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

This inspection was carried out on 11 and 16 August 2016. The service was registered to provide accommodation with care and nursing to older people and those living with dementia. At the time of our inspection there were 82 people using the service. 30 people were receiving nursing care. The service was structured into two neighbourhoods. There was an assisted living neighbourhood across two floors for people who were not living with dementia and a reminiscence neighbourhood on the top floor for those who were living with dementia. There were 22 people on the reminiscence neighbourhood and 60 people on the assisted living neighbourhood.

We previously inspected this service on 12, 13 and 14 October 2015 where we found breaches of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 and we rated the service as inadequate. The breaches of regulation related to safe care and treatment, safeguarding, good governance, staffing, consent, nutrition, person centred care and dignity and respect. The service was placed in special measures with an expectation that the necessary improvements would be made within six months. We further inspected the service on 7 and 8 March 2016 and found ongoing breaches of regulations. The ongoing breaches of regulations related to safe care and treatment, good governance, staffing, consent and person centred care. The service remained in special measures whilst we considered our enforcement powers. The registered provider told us that improvements had been made to the service and therefore we carried out this inspection. At this inspection we found that some improvements had been made, but the registered provider continued to breach the regulations relating to safe care and treatment, staffing and good governance.

At the time of the inspection there was not a registered manager in post, but the manager of the home had made an application to be registered with the Care Quality Commission (CQC). This was being processed by the Commission. A registered manager is a person who has registered with the 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. The registration process was completed shortly after the inspection visit.

At this inspection we found that whilst people spoke positively about the service, not everyone received safe care or treatment. Some people with nursing needs did not have these needs met. For example we found that people who had acquired pressure wounds had not received the appropriate treatment for these. The registered provider had not ensured that people who used a urinary catheter had this changed when required to reduce the risk of infection. Staff training had not been effective in ensuring that staff were skilled to meet people's health needs. Staff working in senior care roles had not been provided with effective training to ensure they were clear about their leadership responsibilities.

Sufficient numbers of staff were not deployed in the service each day in a way that ensured people's needs were met within an appropriate timeframe. People often had to wait for an unacceptable period of time for staff to respond when they called for assistance. The registered provider had not consistently ensured that

agency staff working in the service were suitable and able to do so safely.

People were not adequately protected from the risk of harm or abuse in the service. Some people using the service had been subject to abuse and the registered provider had not made sufficient improvements to the delivery of care to ensure that this did not occur again. Staff were not always clear about how to manage risks to people's safety and welfare. There was a lack of specific guidance for staff to follow in order to keep people safe and this meant that staff did not always provide support in a consistent way, leaving people at risk of injury. There was a lack of clear procedures for evacuating people from the building in the event of a fire or other emergency.

Staff working regularly with people knew them well and were generally caring and kind when supporting people. They were sensitive to their needs and gave them reassurance when they were anxious or distressed. However, we found that people's privacy and dignity was not always respected.

The service was not well led. The registered provider had not ensured that there was good governance of the service. There was a lack of effective systems for identifying failures in service delivery and for making improvements in a reasonable timeframe. There were ongoing breaches of regulations and the service had remained in special measures since October 2015.

The service had not always ensured that people were asked for their consent before referring to their appointed lasting power of attorney. We have made a recommendation about this.

Clear information about the service was provided to people and their relatives about the service. People were clear about the procedure for making a complaint if they needed to. We made a recommendation that the registered provider review the arrangements for involving people in reviewing their care plan to ensure they are enabled to make decisions about their care.

Improvements had been made to people's care plans to personalise them and reflect individuals' needs and preferences. However, further work was required to ensure that staff were provided with clear guidance for meeting people's needs in a personalised way, for example the specific support people living with dementia may require for finding their way around the premises. We have made a recommendation about this.

People were given the support they needed to manage their medicines safely. People told us they received their medicines on time.

People had their nutritional needs met. Significant improvements had been made to ensure that people were provided with sufficient food and drink to meet their needs. People were very satisfied with the quality and range of the meals provided. The service responded quickly to changes in people's nutritional needs.

The service had made improvements to the knowledge and skills of nursing staff in the delivery of end of life care. Following our last inspection the registered provider had decided not to admit any new people to the service that needed to receive end of life nursing care until they felt assured that improvements to the service had been made. The manager told us they were not providing end of life care for anyone at the time of the inspection.

People were supported to be as independent as possible. The service encouraged people to live active lives and to be involved in a wide range of social activities. The service was making further improvements to the way they engaged with people living with dementia to ensure they were appropriately occupied and involved in activities in the service. People were supported to engage with their local community.

The premises were clean, well maintained and safe for people to use. The design of the premises met the needs of people using the service and provided a comfortable and pleasant environment for people.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 safe.

People were not safeguarded from harm and abuse. Risks to their wellbeing were not appropriately managed and this placed people at risk of harm.

There was not a sufficient number of staff deployed in the service to ensure that people's requests for assistance were met within a reasonable timeframe.

People were given the support they needed to manage their medicines safely.

The risk of the spread of infection in the service was minimised.

Is the service effective?

Inadequate

The service was not effective.

People did not always have their health needs met. This was particularly in relation to those with nursing needs.

Staff were not appropriately skilled or supervised to carry out their roles effectively.

People were not always asked for their consent.

The premises were well maintained and met people's needs. People benefitted from a comfortable and clean environment.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always have their privacy and dignity respected.

People were supported by staff that treated them kindly and staff that worked regularly in the service knew people well.

People were encouraged and enabled to be as independent as they wished.

Improvements had been made to the skills of staff to deliver end of life care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's wishes and preferences about their care had been recorded and respected. However, further improvements were needed to ensure staff knew how to meet people's individual needs.

People were supported to take part in a range of social activities. Improvements were underway to support staff to engage positively with people living with dementia.

People knew how to make a complaint if they needed to and complaints had been investigated and responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider had not ensured that effective systems were in operation to monitor the quality of care. The monitoring systems had not identified failures in staff meeting people's assessed needs. Systems for making improvements to the quality and safety of the care and treatment people received had not always been effective and as a result some people continued to not have their health needs met.

Some improvements had been made to the service, particularly in the delivery of person centred care to people living with dementia on the reminiscence unit. The service enabled people to receive visitors and engage with their local community.

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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 carried out 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 was carried out on 11 and 16 August 2016. The first day of the inspection was unannounced. The inspection team consisted of four inspectors, a specialist nurse advisor and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The registered provider had previously completed a Provider Information Return (PIR) before our inspection in October 2015 so we did not request they did so again for this inspection. Before the inspection we looked at records that were sent to us by the registered provider and social services to inform us of any significant changes and events. We spoke with the local safeguarding team and other healthcare professionals to obtain their feedback about the service.

We looked at 13 people's care plans, risk assessments and associated records. We reviewed documentation that related to staff management and we reviewed the staff files for six agency staff. We looked at records of the systems used to monitor the safety and quality of the service, menu records and the activities programme.

