Sunrise Senior Living Limited

Sunrise of Bassett

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 3 and 9 November 2016 and was unannounced. Sunrise Bassett provides accommodation and personal care for up to 104 adults, including people with dementia and physical disabilities, who require nursing care. There were 71 people living at the home when we visited. The home had an Assisted Living Unit providing accommodation and communal areas on the terrace, ground and first floor. A separate Reminiscence Unit provided accommodation and communal areas on the second floor.

At the previous inspection in May 2015 we found the registered person had not ensured that people received all the nursing and health care they required. We reassessed this in May 2016 and found that whilst improvements had been made these changes were not embedded in practice and did not always ensure people received effective care. We told the provider they must take action to ensure people received effective health care. At this inspection we found that action had been taken and people were receiving effective personal and nursing care.

Also at the previous inspection in May 2015 we found that an effective system to regularly assess and monitor the quality of services provided was not in place and that procedures to protect people's legal rights were not followed. The provider sent us an action plan telling us how they would improve. At this inspection we found that action had been taken and effective quality monitoring systems and procedures to ensure people's legal rights were in place.

There was a registered manager at the home. 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

There were not always enough staff to ensure people's needs were promptly met and call bells were not always responded to in a timely manner. Recruitment practices had not ensured that all pre-employment checks were completed before new staff commenced working in the home. Staff received appropriate training and were supported in their work.

People were positive about the service they received. They were also positive about meals and the support they received to ensure they had a nutritious diet and about the activities available. People were supported and encouraged to be as independent as possible and their dignity was promoted.

People felt safe and staff knew how to identify, prevent and report abuse. Legislation designed to protect people's legal rights was followed correctly. Staff offered people choices and respected their decisions. People and visitors' views about the service were sought in a formal and informal way and were acted on.

Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs and preferences. Reviews of care involving people were conducted

regularly. People had access to healthcare services and were referred to doctors and specialists when needed.

Medicines were managed safely and people received these as prescribed. At the end of their life, people received appropriate care to have a comfortable, dignified and pain free death.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home. Visitors were welcomed and there were good working relationships with external professionals.

Staff worked well together, which created a relaxed and happy atmosphere that was reflected in people's care. Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

Quality assurance systems were in place using formal audits and through regular contact by the provider's representative and registered manager with people, relatives and staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always enough staff to ensure people's needs were promptly met. Recruitment practices had not ensured that all pre-employment checks were completed before new staff commenced working in the home.

Staff understood how to keep people safe in an emergency and people were protected from the risk of abuse by staff who knew how to identify, prevent and report abuse.

Medicines and individual risks to people were managed effectively.

Is the service effective?

Good

The service was effective.

Staff followed legislation designed to protect people's rights and freedoms. People received the personal and nursing care they required and were supported to access other healthcare services when needed.

People received a varied and nutritious diet and they were supported appropriately to eat. Staff knew how to meet people's needs; they were suitably trained and supported in their work.

The environment was well maintained and suitable for people.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion. Staff knew people well and interacted positively with them.

People and their relatives were positive about the way staff treated them. People were treated with respect. Dignity and independence were promoted and people were involved with planning how their care needs would be met.

At the end of their lives, people received appropriate care to have a comfortable, dignified and pain free death.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support. Staff demonstrated a good awareness of people's individual needs and responded effectively when their needs changed.

People were offered a range of activities suited to their individual needs and interests.

The provider sought and acted on feedback from people. There was a complaints policy in place and people knew how to raise concerns.

Is the service well-led?

Good

The service was well-led.

People and their relatives felt the home was well organised. Staff understood their roles, were motivated, worked well as a team and felt valued by the registered manager.

The service had an open and transparent culture.

A suitable quality assurance process was in place, including formal audits and informal monitoring of the service.

People benefitted from positive links that had been developed with the community.

Sunrise of Bassett

Detailed findings

Background to this inspection

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

This inspection took place on 3 and 9 November 2016 and was completed by two inspectors, a specialist advisor and an expert by experience in the care of older people. 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 inspection was unannounced.

Before the inspection we reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with 25 people living at the home, and one health care professional. We also spoke with the provider's director of operations, the registered manager, the deputy manager, three nursing and 11 care staff members, and ancillary staff including the administrator, maintenance staff and the chef.

