Sunrise Operations Knowle Limited

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Inspection report

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Date of inspection visit: 16 November 2015
Date of publication: 04/01/2016

Ratings

Is the service safe?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 19 January 2015. After that inspection we received concerns in relation to how the risks associated with people's care was managed. This included people who were at risk of falling and the management of people's medicines. As a result we undertook a focused inspection to look into how the risks associated with people's care was managed. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sunrise Operations Knowle Limited on our website at www.cqc.org.uk

We carried out the focussed inspection on 16 November 2015. The inspection was unannounced.

Sunrise Operations Knowle Limited is registered for a maximum of 131 people offering accommodation for people who require nursing or personal care. At the time of our inspection there were 118 people living at the service. This included people who were 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. There was no registered manager in post and there had

Summary of findings

not been since October 2015, when the previous registered manager left. An interim manager had been in post for two weeks and a new manager was due to start in January 2016.

There was not always enough staff to provide the support people required in order to meet their needs and preferences.

Medicines were not always administered as prescribed, or stored and disposed of safely. There were not always protocols for medicines given 'as required,' so we could not be sure these were given consistently.

People and staff told us they could not always raise concerns with the management team, who were not always approachable. However, they felt more positive with the recent changes and that a new interim manager had been appointed.

People told us they felt safe living at the service. Staff were trained in safeguarding adults and understood how to protect people from abuse. Checks were carried out prior to staff starting work to minimise the risk of recruiting unsuitable staff to work with people who used the service.

Risk assessments reflected the risks to people's health and wellbeing; however they were not always reviewed regularly.

The new management team had identified some areas that required improvement and were putting plans in place to address these areas.

Quality monitoring audits had been undertaken and these had identified some concerns, however we were not always able to see actions taken following issues being identified.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

People told us they felt safe. Staff were not available at the times that people needed them and this put people at risk. Medicines were not always stored safely or given to people as prescribed. There were not always protocols for medicine given 'as required' to ensure they were administered consistently. Risk assessments did not always reflect the current risks to people's health and wellbeing as they had not always been reviewed regularly. Staff knew how to safeguard people from abuse and actions to take if they had concerns. Recruitment checks reduced the risk of unsuitable staff being employed at the service.

Is the service well-led?

Requires improvement

The service was not consistently well led.

People and staff told us they did not always feel supported by the management team. There had been no registered manager in post since October 2015 and an interim manager was now at the service. Despite checks being undertaken each month, many of the issues found during our inspection had not been identified as part of the quality assurance process by the previous management team. Where concerns had been identified, we did not always see actions had been taken in response to these. The interim manager had now identified some areas they intended to improve.

Sunrise Operations Knowle Limited

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Sunrise Operations Knowle Limited on 16 November 2015. This inspection was undertaken in response to concerns received about how the risks associated with people's care was managed. This included people who were at risk of falling and the management of people's medicines. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led.

The inspection team comprised of two inspectors, a head of inspection, a pharmacy inspector and a specialist advisor. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge in nursing care for people with dementia.

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 and 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 11 people who lived at the service, three relatives and three professionals. We also spoke with 20 care staff, one activities co-ordinator, four nurses, the interim manager, a general manager at another of the provider's services, two support co-ordinators, the training and support manager and a human resources assistant. We looked at nine care records and 11 other records relating to people's health needs. We looked at 15 medicine administration records and the quality assurance checks made by the manager. We observed the way staff supported people at the service.

Requires improvement

Is the service safe?

Our findings

This inspection was undertaken in response to concerns received about how the risks associated with people's care was managed. This included people who were at risk of falling and the management of people's medicines.

At this inspection we found there were not enough staff available to support people at the times they preferred or to keep them safe. One person told us, "Staffing is extremely poor, it is not very well co-ordinated." They went on to say, "I had no breakfast at 10.30am, it is shocking mismanagement and no one writes anything down." We asked whether staff came quickly when the buzzer was pressed. One person told us, "It is widely ignored if they are busy doing something else. Staff tell us there is not enough of them, it is not organised." Another person told us, "Staff are lovely, they are all so nice but when I bleep, they are always too long in coming. There should be somebody to reassure you, instead you are just left wondering." One relative told us of their concerns about staffing levels and described them as "Appalling, staff keep leaving." They said when they had raised this issue previously with the manager, the response had been 'defensive'.

