a frame. The person's entry in the daily allocation sheet said they used a frame but the detail of their individual needs

stated they mobilised with a stick. The person did not have a frame in their room when we visited them. A care worker who was unfamiliar with this person would not have the information provided on the assignment sheet to ensure they knew how to safely support this frail person with their mobility.

Record-keeping also needed improvement to ensure the provision of quality care and safety of people. This included one person who had food and fluid intake charts with the same dates on them which documented differing information. Some of the charts were in the person's room and the others in the office. We asked a member of staff about this. They said there was no consistency about where people's charts were kept and that was why the person had charts for the same day which documented different information. The person was frail and living with a complex condition. Because the records were not accurately maintained, a full review of how effectively the person was being supported could not be made.

Other records were not accurate or completed at the time care was given. When we visited a person at 10:50 am on 7 March 2016, they were in bed, lying on their back. They had a turn chart in their room, it stated their last change of position had been at 8:00 pm the evening before, when they has been moved on to their left side. There were no subsequent records of changes in their position, nearly 15 hours later. The section for how often the person needed to be supported to move was not completed on the turn chart. This person had a pressure wound. We found another example where a person had been identified as at high risk of pressure damage. Their chart recorded that staff should help them move position every two hours. The chart did not show that this was being done.

As these people did not have accurately completed records, the provider could not be assured both people's risk of development of pressure wounds was being effectively managed or that they were following guidelines from NICE on prevention of pressure ulceration.

A person had a sling for use with a mechanical hoist in their room. Staff confirmed they used the hoist and sling to support the person each time they needed to move. The person's care plan related to a person who was much more mobile and had not been updated when the person's condition had changed and they needed to be moved using a hoist. The brief information sheet given to junior and agency staff did not document about the use of a hoist and sling for this person. As the provider was using new and agency staff, records of how the person needed to be supported in moving needed to be accurate to ensure the health and safety of both the person and staff.

The provider was not maintaining an accurate, complete and contemporaneous record of each person, including a record of the care and treatment provided to the person and of decisions taken in relation to the person's care and treatment. This is a breach of Regulation 17 of the HSCA Regulations 2014. It is also a continued breach from the inspection of 12, 13 and 14 October 2015. The provider was also recommended to take action to address accurate record keeping in the inspection of 13 and 14 April 2015. They had not taken appropriate action to ensure the recommendation of the inspection of 13 and 14 April 2015.

The acting manager had already had set up meetings with people and their relatives. The records of a recent relatives' meeting documented relatives' concerns about the effect of the use of agency staff. The acting manager said they needed to use agency staff while they were recruiting new staff, so they had established links with the agency to ensure that as much as possible, the same agency staff were provided. The acting manager reported since they came in post, they had felt supported by the provider in making improvements in service provision.

To further develop the service, the acting manager had set up heads of department meetings, which were held regularly. A member of staff described these as "Really positive." A member of staff told us they had

informed the acting manager about some old, deteriorating equipment. They had been impressed that the acting manager had taken prompt action when they reported this, to ensure the safety of the people and staff who used the equipment. The acting manager had also made improvements in the home environment, particularly in relation to standards of cleanliness. A person described the home as "Now very nice, very comfortable." Staff felt because the acting manager had started with making improvements in the Reminiscence Neighbourhood, people living in that neighbourhood were calmer and more relaxed, both within the home environment and with staff.

When we fed back to the acting manager on issues we had identified at the inspection, they were open and transparent, saying they were aware of many of these issues but that it took time to ensure improvements were embedded. They said their main priority had been the development of team-work amongst the staff. Staff were positive about the improvements the acting manager had made since they came in post. A member of staff told us "Things have improved, we're not struggling anymore." Another member of staff said improvements were being made because the acting manager "Gets you to think about what you're doing and if you can do it another way." A junior member of staff said they were getting appreciated more by the acting manager and this "Didn't happen before." They said it made them more motivated in their work and keener to make improvements. Staff said improvements were being made because the acting manager was more visible about the home and prepared to listen to people and take action. A member of staff said "Some managers only do the paperwork, not walk the floor" and this meant they did not actually know what was going on. They said this did not happen with the acting manager.

Although the acting manager had started developing quality audit processes, it is the responsibility of the provider to take action to ensure people receive quality of care. They would have been aware of the need to make improvements from the previous inspection on 12, 13 and 14 October 2015 but had not taken sufficient action to do so before the appointment of the acting manager.

The provider had a philosophy of care about the home community people lived in. People gave us positive comments about Sunrise's community approach and said that was why they had decided to move into the home. This was fostered not just by the home environment, which was attractive and well-maintained, but by the provider's emphasis on participation by people in the home community. People said they appreciated having a visible receptionist who was available to support them, their relatives and visitors. We saw this person was happy to chat with people, direct people to where they wanted to go and knew them well enough to make general enquiries about people's well-being. Staff were friendly and welcoming towards people when they came into and moved from area to area across the home.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not ensuring all people received person-centred care. This was because they were not ensuring that people's care was appropriate, met their needs and reflected their preferences. They were also not carrying out full assessments of people's needs for care and treatment and accurately describing people's care and treatment to ensure their needs were met. Regulation 9 (1)(a)(b)(c)(3)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not ensuring that care and treatment of people was only provided with the consent of the relevant person. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring that care and treatment was provided in a safe way to people. This was because they were not doing all that was possible to mitigate risk to people's health and safety. This is a breach of Regulation 12 (1)(2)(a)(b)(c)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider was not ensuring all people's nutritional needs were met. Regulation 14(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not maintaining an accurate, complete and contemporaneous record of each person, including a record of the care and treatment provided to the person and of decisions taken in relation to the person's care and treatment. Regulation 17(1)(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was not consistently assessing, monitoring and mitigating the quality and safety of the service. They were also not maintaining an accurate, complete and contemporaneous record of each person, including a record of the care and treatment provided to the person and of decisions taken in relation to the person's care and treatment. Regulation 17(1)(2)(a)(b)(c)