We looked at care plans and associated records for 17 people and records relating to the management of the service. These included staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records. We observed care and support being delivered in communal areas and 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. Following the inspection the registered manager sent us some additional information and we have considered this when making our judgements about the service.

Requires Improvement

Is the service safe?

Our findings

There were not always enough staff deployed to ensure people's needs were met in a timely way. People in the assisted living unit told us the delays were "unacceptable". One person said, "It's very nice here, but they're sometimes a bit short of carers." Another person confirmed this, saying the home needed "more full-time staff". A third person told us they recently waited for half an hour in wet night clothes before they were attended to. They said, "The call bell system isn't very good. I don't feel safe with this thing (pointing to their call bell). I don't blame the staff; there's just not enough of them." A further person told us staff rarely had time to chat; they said, "They're so fast, they're in and out [of my room]. By the time I've got out of my bed to ask 'what about this, what about that', they've gone and on to the next patient."

Staffing levels were based on an assessment of people's needs. These were calculated according to their dependency levels. However, the registered manager told us there was also "an element of judgement and common sense". For example, the calculation showed that only one member of staff was needed in the Reminiscence Unit at night, but two had been provided.

The provider analysed the time it took staff to respond to people's call bells and shared this information with us. The most recent analysis, for September 2016, showed that only around half of all calls were responded to within 10 minutes, with some delays of up to 23 minutes. This put people at risk. For example, if a person needed support to go to the bathroom and staff did not respond promptly, they could attempt to self-mobilise and fall. If they were unable to self-mobilise, their dignity could be compromised if they did not get to the bathroom in time.

The registered manager had identified call bell response times as a concern and was working to reduce them through a range of measures. They had allocated additional staff to times of peak demand; they were encouraging staff to complete care records throughout the day rather than at shift change-over times; they were providing alternative means of contact for people who required non-urgent support; and they were helping people to understand when and where to use their call bells. For example, if people were in the dining room and wished to return to their room, they were advised to attract the attention of a staff member rather than use the call bell they carried. In addition, the registered manager was consulting staff about the introduction of a new duty roster that aimed to provide more staff at key times so they could respond to people more quickly.

There was an appropriate recruitment procedure in place to help ensure staff were suitable for their role. This required applicants to provide a full employment history and to undergo reference checks and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruiting decisions. Although DBS checks were always completed, we found other aspects of the procedure were not always followed. There was a gap in the employment history of one of the four staff members whose recruitment files we viewed. In addition, a reference had not been requested for a staff member who had recently been employed by another care provider. The provider was therefore unable to confirm that the staff member's conduct had been satisfactory in their previous role. We discussed these concerns with the registered manager who agreed they were an area for improvement. The registered manager took immediate action to

obtain the missing information related to these staff members.

There were suitable plans in place to deal with foreseeable emergencies. Weekly checks of the fire safety equipment were conducted, together with regular fire drills. A recent activation of the fire alarm had identified that some staff needed additional training in the use of emergency radios and this had been provided without delay. Staff knew what action to take in the event of a fire or other emergency. An emergency "grab box" containing essential equipment and information was kept in an accessible place. Staff had been trained to deliver first aid and personal evacuation plans had been developed. These included details of the support people would need if they had to be evacuated from the building in an emergency.

People told us they felt safe at the home. One person said, "We do feel safe here." Another person told us, "I do feel quite safe here and I get my medication." Staff had received safeguarding training and knew how to identify, prevent and report abuse. They told us they would have no hesitation raising concerns and had confidence that managers would take appropriate action. One staff member said, "If I was concerned, I'd go the nurse, then my line manager, then [the registered manager], then the whistle blowing line if need. But [the registered manager] is a very open person and I know he would investigate it and deal with it." Staff were aware of external organisations they could contact for support, including the local safeguarding authority and CQC.

The registered manager took their safeguarding responsibilities seriously and worked closely with the local safeguarding authority to protect people from harm. Following concerns identified in previous CQC inspections, they had developed an action plan, which they updated monthly and shared with the safeguarding authority. This showed they had taken all necessary action to keep people safe from the risk of neglect or abuse.

There were appropriate arrangements in place for obtaining, recording, storing, administering and disposing of prescribed medicines. People told us they could receive 'as required' medicine (PRN), such as for pain relief, when needed and there were safe processes in place for people to receive 'homely remedies' which had been agreed by the person's GP. There were also effective processes for the ordering of stock and checking stock into the home to ensure the medicines available for people were correct. Nursing staff described how they checked that there were adequate supplies and the action they would take if there was a need for some additional medicines. We checked stocks of some medicines and found all stock levels corresponded with records of medicines received into the home and recorded as having been administered to people.