We asked staff if they thought there was enough of them. Comments from staff included they were 'working flat out', 'there were not enough staff' and they were 'fire fighting.' One staff member told us, "When I started here there was enough, you could have a break, there is less and less staff, it is not good for the residents or us." They went on to say, "All the paperwork is done at the same time, we try to fit it all in, I'm worried if something happens." They said there was no time to chat with people now. Another staff member told us, "I don't go to the toilet, I don't have a chance, I'll end up with a kidney problem." One nurse told us, "When you are the only nurse on, you are literally looking after the whole building, it is stressful, it is three floors." The management team confirmed that there was one nurse for each area of assisted living and reminiscence, and that 45 people had nursing needs that lived at the home. One staff member told us they had previously asked for some 'floating staff' to assist when it became busier and were told this was not possible.

Staff told us they did not think there was enough staff at mealtimes, not enough nurses and they sometimes had to rely on agency staff, particularly at night. Agency staff were used at times to cover vacancies and one staff member commented that the problem was agency staff did not always know people. However they tried to use agency staff that had worked there before. One relative told us their family member was very unwell and was not eating. However, they told us they responded well to consistent staff they knew well and this encouraged them to eat. They reiterated that as this was not happening and they were being supported by staff they did not know, their family member was eating little. We raised this with the interim manager, who spoke with the relative and told us they would try to ensure their family member was supported with consistent staff.

Staff told us that the staffing levels could put people at risk at times. One staff member told us, "Sometimes I come in and there is only three or four staff on in the morning, eventually we get staff in later, but we have residents who try to get themselves out of bed." A staff member said, "There is not enough staff to meet people's needs. The floor is demanding. When it comes to meal times there is four of us but one is a medicine technician and one is needed for the kitchen. There is not enough to do things efficiently." They told us there were five people who required assistance with their meals and they always seemed short at the weekends. One staff member said, "The actual numbers of staff are not always consistent with the rota. Possibly due to sickness. This makes it harder for us."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team were taking action to address some of the staffing issues. The deputy manager told us they were 'heavily recruiting' and had interviews running each week. The interim manager told us there were around 250 staff employed both full and part time and they were, "Focusing heavily on recruitment." Vacancies for staff were calculated in hours and there were 692 hours vacant for care assistants overall. On the day of our visit, the interim manager told us that 14 staff were 'in the pipeline' including nurses to start work at the service and this was around 256 hours in total. A dependency tool was used to calculate the number of staff required to support people's need and the general manager told us, "We are overstaffed to that." Bank staff were used to cover some shifts and

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these were staff employed as and when required. The management team told us they intended to reassess people's needs, develop a plan of action and look at additional hours now.

We looked at the management of medicines and found they were not always administered, stored or disposed of correctly. One person told us, "Medicine is pretty good, occasionally there is a problem." However, another person told us, "I don't always get my medicines on time because staff are too busy, there are not enough staff." Medicines were administered by 'medication technicians' or nurses for people who required nursing care. Staff told us when an agency nurse was working, the medication technician would support them in administering medicine. This was because the nurse did not always know the people and how they took their medicines. However, this information was recorded in care records. Another staff member told us, "We get a lot of agency nurses. We have had a lot that have come in and made errors with medicine. It really shocks me."

A medicine error 'log' contained minutes from two staff meetings that were held in August 2015. The minutes showed in August there were 27 medicine errors. Nine of these were attributed to staff employed by the service and 18 errors were attributed to agency staff. The minutes from the two meetings were not consistent and it was not clear what actions were taken to prevent medicine errors from occurring in the future. The date of the next meeting was written, but no other meeting minutes were in the folder. One staff member told us the previous manager had the missing minutes and they had since left their employment at the home. The medicine error log showed that between 6 November 2015 and 16 November 2015, 30 errors had been recorded. One staff member told us why they felt medicine errors occurred, "It's because we have care staff that are not fully trained still administering medications. That could be improved. I trained for a long time to understand medication and they don't have this level of training or know what they are giving them for or not."

Medicines with a short expiry date were dated when they were opened, so that staff would know when they should be discarded and no longer used. Medicines that required storage in a fridge were not always stored within the recommended temperatures. We looked at the fridge temperature recording in one of the rooms. The fridge temperature had been recorded as 21 degrees C for the last few days. Medicine to be stored in a fridge should safely be stored between 2 and 8 degrees C. The record showed a member of staff had informed the maintenance team, but no other action had been taken. This was against the provider's medicine policy. The policy stated that the prescribing GP and pharmacist should be informed to find out if the medicine was still safe to give or needed to be replaced and this should be done immediately.