We spoke with seven people who lived in the service and five people's relatives to gather their feedback. We also 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 obtained feedback about the service from five health professionals involved in people's care. We spoke with the general manager, the manager, five nurses, two neighbourhood coordinators, two senior care staff,

five care staff, one activities coordinator, and the maintenance staff.

Inadequate

Is the service safe?

Our findings

People that were able to tell us about their experience of the service told us they felt safe. One person said, "I couldn't be anywhere better, the care is good and my room is safe and comfortable." Another person said, "I feel safe here, I have a frame to help me walk and I also have a stick. There is always someone around to ask if I need help." A further person told us, "Safety is not an issue." 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.

The registered provider had not ensured that people were protected from abuse. There was a safeguarding policy in place that reflected the guidance provided by the local authority and staff understood how to recognise and report safeguarding concerns. Staff training records confirmed that their training in the safeguarding of adults was up to date. However, since January 2016 there had been five investigations into abuse in the service in which the allegations had been confirmed. One of these incidents had taken place since our last inspection in March 2016. During the first day of our inspection two healthcare professional visiting the service reported a safeguarding concern to us about a particular practice they had witnessed during their visit. The reported incident was also witnessed by the manager of the service. We spoke with the manager about the incident as soon as the professionals raised the matter with us. The manager had not made a referral to the safeguarding team at that time, but had taken action to remove the staff member involved in the incident from the service. The manager raised a safeguarding alert before the end of the inspection. During our analysis of the nursing records for a person, we found a recorded incident that required a referral to be made to the local authority safeguarding team. We made a referral immediately following our inspection.

The failure to ensure that people were protected from abuse and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

At our inspection on 12, 13 and 14 October 2015 we found that the registered provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. They had not ensured that appropriate action was taken to identify and reduce risks to people's safety and welfare. Additionally, staff did not always follow safe practice when providing care. At our inspection on 7 and 8 March 2016 we found that the registered provider continued to breach this regulation. They had not ensured that avoidable risks were identified and reduced.

At this inspection we found that improvements had been made to the management of risks relating to people who were diagnosed with diabetes. However, other risks had not been appropriately managed. Risks to individuals had been assessed as part of their care plan, but appropriate measures to reduce the risk had not always been put in place. There were a high number of unwitnessed falls reported in the service. One person had had 11 unwitnessed falls since April 2016. A risk assessment was in place, but the control measures were not sufficiently detailed to ensure the risk was reduced. The risk assessment stated that staff were to check upon the person regularly, but there was no specification about the frequency for checks. We asked two staff how frequently they should check the person. One staff member said every two hours and

one said every half an hour. The person's risk assessment instructed staff to position the person centrally in the bed to reduce the risk of falling. A staff member told us "Some nights X is more settled, sometimes he is more agitated so needs more checks. When agitated his Parkinson's also worsens and he often rolls at an angle, so when we find him rolled out at bed at an angle, that's an indication of his agitation." This information about the link between agitation and the risk of falling had not been included in the risk assessment.

Another person had had five unwitnessed falls since June 2016. Their risk assessment stated they needed to be checked frequently, but there was no guidance for staff about the required frequency. Another person had fallen and had been seen by their GP as a result. The GP had given specific instructions about monitoring oedema (a swelling) in the person's legs as this may cause difficulties with mobility. The person's care plan had not been updated to include this instruction. A senior staff member we spoke with was not aware of the GP's instruction to monitor the condition.

A person had a choking incident on 16 April 2016 which required first aid. We asked the manager what investigation had been carried out into this incident. They told us they expected a speech and language therapy referral to be made for reassessment in these situations. When we reviewed the person's records there was no evidence this had happened and no other evidence could be provided to confirm a referral had been made. However, the person was seen by a speech and language therapist when they went into hospital for a different health condition six weeks later. A risk assessment for choking was not implemented until 25 May 2016. The risk assessment was dated as reviewed in June and August 2016, but only the date was recorded and no assessment of whether the risk assessment measures were still working. Another person who had choked whilst eating had been referred to the Speech and Language Team and the advice that was given had been recorded and followed.

People who were unable to use their call bells to summon assistance had care plans that stated they needed to be checked upon regularly. However there was no guidance for staff about how often they should check each person to ensure their wellbeing. The registered provider had not explored other ways to enable people to call for assistance and there was a lack of measures to ensure people could summon assistance when needed. Where people were able to use calls bells they had access to these in their rooms and some people had been provided with a pendant or wrist band to summon for assistance if they could not reach the bell. A staff member told us that they checked on people who could not use their call bells, but there was no pattern to this unless they were being regularly checked for another need, such as the need for repositioning to reduce the risk of pressure ulcers.

A fire risk assessment had been completed and the maintenance staff tested the alarms and emergency lighting at regular intervals. Equipment had been appropriately serviced and maintained. Each person had a personal emergency evacuation plan (PEEP) for evacuating away from a fire to a safe zone in the building. However, none of the PEEP's we saw stated where the nearest safe zone was for that individual. The maintenance staff told us that the service operated a 'stay put' policy unless instructed by the emergency services to evacuate the building. The general manager advised the building was designed to be safe with the sprinkler system and designated safe zones. The disaster plan for the service and people's PEEP's showed that 18 people required the use of a wheelchair to evacuate the building in an emergency, but they did not specify how those that were accommodated on the upper floors would be enabled to exit the building without the use of the lift. There were two emergency evacuation chairs situated near the stairwells and staff told us that these would be used, however two staff told us they would not know how to safely use the evacuation chairs. One member of staff told us, "Once we had practice with the equipment, but only once. We would expect the fire service to direct any evacuation". We spoke with the local fire safety office who advised that the service must ensure that the evacuation procedures are sufficient to ensure there is

enough equipment, staff are trained in its use and that staff are not required to re-enter the building to help others. There had been no assessment of whether two evacuation chairs were sufficient for the numbers and needs of people in the service. Fire drills were carried out regularly, but this did not include testing out the evacuation plans for the service or a practice of using the equipment. The last fire drill record states that staff were slow to respond to the alarm and to get to the fire panel, but there was no record of what action was taken to improve the response time.

The registered provider had failed to ensure that appropriate and effective plans were in place to reduce risks to individuals' safety and wellbeing. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Some people using the service raised concerns that there were not enough staff to meet to their needs within a reasonable timeframe. People were particularly concerned about the length of time it took to respond when they called for assistance using their call bell. One person told us, "It takes forever to answer [the call bell] and you use it because you want someone to come. I haven't needed to use it for something urgent, but that could be a problem." Another person told us, "The care is very good and considerate and the call bell is answered promptly at night when I have needed to use it, but the lifeline in the day can take an hour if you press it before someone comes and if you want help with the toilet you want it then, not have to wait." A person's relative told us, "I do have reservations though about the call bell system if there was to be an emergency, I have told my relative that if no one comes, ring to reception but [my relative] has tried this and no one answers." Another person told us, "The staff are kind but the call bells are not answered promptly enough and we expect more for the fees that we pay." One person we spoke with felt call bell response times had improved in recent months.