We spoke with one registered nurse about their knowledge of medicines and found this was up to date and comprehensive. They told us they had received training in medicines management and administration as part of their induction to the home. Medicines were administered by either registered nurses or care staff who had undertaken additional training to administer medicines. We observed nursing and care staff administering medicines to people in a patient manner, and informing people what the medicines were for. They did not hurry the medicines rounds and Medicines Administration Records (MAR) were up to date and complete. However, MARs did not state the times people had received their medicines. This meant staff could not be sure that medicines which required to be given at certain times, such as before meals or adequately spaced throughout the day were administered correctly. The registered manager immediately arranged for additional documentation to be introduced to ensure people would receive all medicines at a safe time as prescribed.

There was a procedure in place for the covert administration of medicines when this was necessary,

although nobody required their medicines in this way at the time of the inspection. Covert medicines administration is when essential medicines are hidden in small amounts of food or drink and given to people. The procedure in place protected people's legal rights and ensured that all relevant people including GP's, dispensing pharmacists and relatives were involved in the decision to administer medicines covertly. The provider used PRN protocols for pain relieving medicines, and a recognised pain assessment tool was in use for when people were not able to state they were in pain. For other 'as required' medicines, such as laxatives, individual guidelines for when these medicines should be administered were available for people living in the Reminiscence Unit as part of their care planning. These individual guidelines were now being introduced for people living with dementia in the assisted living unit who may be unable to state when these medicines were required. Nursing staff agreed that this was something they needed to consider as people living with a cognitive impairment were now accommodated in this area. There were suitable systems to ensure other prescribed medicines, such as nutritional supplements and topical creams, were provided to people.

People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example, one person had brought a large piece of furniture from home and staff recommended it be secured to the wall for safety. The person declined the offer. They were aware of the risks and had signed a risk assessment accepting responsibility for them, in order to avoid any damage to their furniture from the fixings.

Where individual risks to people were identified, action was taken to reduce the risk. These included the risks to people of falls, choking, poor nutrition and skin damage. A person told us staff assisted them to change their position and that staff used the appropriate equipment when doing this. Records confirmed repositioning was undertaken on a regular basis which would reduce the risk of pressure injury. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. Pressure relief mattresses were set appropriately and there was a system in place to check these weekly. Staff members were provided daily with a comprehensive handover sheet which detailed the management of people's individual risks. This helped ensure staff had quick and easy access to this information when required.

Moving and handling assessments clearly set out the way staff should support each person to move and correlated to other information in the person's care plan. For some people the solution to one risk increased other risks. For example, one person was at high risk of pressure injury and required an airwave mattress. However, this placed them at higher risk of falls and therefore the two risks had been considered and an alternative mattress was obtained that reduced the risk of falls whilst still providing protection from pressure injuries. Staff had been trained to support people to move safely and we observed support being provided in accordance with best practice guidance. Where people were at risk of choking on their food, they had been referred to specialists for advice and were provided with suitable diets to reduce the risk.

Appropriate action was taken when people had experienced a fall. Their risk assessment was reviewed and additional measures to reduce the risk of further falls were considered. For example, one person had slipped out of bed on several occasions, so staff had installed soft supports to reduce this risk, lowered the person's bed to the floor and placed soft mats around it. If a person sustained a head injury during a fall, advice was sought from the ambulance service and appropriate observations were conducted for the following 24 hours to monitor the person's health and vital signs.

The service was piloting new technology to improve the timeliness of advice from the ambulance service. A link had been set up using hand-held computers to allow ambulance staff to interact with the person and with staff remotely. The registered manager told us, "If a person falls, [the ambulance service] can view the

person's injuries, can ask them questions and can speak with staff. It has allowed them to give advice rather than send an ambulance."

The registered manager reviewed accidents and incidents to identify any patterns. They found that a high proportion of falls occurred when people developed urine infections. In response, they had put 'hydration points' throughout the home to encourage people to drink more. This had reduced the incidence of urine infections significantly, which had, in turn, helped reduce the number of falls.