We looked at the Medicine Administration Records (MAR) for 15 people in total. The MAR charts were clear and a running balance of medicine left in stock was kept. It was observed that the running balance was filled in by the staff member administering the medicine by subtracting the medicine given from the previous balance. The staff member told us they did the running balance of the medicines in the trolley without counting the medicines. They told us that as they were the only person with the keys to the trolley, they knew the balance was correct. However, this assumed that the previous balance was correct and if a discrepancy in the number was found, it would be difficult to track where the error had occurred. We asked to see a medicine "trolley audit" that was completed by the staff, but were told that it was not on the premises and a member of staff who was absent due to sickness had taken this home.

During our visit a staff member was observed going back to the MAR folder and filling it in retrospectively for two people. They told us the people did not have their medicine because it was not needed. This was not the correct process as highlighted in the provider's medicines policy. It increased the risk of an error, as it relied on the staff member's memory to complete the MAR correctly.

Some medicines were prescribed as and when people required them, known as 'PRN'. Some people had a PRN protocol written up that would inform staff when to give the medicine. Some people did not have these protocols, which meant we could not be sure that these people would get their medicines consistently or at the times they needed them. For example, during observation of a medicine round, one person did not have a protocol in place for a PRN medicine and the staff member was observed not offering or assessing whether the person required this medicine.

Staff were aware that some people needed their medicine at times other than at the set medicine round. Two people were observed being given their medicine in a timely way

appropriate to their needs. However, one person was observed being given an oral medicine that should be administered after food. This person was given the medicine just before they were served lunch and advised to swallow it. The staff member told the person to drink some water when the person said it did not taste nice. By administering this medicine incorrectly and against the recommended instructions, the person may not benefit from this.

'Covert' medicine is medicine that is hidden, usually in food. We found that the use of covert medication had not always been authorised correctly. We looked at the covert medicine authorisations for two people. Their documents were filled in correctly and were kept with the person's MAR chart. We asked staff to show us the documentation providing the authorisations for another two people who had covert medicine. However they were unable to show us these. We could not be sure if the authorisations had been done correctly as all of the documents were not available.

We looked at controlled drugs, which are medicines that require special storage and recording to ensure they meet the required standards. Four controlled drugs were checked against the Medicine Administration Records (MAR) and controlled drug register and no discrepancies were found. We found that controlled drugs that had been destroyed were not disposed of safely and it was not clear in the controlled drug register why the drugs had been destroyed.

Some people required medicines in the form of a patch. This is placed on the skin to deliver a specific dose of medicine through the skin and into the bloodstream. People with patches had extra documentation to indicate where the patch had been applied. This ensured that the patch could be rotated and changed with clear instruction, to avoid skin irritation. However, the documentation was not filled in correctly for all people, which meant that patch rotation may not be taking place. One person had a controlled drug patch. However, this documentation did not match up with the controlled drug register.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the management team about medicines management. The deputy manager told us there had been some errors around administration of medicine, however said they did not understand why there had been so many. They told us, "I think staff need more support and guidance." The interim manager told us there had been some 'silly errors' made by staff such as not recording the declining balance of stock and gaps in recording. However, last week they had noted there had been no errors of gaps in recording.

Staff were given training before they are able to do a medicine round and then had competency assessments each year. A record was kept that competency assessments had been completed but not of the actual competency assessment. The interim manager was unable to provide assurances of what was covered during the assessment. Medicine training totalling eight hours was being arranged for all staff via a national pharmacy to address these issues.

The management team told us they were also piloting a 'blister pack' system in an effort to reduce the number of medicine errors. Training had been arranged for staff in order for them to be able to safely administer medicine using the blister pack system.

A monthly medicine compliance audit was completed by the management team and in October 2105 we saw some examples of where issues had been identified. For example, the medicine trolley was not always secured safely and medicine fridge not kept clean. Audits were completed and highlighted areas that required improvement and these had been made. One staff member told us, "We have a medicine champion plan for audits. They audit stocks and medicine administration records." We saw a meeting had been held in September 2015 with the medicine champions and further training and supervision had been discussed for staff involved in administering medicine.