The manager told us that they had an accepted timeframe of up to ten minutes to respond to call bells. They said they routinely monitored the call bell response times for the reminiscence neighbourhood, but not the two assisted living floors. We asked for a print out from the call bell system to show the response times for the assisted living floors between 3 August 2016 and 9 August 2016. We found 13 occasions where the call bells were not responded to within the expected ten minute timeframe. Two calls were not responded to within 20 minutes. Three calls had taken over 40 minutes to respond to and three had taken over one hour to respond to. However, during our inspection we saw that staff responded to people's call bells within an appropriate time.

The registered provider carried out a dependency assessment for each person using the service to establish how many hours of care and nursing they required. The rotas showed that this number of staff was employed in the service. Some people received additional funding to receive one to one support from a staff member for particular times of the day or week. The rota showed that this had been provided and the manager monitored the delivery of these hours to ensure it remained in addition to the standard staffing arrangements in the service. Where there were changes in people's needs the registered provider had supplied additional staffing until a reassessment could be carried out. In addition to the care and nursing staff there was a team of housekeeping, catering and maintenance staff. On the first day of our inspection the assisted living floors were short staffed by one care staff and they had been unable to find a replacement. The day before our inspection the registered provider had increased the number of nurses on duty to provide an additional nurse to work on the first floor. However, despite assurances from the registered provider that the staffing numbers were sufficient to meet people's needs, staff and people using the service told us that there were not enough staff working on the floors to meet people's needs in a timely way. One staff member told us, "I have two pagers and a phone to respond to. I've been assigned a list of people to get up, washed, dressed and assisted to eat. How can I also [carry out other assigned duties]? I'm falling down on that [failing to do that] because I can't know what's going on. And it's not best practice for

medicines I do one then have to do something else. I have to ring district nurses. I'm so busy with the urgent things I can't do everything else and there are not enough people to allocate to. It's very rare on my shifts we have a full staff; mornings are the main problem."

A staff member said, "Care ratios don't seem enough, although the company say they have a system for calculating." Another staff member said, "Waiting for bells to be answered is a big problem." A staff member told us, "We feel there are some residents who need more time than we can give. You notice things like nail cutting and shaving getting missed." Another staff member told us, "Weekend evenings, and some midweek, we only have one senior care to cover both floors." However, some staff members felt there were improvements in the staffing levels in the service. One staff member told us, "It's getting better. We have more staff, a 6:45 to 9:15 shift and bistro staff to circulate with fluids and make sure people in the lounge are ok." Another staff member said, "There's always time to talk with people."

We saw a recorded entry in a person's activity record by a visiting activity provider commenting that they had found it difficult to find a staff member. This stated "It took some while for me to get staff support to take X to the activity lounge; waited almost 10 minutes. Once finished, X asked to return downstairs so I pressed a call buzzer for a member of staff to help. After about 10 minutes I went around the building to find a staff to help."

The registered provider had employed more staff since our last inspection, but still relied on the use of agency staff to fill vacancies for both care and nursing staff. They had appointed agency staff to work as permanent staff on the team, but we found that some shifts were still covered by agency staff who had not been recruited to these posts and did not work regularly in the service. Staff told us that this placed additional pressure on them as they had to spend time inducting new agency staff. One staff told us, "It would be better if all nurses were permanent, a lot of the agency RNs are actually quite regular, but still don't have the same commitment." Another staff member said, "All mornings are a mad rush. Agency staff need a lot of support. Current agency staff may be consistent, but they have only been coming here four or five weeks."

The registered provider generally followed robust procedures for the recruitment of new staff to ensure that staff were of good character and fit to carry out their duties. However, on the second day of our inspection a nurse had been supplied by an agency and was working for the first time in the service without checks being made of their suitability to work. When we highlighted to the manager that no checks had been made they obtained a copy of the staff profile for the nurse from the agency to evidence their nursing registration and criminal checks. This was in place before the end of the inspection. We asked the manager how they were assured about the person's skills and qualifications to work with people and we were told the member of staff would be working as a 'med tech' only that day. This was a role for senior carers who were trained in administering medicines to people on a residential contract to relieve some time pressure on the nurses. However we found the nurse had been assigned to assess and replace dressings on people's pressure wounds that afternoon by the lead nurse on shift.

The registered provider had not ensured that sufficient numbers of suitably skilled and competent staff were available to meet the needs of people using the service. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

People told us they received the support they needed to manage their medicines. One person told us, "If you have a headache you just ask for a tablet; no problem". Another person said, "The medication side has been handled very well as we found it very confusing with warfarin tests and different medicines, so it is a great relief to us that they know what they are doing." People were supported to manage their own medicines if

they wished and had an assessment to ensure they could do this safely. A staff member told us they had completed a training course provided by the external dispensing pharmacy and were required to undergo observations of their practice before they were authorised to give medicines. People's medicines were stored appropriately and we saw staff administering medicines and accurately recording when people had taken these. Topical medicines, such as prescribed creams and barrier sprays, were applied by care staff during personal care. Care staff were responsible for signing a topical medicines chart when they had done this. We found that these records were not completed consistently. This meant nursing staff could not be sure people had received their prescribed creams. This was particularly important for those people who were prescribed creams and sprays to protect their skin from friction, incontinence or pressure damage. We recommend that the registered provider review the process for the application and recording of topical medicines.

The premises were kept clean, which minimised the risk of people acquiring an infection whilst using the service. There was a team of housekeeping staff that worked in the service seven days a week carrying out a daily and weekly cleaning schedule for all areas of the service. This included deep cleaning of bedrooms and bathrooms and steam cleaning of carpets and furnishings. The service was free from any unpleasant odours at the time of our inspection. The service held a policy on infection control and practice that followed Department of Health guidelines and helped minimise risk from infection. The head of housekeeping was the infection control champion for the service and attended monthly networking meetings with other services to share good practice. All staff we spoke with understood infection control practice concerning the environment and the importance of effective handwashing in reducing the risk of infection. Staff understood and followed safe procedures for managing soiled laundry and clinical waste and used personal protective equipment when needed.

The premises were well maintained to ensure they were safe and comfortable for people to live in. People's bedrooms were spacious to allow them to move around safely. Equipment needed for people's care and treatment was maintained in good order and had been checked and serviced at appropriate intervals to make sure it was safe to use. Maintenance staff tested the temperature of the water from various outlets each week to ensure people were not at risk of water that was too hot. There was a system in place to identify any repairs needed and action was taken to complete these within a reasonable timescale. Maintenance staff completed a weekly health and safety check of the premises and took action to address areas that required repair or improvement.

Inadequate

Is the service effective?