Risk assessments were completed for all aspects of the environment and measures identified to reduce the likelihood of harm. For example, the temperature of hot water was regulated to prevent scalding and arrangements were in place to check that gas and electric systems were maintained in good condition. Equipment such as hoists and lifts were serviced regularly to help ensure they were in good working order and safe to use.

Good

Is the service effective?

Our findings

At the previous inspection in May 2015 we found the registered person had not ensured that people received all the nursing and health care they required. We reassessed this in May 2016 and found that whilst improvements had been made these changes were not embedded in practice and did not always ensure people received effective care. We told the provider they must take action to ensure people received effective health care. At this inspection we found that action had been taken and people were receiving effective personal and nursing care.

People received the personal and nursing care they required. One person told us "Some of the nurses are brilliant; the nursing attention is better than you'll get in most places and they get things done." Another person said staff assisted them when they were ready to get up and that they were encouraged to be as independent as possible. Staff recorded the personal care they provided to people including if people had declined care such as a shower or bath. These records showed people were supported to meet their personal and other care needs. Systems were in place for a senior staff member to review records of care monthly to monitor that people were receiving the care they required.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. Nurses undertook monthly wellness checks on all people. We saw that where routine observations, such as pulse or blood pressure, were significantly different to previously, action had been taken by consulting medical staff and repeating the observations. Nursing and care staff described how they supported people which reflected the information in people's care plans, which included information about previous health conditions, and risk assessments. People were seen regularly by doctors, opticians and chiropodists as required. Sunrise Bassett had equipment suited to the needs of people living there. We saw this included individual equipment such as specialist chairs, hoist slings and slide sheets. Where necessary staff advocated on behalf of people with health care professionals to ensure they received appropriate care and treatment.

Nursing staff told us they had received wound management training from a specialist tissue viability nurse who they felt able to contact for guidance when necessary. Systems were in place to ensure nursing staff were aware of which wounds required attention and when. Documentation viewed showed wounds were managed appropriately. During the staff shift handover meeting care staff were reminded to encourage/assist some people to return to bed in the afternoon to change their position which would protect any vulnerable areas of skin from damage.

At the previous inspection in May 2015 we found the registered person had not made suitable arrangements for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided. The provider sent us an action plan telling us how they would rectify this. At this inspection we found that action had been taken to improve staff knowledge and the procedures were in place to protect people's legal rights.

People can only be deprived of their liberty 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 found the provider was following the necessary requirements. DoLS applications had been made with the relevant local authority for people living within the Reminiscence Unit. Nursing staff told us they were now making applications in respect of some people living in the Assisted Living Unit where people may lack the capacity to make decisions about staying at the home. Staff told us they would take action should these people leave the home and had recently realised that DoLS applications were required.

People's ability to make specific decisions was assessed in line with 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Some people living at the home had a cognitive impairment and were not able to give valid consent to certain decisions, such as the delivery of personal care or the administration of medicines. Staff therefore made these decisions on behalf of people in consultation with family members and health care professionals as required by the MCA. For example, we saw that decisions regarding some people receiving the flu vaccine had followed this process where they were unable to give informed consent to receiving this.

Staff understood the MCA and their responsibilities within this. Staff members explained that if the person did not have the capacity to make a decision about the care and support they were receiving then they would need to act in the person's best interests. One care staff member said "One person has difficulty making decisions and communicating them, so you have to take a while, hold his hands and [offer choices]. If he can't say 'yes or no' you have to make a decision for him from what you know he likes." They then described the foods that the person did and did not like. Another care staff member said "To help [one person] make decisions, I explain who I am, offer choice and check they aren't in pain. We offer food to his lips; if he accepts, we go ahead, but if he doesn't open his mouth it means he doesn't want to eat. Sometimes we just don't know what they want, so we give it five minutes and try again, or get someone else to try. [One staff member] is particularly good with him, so I'll ask her to try."

Care plans in the Reminiscence Unit contained information about the specific decisions people required staff to support them to make. Care plans also contained information as to who had the legal right to make other decisions on behalf of the person. When in place, copies of the legal documents confirming this were held. Senior staff told us that they were aware of the need to consider more fully the MCA for people in the assisted living part of the home. They told us they would be extending the systems which were in place in the Reminiscence Unit for people living with dementia in the assisted living area.