People told us they felt safe living at the service. One person told us, "Yes I feel safe, I feel comfortable speaking to the staff." Another person told us, "I feel safe, I know it well here and it suits me to be here." Prior to staff starting at the service, the provider checked their suitability to work with people who lived there. This included contact with their previous employers and the Disclosure and Barring Service (DBS). This is a national agency that keeps records of criminal convictions. This was to minimise the risks of recruiting staff who were not suitable to support people who lived at the service. Staff told us background checks were completed before they were able to start work. One staff member told us, "Yes all my checks and training were done before I could start work." Another staff member told

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us, "I had to wait around seven weeks before starting, as I couldn't start until my references and DBS were done." We looked at three personnel files and saw checks had been completed.

Staff were made aware of their job roles when they first starting work at the service. A code of conduct was given to staff to set out expectations while at work. Alongside this, a team member's handbook was given to all new staff which covered areas such as the provider's policies and procedures. A 'buddy' system was in place for new starters and staff shadowed a person for one week before working independently, to ensure they were safe and felt confident to do this.

Staff understood how to safeguard people and they had received training about this. One staff member told us, "I did my training about six months ago. If I saw someone say, lifting someone badly, I would go to the boss, I know there is a whistleblowing policy." Another staff member explained they did the on-line training at home as they were too busy to do it at work. Another staff member told us, "I would go to the manager if I saw any abuse. I would write a statement. We do have a policy for whistle blowing." However, one staff member said that they had made a safeguarding referral themselves as they did not feel confident that their manager had followed this up and that this person was not always helpful or approachable. Staff were aware of the possible different types of abuse and gave us examples, such as errors with medicine and incidents between people who lived at the service. Staff knew actions to take to protect people, and we found safeguarding concerns were reported appropriately.

We looked at how the provider identified and managed risks associated with people's care. Records confirmed that risk assessments had been undertaken and management plans were in place to minimise risks. However, we could not be sure that people were supported with these risks as there was not enough staff to keep people safe. One staff member told us, "People have risk assessments." They gave examples of how they kept people safe, including making regular checks on people and by ensuring when moving people this was done in line with their support plans.

Risk assessments were in place for areas such as moving and handling, and nutrition. Referrals had been made to other professionals to mitigate risks including a 'tissue viability nurse' for skin problems and a falls service to seek advice to prevent a person falling.

A falls prevention policy was documented; however we could not be sure this was being followed by staff and falls reviewed regularly. For example, the policy stated: 'The assessment and plan should be evaluated every month and completely reviewed if a person has a fall'. We were aware this had not happened for one person who concerns had been raised about due the number of falls they had sustained. Some staff had been unaware of the policy. A letter had been sent to staff in October 2015 in relation to safely supporting a person after a fall, and this was directly in relation to the concerns that had been raised. One staff member told us they had previously raised some concerns about the number of falls at the service but this had been 'dismissed' by the previous management team and they were told, 'people with dementia do fall'.

Staff told us risk assessments were updated monthly by nurses and reviewed at six months. However, we saw one person had a risk assessment for their footwear as a result of trips and falls. This was not dated, so it was not clear how often this was reviewed in this instance.

A monthly falls analysis was completed for each area of the home and trends analysed. On October 2015 it had been identified that 'the majority of falls were from people who had fallen on their crash mat, having rolled out of bed'. We asked the management team who told us most of these were considered as 'controlled' incidents where people rolled onto the mats to avoid a possible fall.

One person was now having 'one to one' support from staff to reduce the number of falls they had. A relative confirmed this was working and the number of falls had reduced drastically. One staff member told us if there was a fall, "We call the nurse to check the resident and take guidance from the nurse. If there is a number of falls it gets reported to the falls team to assess the resident." They gave examples of ways they tried to reduce falls. These included, the use of crash and fall mats by the side of the bed, fastening slippers, ensuring there were no hazardous objects in people's way and picking up cushions that may have fallen on the floor.

Some checks had been undertaken to assess the safety of the service. Accidents and incidents were recorded, and these were analysed to identify any trends which may assist staff in preventing recurrences. We saw a monthly accident analysis trend tracker from October 2015 and it had been noted that less falls were now happening at night. Each person had a personal emergency evacuation

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plan which detailed their care and mobility needs in an emergency. However, we saw these had not been reviewed recently. For example, one was dated March 2014 and we were aware this person was now very unwell and receiving end of life care. Daily equipment checks took place, for example of specialist mattresses, to ensure the equipment used was safe for people.

At times, the correct equipment was not available to support people and this placed people at risk. For example, on the day of our visit the blood pressure machine was missing so the staff member had to wait for the GP to come and ask them to do this. One staff member told us, "There is no system to make sure equipment is put back centrally, or logged in and logged out. There should be, what if there is an emergency? People just pick things up and leave them all over the home, so we need a system to make sure equipment is available."