Our findings

People told us that the staff that were employed to work permanently in the service worked hard and understood how to meet their needs and had the skills to do so. One person told us, "I am confined to a wheelchair and I do need help with everything including the hoist. I have never felt uncomfortable with this as the staff know what they are doing." Another person said, "The staff are very good and the care is excellent, there is more nursing cover now." However, many people expressed concern about the number of agency staff working in the service and the impact this had on their care. One person told us, "The staff are kind and know me, but I have to explain to some of the agency staff what I need help with and there have been a lot of these lately, sometimes I find them hard to understand." Another person said, "I sometimes have to explain to the agency staff what I need and sometimes I don't understand them." A healthcare professional involved in providing care for people in the service told us, "We have always struggled to get continuity for [a service user]. A continual supply of agency staff isn't going to work."

Some people told us that the staff were skilled in meeting their health needs. One person said that hospital appointments and GP appointments had been made for them and they felt that everything was being done to meet their health needs. However, a person's relative told us that they did not feel the service met their relative's health needs. They told us, "He is often in pain and they said they will reposition him every two hours [to relieve pressure], but I haven't seen it happen consistently. I am not happy with the care we are getting." A health care professional told us "We've been trying to resolve this for years [a person's pressure wounds] and we still aren't there. There are still issues with pressure sores." The health care professional told us this was despite frequent guidance on repositioning being provided to staff.

At our inspection on 12, 13 and 14 October 2015 we found that the registered provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. They had not ensured that people received the care they needed to prevent and treat pressure wounds. At our inspection on 7 and 8 March 2016 we found that the registered provider continued to breach this regulation. The manager told us at the last inspection that 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.

At this inspection we found that the required improvements had not been made and people who had pressure wounds did not receive the care and treatment their care plan said they needed. The manager told us there were five people with pressure wounds at the time of our inspection. Some people had more than one wound. We looked at the wound care arrangements for four people. We found they had not had their wound dressings changed or their wounds cleaned and reassessed at the frequency specified in their care plan. The care plan for one person's pressure wound, written 5 May 2016, required that the dressing be changed every one to two days. The nurses' records showed the dressing had not been changed at the frequency stated in the care plan, including one period of 25 days where the dressing was not changed. Another person's care plan for a pressure wound, written 9 June 2016, required that the dressing be changed every two days. The nurses' records showed the dressing had not been changed every two days on several occasions including one period where the dressing was not changed for five days. We asked the nurse in charge why the dressings had not always been changed according to the plan and we were told

that they were not aware of any reason for this. The person's wound care record also stated the dressings recommended by the Tissue Viability nurse and detailed in the care plan could not be applied on 16 and 19 June 2016 as there was none of the dressings in the service. the nurse told us these had not been ordered.

Another person's care plan for a pressure wound, written 25 May 2016, required that the dressing be changed every two to three days. The nurses' records showed the dressing had not been changed at the frequency stated in the care plan. Another pressure wound required dressing each day, but had not been changed daily throughout August 2016. This person also had wounds to both heels that were not recorded on the nurses' white board in the office to ensure that all nursing staff knew when the dressings needed changing. There were care plans in place for both wounds that stated the wounds should be re-dressed every two to three days. The records showed that neither wound had been redressed since 15 July 2016. We spoke with the nurse in charge who was unaware of the wounds to heels. They undertook to review all the person's pressure wounds that afternoon and ensure that care plans were up to date.

Another person's care plan for a pressure wound, dated 21 April 2016, required the dressing to be changed every day. The nurses' records showed that between the 20 May 2016 and 5 July 2016 the dressing had only been changed nine times rather than daily. The plan had then been reviewed by a nurse and the frequency of re-dressing changed to every four days. The records showed that the dressing had not been changed between 13 July 2016 and 24 July 2016 or between 28 July and 12 August 2016. The nurse in charge told us that a photograph of the wound should be taken every one to two months. We were only able to find one photograph and the nurse was unable to find any other evidence of photographic wound monitoring. The nurse told us the person's wound dressing should be changed every four days and was due to be changed that day. Another nurse told us the person's dressing should be changed weekly. The white board in the nurses' office stated the dressing required changing the previous day, but this had not happened, which was not consistent with the care plan. There was inconsistency in the understanding of nursing staff regarding the person's care plan for wound care. The person's wound assessments identified them as being at high risk of developing pressure wounds, but they did not have a care plan in place for regular repositioning to relieve pressure. We checked this with two care staff who confirmed this was not in place. This meant that they may be at risk of further pressure wounds.

The registered provider had not ensured that appropriate action was taken to reduce the risk of people developing pressure wounds. One person was identified as being at risk of developing pressure wounds and required repositioning at regular intervals in a care plan dated 21 June 2016. This care plan had not been followed and nursing staff were not able to demonstrate that the person had been repositioned frequently to relieve pressure. The person developed a pressure wound on 10 August 2016, but a repositioning plan was not implemented until 16 August 2016. On 16 August 2016 a nurse told us they had "Just started turning charts yesterday" however there was no evidence of a repositioning chart or review of the care plan before the 16 August 2016. The person's records showed that the wound had further developed and was assessed as a 'grade three' wound on 16 August 2016. Another person's wound assessment noted that there was no need for further dressing to the area as the wound was healing, but instructed nurses to monitor the area. No photograph of the wound or measurements had been taken to allow nurses to carry out this monitoring. A person who required a pressure relieving mattress did not have a record to show that checks had been made to ensure the setting of the mattress was correct for their weight. Staff told us "Although the air mattress is checked daily, we don't record that. Due to [the person's] weight, the setting will be 50." We found that the mattress was set at 60 on the 11th August 2016. This left the person at risk of further pressure damage.

A person's care plan stated that nursing staff must take a photo of the person's pressure wound at least once a week for monitoring. No photograph had been taken between 30 May and 18 June, the 18 June and 3

July, the 3 July and 15 July or the 15 July and the 13 August 2016. We asked the nurse in charge why no there had been no weekly photo taken and they told us that some nurses did not know how to operate the camera or to print out the photos. We asked if there were any other photos to show the monitoring of the wound, but the nurse was unable to provide these. The person's plan said they required repositioning to sit at a 30 degree tilt in their bed every two hours. The records of repositioning were incomplete and did not show that this had happened. This meant that nursing staff could not be sure that the required preventative action was being carried out. The person's care plan recorded that they needed two prescribed topical creams to be applied daily to protect their skin from further breakdown. The topical medicines chart was not consistently completed and did not show this had been applied with the frequency prescribed. A nurse told us they were concerned that wound was not healing.

We also found at this inspection that people had not received the care they needed to manage their urinary catheter. One person had a urinary catheter and a care plan that stated it should be changed every 12 weeks. The last recorded change was 6 May 2015 and an entry in the diary had been made for 30 July 2016 for the catheter to be changed again. A visiting health care professional raised concern with us on 11 August 2016 that the person's catheter tubing was black and they suspected an infection. We raised this with the manager who looked into the matter and confirmed that the catheter had not been changed on 30 July 2016 as required. The records showed that a nurse had identified on 10 August 2016 that the person may have an infection and that the catheter was overdue for a change. They had faxed the GP for advice on changing the catheter. The visiting health care professional advised the nurse in charge to contact the GP to discuss the need for antibiotic treatment for the possible infection. A urine test showed an infection was present and antibiotics were prescribed. Nursing staff changed the person's catheter on 11 August 2016 during our inspection. No action had been taken between 30 July and 10 August 2016 to change the person's catheter which meant the manager could not be sure that the failure to change the catheter had not contributed to the infection. The manager told us that the catheter site should be cleaned and the urine bags changed weekly. We asked to see evidence that this had happened, but there were no records in place to show this care had been provided.