People's nutrition and hydration needs were met by staff who had time to support them to eat, when necessary. One person told us "Food good and you get a choice". Another person said, "The food is good especially in the evenings." Another person commented "This place is like a five star hotel in every way. If you don't like the meal, they'll change it five or six times." Nobody expressed any concerns about the meals provided at Sunrise Bassett. The chef told us they always received information about people's dietary requirements and preferences. For example, they were able to tell us about one person and the information corresponded to that which the person had told us. The chef confirmed they had undertaken specialist training to meet the dietary needs of older people and were supported to access other training as required. Records showed people were provided with food when they wanted it. Staff told us they could provide people with food and drinks at any time this was requested or required. Staff, including kitchen staff, were aware of the specific dietary needs of individual people. For example, the chef was aware of which people required their meals in a softer format or had dietary restrictions such as due to a medical condition. A staff member correctly told us a person required their meals in a softer texture and their drinks thickened to a

specific consistency. Meals, including those which had been pureed, were pleasantly presented. Drinks were available throughout the day and staff prompted people to drink. Staff monitored the weight of people and we saw people were referred to their GP for advice when they experienced unplanned weight loss. As a result, a person had been prescribed a supplement which they were receiving. Where necessary, records of the amount people had eaten or drunk were kept.

People received the appropriate amount of support and encouragement to eat and drink. Staff were attentive to people and, whilst promoting independence, noted when people required support. For example, in one part of the home staff ate meals sitting with people. This provided visual prompts to people as to what they should be doing. When people stopped eating staff quietly prompted them to resume eating. This showed people were supported to help them overcome their difficulties whilst maintaining independence. Where people required more support this was provided patiently, giving people time to finish one mouthful before they were offered more. In the other part of the home staff were also attentive to people at lunchtime, making sure their drinks were topped up and they were happy with their meals. When a person got up from the table half way through their lunch, a staff member checked they were alright and that they had eaten enough.

People's needs were met by staff who were suitably trained. Staff were positive about the training they received and said they could ask for any additional training they felt would benefit people. Staff demonstrated an understanding of the training they had received and how to apply it. For example, when supporting people to move, they used appropriate techniques and communicated with people living with dementia by remaining patient, asking simple questions and providing continuous reassurance.

New staff completed a comprehensive induction programme before they were permitted to work unsupervised. This was based on a range of computer-based modules, supplemented by face-to-face training and practical training, including supporting people to move safely. They then worked alongside more experienced staff until they were considered confident and competent enough to work unsupervised. A staff member told us, "I had to do three courses before I started work, then I did three shadow shifts [with experienced staff]. I could have done more, but that was enough."

All staff were up to date with the provider's mandatory training. Nurses were supported to undertake study to meet the needs of their registration and training to meet the specific needs of people living at Sunrise Bassett. Arrangements were in place for staff who had not worked in care before to undertake training that followed the standards of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. In addition, a high proportion of experienced staff had completed, or were undertaking, vocational qualifications in health and social care.

People were cared for by staff who were appropriately supported in their role. All staff received regular one-to-one sessions of supervision. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Additional supervisions were arranged when staff needed additional support. For example, a group supervision was held to discuss a recent death in difficult circumstances and any lessons that could be taken from it. This had led to a review of the way syringe drivers were set up and managed. Staff who had worked at the home for over a year had also received an annual appraisal to assess their performance and identify development objectives. Staff told us these sessions were helpful and spoke positively about the support they received from the management on a day to day basis.

The Reminiscence Unit was specifically dedicated to providing accommodation and care for people living

with dementia. This area was being refurbished and we were informed that current best practice guidance was being followed to make this area suitable for the people living there. For example, carpets and colour schemes had been selected that would help people differentiate the areas and be less confusing. Items of interest and reminiscence had also been increased and were available for people on an ad hoc basis and for use by staff when working with people. Care staff were positive about the changes to the environment and felt this would help them provide suitable care for people. Changes were also planned to the enclosed balcony, which provided access to fresh air for these people, to make it more inviting. Where people required specific furniture, such as special chairs, these were available. Other areas of the home were also well maintained and suitable for the people living there. People were able to bring in items of their own, including furniture, to make their private rooms feel homely and familiar. This helped people settle in and feel more at home. There was a range of communal and bathing facilities suitably equipped to support people with high care needs. People had access to a safe enclosed garden providing access to fresh air and sunlight if they wanted this.

Good

Is the service caring?