The interim manager told us two maintenance people were employed by the service and they checked areas such as legionella testing, fire alarm testing, fire drills and electrical testing. They checked areas in the home generally around health and safety and ensured the grounds remained safe. Fire equipment had been serviced recently, however not all staff we spoke with were clear about emergency or evacuation procedures. One staff member told us, "People should stand at the fire point and make sure residents are out of their rooms. The fire marshall directs. I think there is a plan in place for evacuation." Another staff member told us, "If the fire alarm goes off we stay in the local area until they see where it is. We have fire training every 6 or 3 months. Maintenance talk it through but I'm not sure of the channel we need on the radio. We need more training on it." A different staff member told us they would use blanket or duvets to possibly carry people down stairs. In an emergency we could not be sure people would be supported to evacuate the building safely and in a timely way. We discussed this with the interim manager who told us further training for staff would now be arranged.

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Our findings

This inspection was undertaken in response to concerns received about how the risks associated with people's care were managed. This included people who were at risk of falling and the management of people's medicines.

The service had been inspected by us in January 2015 and rated overall as 'good'. Since this time the registered manager and two deputy managers had left the service. At this inspection we found the new management team consisted of an interim manager, two co-ordinators, two deputy managers and three senior care staff. The interim manager and one deputy manager had been in post for two weeks. The interim manager told us, "The managers all left at the same time, there has been a period of unsettlement."

Overall people and staff were not positive about the recent management at the service. One person told us, "The management are not visible, they are not around, people are not supported." Another person told us, "There is a very 'hands off' attitude by the management." A staff member told us, "We are not very supported, sometimes when you want to say something they don't listen, what is the point." Another staff member told us, "I've had five different managers in the two years," referring to one area of the service. Staff did not feel they were listened to or valued.

The change of managers had resulted in inconsistency of leadership at the service. One relative told us their family member had been there for 6 years and in that time there had been 5 general managers and 5 co-ordinators. They said, "The care staff are excellent, you don't see enough of the manager. The one major problem is the change of management." They went on to say, "The staff are hardworking and sincere. The management can be indifferent."

Some staff and relatives told us some of the existing management team remained unapproachable. One relative told us, "The attitude, if you raise anything, is you are making a fuss." One staff member told us they felt intimidated by the previous manager and could not go to them if they had any concerns. Another staff member told us they would not raise any concerns 'higher up' to management because any response would come back through their line manager so there was 'no point'. Another relative explained that they had complained to the previous manager and they were told if you don't like it here, 'Go.'

There was not enough staff to support people at times they preferred and this placed people at risk. A high use of agency staff meant people were not supported by consistent staff they knew and this impacted on their care. Over recent months there had been a high number of falls at the service, staff had not always reviewed these falls and had not been aware of the falls prevention policy. Staff had not been supported with one to one supervision meetings or staff meetings recently so had not had the opportunity to put forward their suggestions about the running of the service. Systems were not in place to ensure equipment was available for staff at times they needed this.

Medicines were not always administered, stored or disposed of correctly. There had been a number of medicine errors and some of these related to the use of agency staff. Staff told us there was no process to ensure all staff were made aware of medicine errors, as they were dealt with by management. They felt staff needed to be given the opportunity to learn from any errors made.

Staff required training in this area and this had not been addressed by the previous manager. MAR charts were not always completely correctly, protocols were not always available for people requiring PRN medicine. Covert medicines were not always authorised correctly. We could not be sure people were safely receiving their medicine.

Despite checks being undertaken each month by the management team, several of the issues found during our inspection had not been identified and addressed as part of the provider's quality assurance process. Some actions had been undertaken to drive improvement for the benefit of people who lived at the service. However, there remained shortfalls in staffing levels, risk assessing and medicines management.

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

Some nursing staff expressed concerns about their roles and responsibilities in the service. One staff member told us, "The nurses don't hold the nursing role." They explained some care staff went straight to management with concerns previously even though nurses held the

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'responsibility' for the area of work. They went on to say about the new management team, "They are trying to correct things, I feel more confident, I know it's early days." They told us the new deputy manager was more 'hands on' and they appreciated that. Another nurse was positive about the changes introduced during the interim management arrangements and that there was a focus on improving the systems so that care planning and direction was clearer.