Following the first day of our inspection the manager instructed nursing staff to check the catheters of other people in the service. When we visited again on 16 August 2016 we found that another person had their catheter changed on 12 August 2016, following our first visit, but prior to that had not had this changed since 15 February 2016. The person's care plan stated that they required their catheter to be changed every 12 weeks. On 23 July 2016 the nursing notes state that a paramedic ambulance was called as the person was in 'excruciating pain'. A doctor diagnosed a urinary tract infection that same day and prescribed antibiotic treatment.

Another person had a care plan for their catheter which stated they needed this changed every 12 weeks. It had last been changed on 11 June 2016. We asked nursing staff what the system was for ensuring how all nurses knew when the catheter was next due to be changed. We were told it would be recorded in the diary; however this had not been added to the diary for this person. The nurse was unable to find this information recorded anywhere.

The registered provider had failed to ensure that staff followed care plans to ensure that people received the care and treatment they needed. This is a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

At our inspection on 12, 13 and 14 October 2015 we found that the registered provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. They had not ensured that staff were suitably skilled and competent to meet people's needs. Staff did not always have the

appropriate knowledge, support and training to ensure they delivered care and treatment to people safely and effectively. At our inspection on 7 and 8 March 2016 we found that the registered provider continued to breach this regulation.

At this inspection we found that the registered provider continued to breach this regulation. Some improvements had been made as staff had been provided with further training, particularly nursing staff, in meeting people's needs. The service had ensured that the majority of staff had completed training in safeguarding, safe moving and handling, equality and diversity, infection control and dementia care. Nursing staff had been provided with additional training in end of life care, syringe drivers (a device that allows medicines to be administered continuously over 24 hours) and wound prevention and management. The manager told us that all nurses had either attended or were scheduled to attend an external Royal College of Nursing accredited clinical skills workshop in the next few weeks. Nursing staff told us they felt supported by the registered provider's training provision. One nurse said, "All the nurses here have had masses of training." Another told us, "There was a lot to improve. There have been huge improvements. As nurses we've had lots of training, pressure ulcer prevention, syringe drivers, wound care. The team has become more stable." However, we found that the training provided to nursing staff had not been effective and had not ensured that nursing staff were skilled and competent to provide appropriate wound care to people. Nursing staff had also not demonstrated competence in providing safe and effective care to people in managing urinary catheters.

Some staff felt that sufficient training had not been provided to senior staff who were now required to take on more duties, such as care planning and the 'med tec' role. A nurse told us "The care staff aren't fully trained up. They [the registered provider] should have trained the senior care staff before they split the roles between them and us. I train them when I can, but I tend to just do what needs doing. The 'med tec' role makes a great difference, but they are also on the floor and can't just get on with the medicines round, let alone have time to be shown things." Another nurse told us, "We're responsible for the senior care staff. They need to learn more about care planning. We have to do the training, I don't know where the company is in their formal training." A senior carer told us, "I'm expected to do care planning, but I don't know what to do. I should have training, or at least someone to show me."

Staff that worked permanently in the service told us, and records showed, that their induction included at least three days shadowing a more experienced member of staff before working unsupervised. All staff had attended a supervision meeting with their line manager and nursing staff were responsible for the supervision of care staff during each shift. However, we found that agency staff were not always appropriately supervised to ensure their competence before they worked unsupervised in the service. Agency staff that had been recruited to work regularly in the service had completed an induction, but some agency staff that were not familiar with the service were still being used and they did not always have an induction before starting work. On our first day of inspection an agency staff was on shift and it was their second day working in the service. They were working unsupervised in the lounge area and they did not know people's names. They told us it was a struggle as they did not know people's needs and there was no available staff to guide them in their role. On the second day of our inspection a new agency nurse worked the afternoon shift. They were shown around by another nurse and then asked to work unsupervised to change people's wound dressings and re-assess the wounds. At this time the registered provider did not have evidence from the agency of the nurse's registration status or qualification to carry out this task.

The registered provider had not ensured that staff were skilled and competent to carry out their roles. This is a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Staff were encouraged to gain qualifications relevant to their roles and their personal development objectives. New staff completed the Care Certificate as part of their induction. The Care Certificate was introduced in April 2015. It is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care homes are expected to uphold. A staff member told us they had meetings at four and 12 weeks to discuss their progress and to support them to complete the Care Certificate. Staff in care roles had been enabled to complete National Vocational Qualifications (NVQ) and Diplomas in health and social care.

At our inspection on 12, 13 and 14 October 2015 we found that the registered provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. They had not ensured that staff acted in accordance with the requirements of the Mental Capacity Act 2005. At our inspection on 7 and 8 March 2016 we found that the registered provider continued to breach this regulation. At this inspection we found improvements had been made. Staff were trained in the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff we spoke with were able to describe the main principles of the legislation. Where a mental capacity assessment showed that a person did not have the mental capacity to make certain decisions, meetings were held with appropriate parties to decide the best way forward in their best interests. A best interest decision had been made for person to move to the reminiscence neighbourhood. Consent was sought before care was provided and most people were supported to make their own decisions about their care and treatment. However, we found that four people, who had an appointed lasting power of attorney (LPA) for care and welfare, had not always been asked to give their consent. The LPA had been asked to sign all consent forms without an assessment of the person's mental capacity being carried out first to check whether they could make that particular decision. This meant that people may have been deprived of their right to make their own decisions before going to the LPA to obtain their consent. We recommend that the registered provider review the arrangements for seeking consent from LPA's to ensure people have the opportunity to make their own decision first.

People's right to liberty was promoted and staff understood and followed legislation and safeguards in place in relation to this. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to go out unaccompanied. The registered provider had considered the least restrictive options for each individual. Staff were aware of the people that were subject to DoLS restrictions and any conditions to the authorisation.

At our inspection on 7 and 8 March 2016 we found that the registered provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. They had not ensured that people were provided with nutrition and hydration appropriate to their needs. At this inspection we found that significant improvements had been made. People were extremely positive about the meals provided and the range and quality of the food. One person told us, "I like the food here it is fresh and hot and a good choice" and another said, "It is like a first class hotel, I never thought a home would be like this." Another person told us, "There is plenty of it and there is always fresh fruit around if you want it."

People's dietary needs and preferences were met. They were provided with a varied diet and were enabled to choose what they ate and drank. Since our last inspection hydration and snack stations had been placed on each floor to enable people to help themselves to drinks and snacks whenever they wished. This included juice, fresh fruit and packets of biscuits. This had been particularly successful in the reminiscence neighbourhood where some people living with dementia were unable to ask for snacks and drinks. Those at risk of dehydration were encouraged to drink at regular intervals and people were given the support and time they needed to enjoy their meals. When one person refused their meal the staff member asked another staff member to try providing the support which resulted in the person enjoying their meal. People told us they enjoyed the mealtime experience. Wine and juices were offered throughout the meal time. People were able to use the bistro at any time and this was staffed between 8am-5pm to provide hot drinks and homemade snacks.