Our findings

People were positive about the way staff treated them saying that all the staff were kind and caring. One person said "The staff are nice to me and welcome visitors". When asked if they thought the staff were caring another person said "Yes, staff very nice here". A third person said "Staff treat me with respect; they help me with showers and are very gentle with me." Everyone we spoke with made positive comments about the staff.

We observed staff over the course of our inspection and found they were caring, patient and kind. Staff spoke with people in a respectful but friendly way and people responded in a similar manner. We saw staff crouched to people's eye level and spoke in soft warm tones. We observed staff supporting people with their meals in ways that were kind and patient. Staff did not rush people and they spoke with them about their food.

People's dignity was protected during the provision of care. People told us curtains were always drawn and doors shut when any personal care was provided. From conversations with staff and observations of the interactions between them and people it was clear that staff understood the importance of promoting people's dignity. People told us they could choose the gender of the care staff member, or request a particular staff member, to support them with personal care. This information was included in care plans. Care staff told us which people preferred care from staff of a specific gender. They told us this was always met and described how staff from another area may at times switch to provide support for individual people.

Staff protected people's privacy at all times. They took care to make sure toilet and bathroom doors were closed when they were in use and described practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and checking people were ready and willing to receive the proposed care and support. A staff member told us, "It's the same as I would do at home; I wouldn't get dressed with the blinds open." We also saw dignity screens were available if required for use in communal areas. Staff knocked and sought permission before entering people's rooms. In addition, confidential care records were kept securely and only accessed by staff authorised to view them.

People received care and support from staff who knew and understood their history, likes, preferences and needs. For example, they knew about a person's preference for sweet items such as chocolate or cakes. Discussions with staff showed they had an awareness of people's previous occupations. There was information in the handover sheet about topics some people liked to talk about, how they preferred to be dressed and preferred names staff should use. This helped ensure that staff had a good knowledge of people, their needs, usual routines and preferences.

People were supported to express their views and were involved in making decisions about their care, treatment and support. A person told us they could choose how they spent their day and where they took their meals. They told us they had decided to remain in their room the day we spoke with them and that

staff brought them meals and drinks. Staff described how they involved people in choices. One said "We ask them, or we will show them a few choices such as clothes". A person confirmed this telling us staff had offered them choices and helped them choose by suggesting items they had not worn in a while. Most people living at the home were able to make all day to day choices. Staff working with people living with dementia described how they supported people with decision making. They told us people were often able to make choices if they were given a couple of options rather than too many choices. They described how they would also use visual prompts such as showing people two choices of clothing. At lunch time in one area plates of food choices were shown to people for them to choose from. This meant people living with dementia were able to make an informed choice about which meal they would prefer.

Care was individual and centred on each person and staff had a good awareness of people's needs. People, and when appropriate relatives, were involved in care planning and reviews of care. Care files were reviewed monthly by a senior staff member. This included a discussion with the person or a relative about their care plan and any changes they would like made. Staff told us they worked with family members who had Lasting Power of Attorney for their relative to be clear about what information they could share with other family members in order to protect people's privacy. Other staff were also conscious of the need to ensure people's wishes and choices were respected. One staff member told us, "Family members tell us what they want for their parent, but we have to remind them the person has the choice."

Where people had religious or cultural preferences these were known and met. Care plans contained information about people's religious needs and how these should be met. If requested people were individually visited by a religious leader of their choice with weekly services provided by a visiting minister. Staff aware of how to contact religious leaders of various faiths should these be required.

Staff caring for people living with dementia understood that this could also be a difficult time for family members. Senior staff described how they supported family members and had provided guidance and advice for them as to how best to respond to people when they visited. Senior staff told us people could bring their pets, such as dogs or cats, with them on admission. They described how a door closure device had been fitted to one person's bedroom door to enable the person's cat to have free access outside but ensure the door would close should the fire alarms sound.

Staff followed people's end of life wishes wherever possible. Care plans contained individual information about people's preferences and wishes for care at the end of their life. Care staff described the care they had provided for people in a caring and individual way. For example, they described how one person liked to hold a favourite cuddly toy and they had 'snuggled' this into the person's arms to go with them to the funeral home. For another person staff described the type of music they liked to listen to and had ensured this was playing when they were in their bedroom.