Overall staff were more positive since the new managers had been in post. One staff member told us, "The new manager introduced themselves, they seem very good." Another staff member told us, "Yes I feel able to raise concerns with management. The new managers' seem better." Other comments included, "There have been a lot of challenges to deal with but we have been working through them and we are getting there." One staff member told us they thought the new interim manager was brilliant, but what was disappointing was that there will be another new manager soon. Another staff member said they would like a staff meeting about their jobs to eradicate fears, as it made them concerned, when managers kept going.

The interim manager told us they were committed to the continual improvement of the service and the care people received. They had identified four key areas of concern they were currently addressing. These were staffing recruitment and retention, and they acknowledged there was a high use of agency staff. Another area was team morale, with the goal, "For staff to feel supported, be conscious of what is going in and up to date with information." They wanted care records to be up to date, and to provide further support and guidance around medicine. They had implemented a weekly nurses meeting to aid communication and consider strengths and weaknesses. They told us, "We want to know what skills people have so these can be cascaded down, find out who needs support and what they need." The interim manager told us, "I am beginning to feel I am not just a name." They went on to say, "We aim to be open, honest and transparent." They told us they had, "An open door policy" and staff were coming in to see them now. A helpline had been set up for staff to call if they had any concerns. However, the general manager told us this had not been well used and they were unclear why this was.

General staff meetings had been started by the interim manager for staff to be able to put forward their suggestions about the service provided. The management team told us they wanted to let staff know they were appreciated. A further staff meeting was being held the week of our visit and the plan was they would be held every two months now. The management team met daily themselves to discuss any issues or concerns.

Staff had not been supported with regular one to one meetings or appraisals recently; however this was now starting again. One staff member told us, "I can't remember the last time I had supervision." Another staff member told us they had not had supervision since they had completed their probation and this was over six months ago. Another staff member told us they had not had an appraisal meeting to look at their development and performance, however one of the new manager's was now arranging this. The interim manager told us, "Staff supervision has been sporadic."

A group 'supervision' meeting of senior care staff had been held in October 2015. Checking of equipment safety and medicine errors had been discussed. For example, staff had raised a concern that as senior staff they were sometimes 'disturbed' by other care staff while giving medicine, which could lead to a medicine error. It had now been agreed it was mandatory to wear a red 'tabard' to indicate they were giving medicine and should not be disturbed while doing this. Topics planned for future discussion were record keeping, medicine and roles and responsibilities.

People and staff had some opportunities to be involved in the running of the service. A monthly 'resident council meeting' had been held in September 2015 where it had been discussed that a certain food be made available and this was arranged. At this meeting comments were made that some people felt 'rushed' at meal times when being served by care staff and actions were being taken by the management team to address this.

Staff had been asked for their feedback, and a staff survey was completed in September 2015 by 137 staff. Positive comments included 'I would recommend the company as a good place to work' and 'The people I work with co-operate to get the job done.' However, areas for improvement were identified and people had raised staffing levels as one. One staff member had said, 'I work beyond what is required to help Sunrise be successful.'

During our visit, the interim manager told us the local authority had visited the previous week and they were

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hoping to provide some continued support with the issues they had identified as requiring improvement at the service. They described this as a positive visit and they looked forward to working with them.

We received a copy of the provider's action plan that they had submitted to the local authority. This identified some areas for improvement and a plan to address these, including whose responsibility this was and timescales. For example, a full audit was to be undertaken for people at medium or high risk of falls to ensure care records were up to date and an analysis of the falls was undertaken. Training for staff was to be undertaken in care planning and report writing. Staff were to be reminded of the policy around falls. An equipment inventory was to be undertaken to ensure equipment such as falls mats were in a suitable condition.

Audits of the quality and safety of the service were undertaken by the management team. However, despite these checks being undertaken each month, many of the issues found during our inspection had not been identified as part of the quality assurance process by the provider or previous management team.

The manager was able to tell us which notifications they were required to send to us so we were able to monitor any changes with the service. The provider has a legal duty to display their last inspection rating. On the day of our visit we saw the rating for the service was on display.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg 12 (1) (2) (c) (g) Care and treatment was not managed in safe way for service users. Person's providing care or treatment to service users did not have the competence and skills to do so safely. Medicines were not managed properly or safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Reg 17 (1) (2) (a) (b) 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 effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Reg 18 (1) (2) (a) Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in order to meet the requirements. Staff did not receive appropriate support and supervision as is necessary to enable them to carry out the duties they are required to perform.