Staff understood how to monitor and respond if people had significant changes in their nutritional wellbeing or their weight. Staff told us "The food here is phenomenal and the kitchen supplies really high calorie fortified drinks when asked. The GP sees our fortified milk shakes as preferable to prescribed supplements." Where people had lost weight staff had responded quickly to reassess their needs and provide a supplemented diet if needed. A diet board in the reminiscence neighbourhood had laminated sheets for each person showing the degree of nutritional risk and a summary of their dietary requirements and support needs.

The service was designed and decorated to meet people's needs and suit their tastes. People had a choice of communal areas where they could spend their time. In the assisted living neighbourhood there were two lounges and a large dining room and bistro on the ground floor. There was also a smaller quiet lounge that was used by people when they received visitors. The ground floor lounge was spacious and had comfortable armchairs and a large screen television. There were newspapers on tables in both the lounge and the bistro, with a selection of books and DVDs. The lounge on the second floor was also spacious with comfortable armchairs and was mainly used as an activity lounge with music playing and a range of activities and crafts available.

The reminiscence neighbourhood had been updated since our last inspection to provide new carpet and lighting to better meet the visual needs of people living with dementia. The main lounge was comfortable and homely and people were encouraged to make choices of where they wanted to sit and what they wanted around them. There was a separate dining room with tea and coffee making facilities, plus a conservatory. People were able to access a balcony garden area where there were sunhats, garden tools and pots provided for people to use. There were objects of interest around for people to look at our engage with, such as musical instruments, a dressing area with clothing and an old fashioned dressing table. There was an old fashioned desk set up at the end of a corridor, with associated accessories. People had pictures next to their bedroom doors to help them recognise their own bedroom. There were some signs around the reminiscence neighbourhood to help people find their way around. The dementia lead for the service told us that this was an area they were continuing to develop.

All bedrooms were single and had either private en-suite facilities or a bathroom they shared with one neighbour. Couples were enabled to share a larger suite if they wished. People's bedrooms were well furnished and had been personalised with their belongings. The main gardens were accessible from the ground floor and were suitable for people using wheelchairs. People said they enjoyed going out into the gardens. We saw that people were able to move around with ease through the premises and the gardens.

Requires Improvement

Is the service caring?

Our findings

People told us they found the staff to be caring and kind. One person told us, "This is a very large home and it is not easy for the care staff, but they are caring, aware and efficient." Another person said, "The care here is very good, it is kind and considerate" and a further person said, "I am very happy here the care is wonderful." People told us that the atmosphere in the service was relaxed and comfortable. One person said, "It is a nice place to be and I have made friends so I have people to talk to". A person's relative said, "It is a nice relaxed atmosphere here and we can visit any time we want to." Another person's relative said, "My relative loves it here, it's nothing like a home just a really pleasant and relaxed place to be." People and their relatives told us that there was a buddy system to help them settle in when they first moved to the service. One person told us, "I think the buddy system when someone comes here is very good. This is a large home and it is very daunting if someone has lived alone, it could be very confusing and scary."

People's privacy was not consistently respected in the service. On both days of our inspection we saw that the handover meeting between shifts took place in the activities lounge where people using the service were present. There was discussion about people's health and care needs and their wellbeing. This did not respect people's privacy or protect their dignity. During the handover the neighbourhood coordinator directed staff to use the office, however the office space was not big enough for all the staff who needed to attend and some had to stand or sit on the floor. An assessment in one person's care file stated they may go into other people's rooms and rummage through their belongings. Records showed this had happened twice during August 2016, however there was no plan in place for reducing the risk of this happening again or how to respond when it happened to protect the privacy of other people.

People did not always have their dignity preserved. We found that one person's continence care plan said they required support to use toilet facilities regularly, but there was no guidance for staff on how often they should provide this support. Records of the care provided were incomplete and did not demonstrate that regular opportunities to use the toilet facilities were offered. Entries were seen in the records that showed the person had been found to be in very soiled clothing. For example, on one day the record stated the person was helped to use toilet facilities at 7.30am and there were then no entries until 12pm when it was reported the person was found to have been very wet with urine. A record for another date showed personal care was given at 7.30am with no further record of support to manage their continence until 4pm when they had been found to be soiled with faeces and very wet with urine.

The registered provider had not ensured that people were treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

People's care records were kept securely to maintain confidentiality of their personal information. People were supported to maintain contact with their family and friends and develop new relationships as they wished to. There were lots of opportunities for people to socialise and meet new people within the service. People could receive visitors when they wished and could see them privately in their own rooms or the visitors lounge.

People's spiritual and cultural needs were met. People were supported to practice their religion and were enabled to attend religious services if they wished. The service celebrated people's birthday and key calendar events. It was a person's birthday during our inspection. Staff had put up birthday decorations and cards and sang happy birthday to the person.

Staff encouraged people to do as much as possible for themselves. People told us they were supported to be independent. One person said, "I do have some independence, although I do need some personal care." Another person said, "I am still very independent and able to walk around the garden unaided, I am comfortable with this as there are always people around to help you if you need it." People's care plans reflected where they could do things for themselves and where they required support. This was an area that could be further developed to ensure that people were enabled to develop new skills. The dementia lead for the service described plans that were in place to support staff to recognise opportunities where people could be engaged in activities that promoted their independence.

At our inspection on 7 and 8 March 2016 we found that the registered provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. They were not providing person centred care that reflected the wishes of people who were receiving care at the end of their life. Following our inspection the registered provider had decided not to admit any new people to the service that needed to receive end of life nursing care until they felt assured that improvements to the service had been made. The manager told us they were not providing end of life care for anyone at the time of the inspection. Nursing staff had completed training in end of life care and the use of syringe drivers for pain relief. Some people had an anticipatory care plan in place ready to provide medicines and pain relief should their condition change to require end of life care.

Staff working regularly in the service knew people well and knew what was important to them. This included agency staff that worked regularly with people. During the inspection we saw that staff knew what people liked to talk about and tailored their conversations to people's individual interests. Staff were talking with people about the Olympics whilst it was on the television and other staff were dancing with people. With the exception of one incident which was reported to the safeguarding team on the first day of the inspection we found staff to be kind and patient when supporting people. A person appeared to be distressed trying to find a towel and a member of the housekeeping team spoke with the person in a kind a caring manner and gave them the opportunity to choose what colour towel they would like. One person approached the nurse during medicines round and asked to have a chat. The nurse replied in a caring and warm manner saying, "Is it all right if I come and visit you in your room after I give out medication." We saw that the nurse made sure they went back to speak with the person after they had finished their task.

People had been involved in the assessment of their needs and, where they were able, had signed to agree their care plan. Records showed that most people were involved in reviewing their care plan, however a nurse told us "We should visit the resident as part of it [reviewing the care plan] but there's no time. Care staff could do it if they were trained, but most don't have computer access." We recommend that the registered provider reviews the arrangements for involving people in reviewing their care plan to ensure they are enabled to make decisions about their care.

Clear information about the service was provided to people and their relatives. A brochure was given to people who wished to move into the service, to help them make their decision. There was a clear complaints procedure which was made available to people and was displayed in the entrance hall. A designated care staff board had been developed since our last inspection. This was displayed in the entrance of each neighbourhood so that relatives would know who to speak with about the care of their relative each time they visited.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that the staff listened to them and took account of their preferences when providing their care. They told us that the routines of the service were flexible to allow them to live their life the way they preferred. One person told us, "I am very happy here, I have everything I need and I can do what I want to do." Another person said, "I am able to get up early and come down before breakfast and go to bed when I choose." A person's relative told us, "I am happy with the care here, she settled in very well." People told us that residents' meetings were held regularly with discussions on staffing, catering and activities taking place. One person said, "Anyone can come along, but there are usually only a few of us." People were complimentary about the range of activities provided and felt there was enough to do to keep them occupied.

People's plans did not always meet their individual needs. For example, an assessment of the specific needs for people living with dementia had been completed, but this had not yet been used to formulate the care plan. One person's assessment contained information about what helped them to become calm if they were anxious, but this had not been added to their care plan. A person's care plan noted they often became anxious and had short term memory loss. The plan instructed staff to be aware of the triggers for their anxiety, but there was no information recorded about what the triggers were. Another person's care plan for having a bath noted that they could become anxious, but there was no guidance for staff on how to reduce the risk of anxiety for them nor how to respond if this occurred. One person's assessment stated they needed assistance to find their way around the reminiscence neighbourhood and the care staff were to orientate them. There was no care plan in place for this or guidance for staff about how to do this. We recommend that people's care plans be developed to ensure staff know how to respond to all their assessed needs.

Further improvements were planned to support staff to engage with people in a personalised way. Staff had been provided with more training in supporting people living with dementia and a team of specialist advisors had visited the service to carry out an audit of how dementia friendly the neighbourhood was. An action plan for improvements had been developed, which included the introduction of a 'live with purpose' activity model. This was to include personalised rummage boxes, opportunities to be involved in household tasks and the development of life story books. The action plan was in the early stages of implementation. We recommend that the improvements be delivered and monitored to ensure that personalised care is delivered consistently.

Some improvement's had been made to the planning and delivery of care to meet people's needs in a more personalised way. People's care plans had been developed to contain more personalised information about them and their needs. They had been asked how often they preferred to bathe or shower, what their preferences were at night and any items of comfort they liked to have with them. The plans recorded whether the person wore glasses or hearing aids, their preferred daily routine and their preference of food and drink. We saw that people had been asked about what was important to them during the assessment of their needs. This included important family and friends and how they would like to be supported to stay in touch with them. People's requests for male or female staff had been recorded on their care plan and, where

possible, their wishes had been respected. We saw that staff asked people how they wished to spend their time during the day and helped them to move to where they wished to be. Staff asked people what help they needed and responded to their requests. Staff described the work they had done with a person who was anxious and banged their cup on the dining table. They had offered an alternative place to sit which had made the person more settled. Staff had shared the positive results in a handover and implemented this method in daily practice. The care plans contained hand-written notes that showed the plans were regularly reviewed and amended. Staff told us they revisited the plans when there was a change in need to ensure they were aware of any changes to the person's care or routine. Each staff member was issued with a daily assignment sheet at the beginning of each shift. This contained key information about the needs of each person they would be caring for that day.

The programme of social activities provided in the service had been further developed since our last inspection. There was a team of four activity workers and the registered provider was in the process of recruiting an activity coordinator. A programme of activities for the month was displayed in the service and people were issued with a list of the available activities each day by the concierge team. Group activities provided in the service included, word games, general knowledge and music quizzes, crosswords, arts and crafts and bowls. There was a weekly music for health session, a jazz appreciation group, a poetry group and a cookery club. Regular film nights and musical entertainment were arranged. There was a library of books for people to use and newspapers were provided daily. Colouring and doodling sheets with pens were available for people to pick up as they wished. In the reminiscence neighbourhood there was a nursery with a crib and baby dolls so that people living with dementia could care for them to meet some of their emotional needs. There were computers available for people to use and an external group visited regularly to help people learn IT skills. People were able to go out on organised trips, for example on the first day of the inspection a group of people were going to a Llama park. Other trips planned for the month of August included visits to various local supermarkets, a local airport for coffee, tea shops, managed gardens and buildings of interest.

Activity staff knew people well and knew information about their backgrounds to help them when providing activities. Activity staff told us that they visited people who liked to remain in their bedrooms at least once a day to chat with them or provide one to one activities. A travelling shop provided personal care items and newsagent items to people who were not able to go out on one of the shopping trips.

People knew how to make a complaint if they needed to. Some people did not feel that complaints had been managed effectively. One person told us they had been kept waiting for some time before they were able to speak with the manager to raise an issue and then had not received an apology. Another person told us they had used the complaints procedure, but said that the management team were slow to respond. The person said, "I expect more when these fees are being paid." However, we reviewed the records relating to complaints and found that complaints had been investigated appropriately and a response given to the complainant. Detailed information about how to complain was provided for people in the brochure, in the reception area and on the notice boards in the main areas of the home.

People had an opportunity to give their feedback about the quality of the service through the residents and relatives' meetings. Minutes showed that the meetings were held regularly and took account of all areas of service delivery. The registered provider had met with relatives and written to all relatives and people using the service following our last inspection to discuss inspection rating and their plans for improvement. Larger meetings across all Sunrise services in the region were also held and a representative from the people living at Sunrise Sevenoaks attended and spoke on people's behalf. People and their relatives were invited to complete an annual satisfaction survey. This was managed by an independent company who collated the results and produced a report for action which was given to the registered provider. The survey for 2016 was

underway at the time of the inspection.

Inadequate

Is the service well-led?

Our findings

People told us they had seen improvements in the service with the appointment of the new management team. One person told us, "There have been lots of improvements, there is more nursing cover and although the care was good before it is excellent now." Another person said, "The general manager has made huge improvements, the communication is better and they listen." Another person said, "Things have improved since the general manager started; he's quite firm and earning people's respect." However we found that the service continued to fail to ensure that effective systems were in operation for monitoring and improving the delivery of safe and effective care.

At our inspection on 12, 13 and 14 October 2015 we found that the registered provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. They had not ensured that effective systems were in operation to monitor and improve the quality and safety of the service. At our inspection on 7 and 8 March 2016 we found that the registered provider continued to breach this regulation.

At this inspection we found that the registered provider had continued to fail to ensure that effective systems were in place to monitor whether people received the care and treatment they needed. The quality monitoring systems for the service had failed to identify where there had been a failure to meet people's needs. This was particularly in relation to people's nursing needs and we found that clinical governance systems were not effective. The clinical governance systems in operation in the service had not ensured that people had their wound dressings and catheters changed in accordance with their care plan. The registered provider had not ensured that there was adequate overview and supervision of nursing staff to ensure that basic nursing needs were met.

There was not an effective system in place for identifying trends in people falling in the service. On a monthly basis, incidents and accidents, including falls, were transferred onto quality of care indictors on the computer system which recorded rates of infections, pressure damage, falls and weight loss. Whilst the number of falls was being monitored there had been no analysis of the times or locations of falls to identify if there were trends and risks that could be reduced. There was a monthly clinical governance meeting to discuss incidents and accidents; however this had not taken place in July 2016. The clinical governance meeting held in May 2016 identified that falls analysis was not taking place and needed to be implemented. This had not yet begun and the manager said a new computer system for monitoring accidents and incidents was being launched in August 2016 that would address this. The registered provider had not ensured that a system was put in place to carry out this analysis whilst waiting for the new computer system. The manager advised that care plans have individual falls logs and monthly falls analysis which should be completed, however we found this was not in place for three people who were falling frequently. The quality indicators reflected that on all floors a large number of people were being found on the floor having had an unwitnessed fall. The falls prevention and management policy in place, dated April 2016, stated that after a fall the falls risk assessment should be updated. Records showed that this had not happened consistently. Records, for the purpose of monitoring the care delivered to people had not been consistently maintained. We found that charts had not always been completed for the application of topical medicines. The manager

said the completion of charts was checked at each handover, however we found this system had not been effective.

The registered provider had not ensured that sufficient improvements had been made to the service as a result of the findings of safeguarding investigations into neglect to ensure that neglect did not occur again. An improvement plan had not been developed at the time of the inspection to identify and implement any lesson learned from the investigations and outcomes. At this inspection we found evidence that some areas of people's nursing needs continued to be neglected. The registered provider had not monitored the response times to call bells on the assisted living neighbourhood and as such had not identified that some response times to call bells were unacceptable and placed people at risk of harm or compromised their dignity.

The service worked with a range of multi-disciplinary partners including the local authority, safeguarding teams and NHS services including GP surgeries, physiotherapists, district nurses, tissue viability, speech and language therapy and occupational therapy. We received some feedback from health care professionals that the service did not always work jointly with them to meet people's needs. One professional told us that recommendations they made about a person's care were not always carried out. Another professional told us that when they visited the service they always found it hard to find a nurse to speak with about people's care. However, one nurse working in the service said "We are really lucky with our GP, we have a weekly GP round, great support from tissue viability nurses and podiatry, and the hospice team are just the best. We get support about degenerative diseases as well as end of life."

The service had a set of vision and values that included enabling freedom of choice, preserving dignity and encouraging independence. Staff told us that they worked to this set of values, which they told us respected people as individuals and ensured personalised care. A staff member told us that, "The home is about enabling people to have quality of life and being in charge of their own lives as far as possible." Whilst we found that the service demonstrated they delivered these values for some people using the service, we found that not everyone had the same experience. Those with nursing needs did not always receive a service that met their needs and ensured they retained their dignity. The registered provider had not always ensured that people were safe from harm in the service.

There had been a number of changes in the management of the service since our last inspection. This included a new general manager, who oversaw the delivery of all aspects of the service including catering and the premises, and the new manager who was responsible for the delivery of care and nursing. New coordinators had been appointed to each neighbourhood and had started work. We found some improvements had been made to the overview and governance of the service, particularly in the delivery of care in the reminiscence neighbourhood. However we found that staff were still not always clear about their delegated responsibilities. One staff member told us, "It's hard working out who is responsible for what. I've been bringing it up in team leader meetings." Another staff said, "Handovers are good, but less so if conducted by an agency night duty nurse. We are held back by the lack of proper room for handovers and not really enough time at the morning handover." A nurse said need more clinical meetings were needed. They told us, "The meetings are good regarding residential issues; it's clinical issues needing more, although the manager is really supportive on an as needed basis." There was a lack of effective systems in place to ensure that information about people's needs was handed over at the end of each shift. For example, information about when catheters and wound dressings required changing had not been effectively handed over to ensure this was carried out.

The registered provider had failed to ensure that effective systems were operated to monitor the delivery of care, identify any failures in service provision and make necessary improvements. This meant that people

did not always receive the care they needed and risks to effective service delivery were not always identified. This is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

There was not a registered manager in post on the day of the inspection. However, an application had been made by the manager who had day to day responsibility for the running of the service. This had been received by the Commission and the application was processed and the manager was successfully registered at the time of issuing this inspection report.

Staff were positive about the culture of the working environment and the support they received from the manager and unit managers. One staff member said, "We are listened to and there is more support for staff now. I enjoy working here." Another said there was "good communications both ways." A nurse told us, "Whatever we need regarding equipment and supplies we get, and it's quickly and good quality. We don't want for anything." One staff member said "It has improved, teamwork is getting there and as we are losing agency and gaining our own staff it's getting there." Staff saw the introduction of the unit manager as very positive, they said the person brought, "more visible management and supervision, all together better organised. They put an emphasis on person centred care and developed better team cohesion, which has led to more permanent staff. They've got the ethos right." Staff told us they felt involved in the development and running of the service. They told us about listening groups held by the general manager and confirmed that they found these useful. All staff had completed training in whistle blowing and knew how to report concerns about people's care and safe practice. Staff told us they felt they would be listened to if they raised concerns.

The registered provider was aware of updates in legislation that affected the service and communicated these to staff effectively. The service's policies were appropriate and clear for staff to follow when they needed to refer to them. The registered provider had met the requirement to notify the Care Quality Commission of any significant events that affected people or the service.

The service had developed an improvement plan for the service which included retraining nursing staff. The improvement plan had resulted in some improvements in service delivery, particularly in relation to the reminiscence neighbourhood. Specialist dementia audits by external auditors had been carried out. Improvements were underway including the development of appropriate engagement for people such as household tasks. Signage to help people find their way around was being added to the reminiscence neighbourhood and life history work was underway. The registered provider had developed conversation starter prompt sheets for each person with key information about things that may be interested in talking with staff about. These were being printed at the time of the inspection. One person said they had been involved with the recruitment of new staff which had been one of the improvements under the new management. The service was creative in the way they provided opportunities for people to socialise with each other and with people who visited them. The bistro provided a focal point for people to meet in, have a coffee and offer their guests snacks. The service also provided a private dining room that allowed people to host their own private dinner parties. This supported people's right to develop and retain relationships with people outside the Sunrise community. However, sufficient improvements had not been made to ensure that safe and effective care was provided consistently across the nursing and personal care aspects of the service delivery.

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 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 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had not ensured that people were treated with dignity and respect. Regulation 10(1)

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 registered provider had not ensured that sufficient numbers of suitably skilled and competent staff were available to meet the needs of people using the service. The registered provider had not ensured that staff were skilled and competent to carry out their roles. Regulation 18(1)(2)