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death. Within care files there was information about people's end of life preferences. A specific end of life care plan detailing the care the person required had not been put in place for a person whose file we viewed, although records showed the person had received appropriate care. A nurse and senior care staff member had attended training to enable them to better manage symptoms people may have at the end of their lives. They were planning to provide further training to other staff members. Nurses were aware of how to obtain and administer symptom management medicines should these be required.

Good

Is the service responsive?

Our findings

At the previous inspection in May 2015 we found the registered person had not ensured that people received all the nursing and health care they required. We reassessed this in May 2016 and found that whilst improvements had been made these changes were not embedded in practise and did not always ensure people received responsive care. We told the provider they must take action to ensure people received effective health care. At this inspection we found that action had been taken and people were receiving a responsive care service.

Staff had information as to how they should respond to medical emergencies. For example, one care plan contained information about the support a person should receive if they had an epileptic seizure. This included the use of a monitoring mat and guidance for staff as to when to call paramedics or administer rescue medicine. However, nursing staff were not immediately able to locate an item of emergency equipment. The delay in providing this could have significantly impacted on the emergency care provided to people. The registered manager took immediate action to make changes and ensure all staff were aware of the location of emergency equipment. Staff were kept up to date about people's needs and any changes to these through a formal handover meeting at the start of each shift. They were also provided with a detailed handover sheet which provided all relevant information for care staff such as how the person should be supported with food and drinks and moving around the home.

Care plans were well organised and provided comprehensive individualised information for staff, which usually corresponded with the care people were receiving. Care plans contained information about how people's individual personal care needs should be met. For example, one person's care plan clearly detailed the tasks relating to personal care they could complete and those they required staff to assist them with. The person's care plan contained other individual information such as their preference to wear makeup and the assistance they may require with this. A process was in place to ensure care plans were reviewed every month by a member of the senior team. In some care plans we saw hand written amendments had been made prior to the updating of care plans on the computer. When this had occurred staff would have immediate access to up to date information about a person's needs.

Staff responded appropriately when people's individual health or personal care needs changed. Another person had been referred to an NHS falls assessment clinic and relatives were organising a physiotherapist for a third person who had experienced a number of falls. Care plans contained information for staff about the signs and indicators a person with epilepsy may show prior to a seizure. Likewise there was information about the support a person with diabetes required including guidance for staff as to the signs and symptoms the person may experience if their blood sugar levels were too high or too low. Nursing and care staff were able to describe the care and support required by individual people. For example, care staff were able to describe the support people required to meet nutritional needs. Two people required a fluid thickener to be added to their drinks to enable them to swallow safely. Staff were aware of this and we saw the thickener being added to their drinks.

When untoward incidents or accidents occurred, procedures were in place to ensure people received all the

necessary care. Incidents and accidents were recorded. Care staff described the action they would take if they identified a person had a bruise or skin injury. This was then followed up by a senior staff member to investigate the possible cause of the injury and take action to reduce the likelihood of a repeat occurrence. Forms showed that, where necessary, external medical advice was sought and action was taken to monitor the person for any signs of deterioration. The senior nurse reviewed accidents and incidents to identify any patterns. None had been identified, but they described the action they would take if any themes were found.

People had access to a variety of activities to promote mental and physical stimulation and enjoyment. These included: Social events; card and board games; quizzes; arts and crafts; external entertainers; trips to local attractions in the home's minibus; yoga; gardening; and flower arranging. Everyone we spoke with felt that the activities provided were suitable and they were happy with these. Care plans included information about people's life histories, hobbies and interests which helped staff design suitable activities for people.

The home employed an activities coordinator who organised activities in small groups or individually depending on people's needs and wishes. A programme delivering activities of engagement called 'Live with purpose' was being rolled out. One initiative was called "Living with anticipation" which aimed to give people something to look forward to each day. Other staff were also involved in providing activities. For example, the maintenance coordinator ran a 'Gents Club' every Thursday. We saw this in action. Three people were taking part in drinks and a chat with two members of staff. The registered manager hosted a monthly lunch in the private dining room to provide an opportunity for new people or those celebrating birthdays to discuss their experience of the home in a social setting. It included drinks and a leisurely lunch with table service. The maintenance coordinator told us "We use it to introduce new residents and we find it really clicks with them and makes them feel welcome." Care staff working with people living with dementia told us they had time to support people with activities and showed us the range of specialist and individual activities they had access to. A small lounge had been furnished to provide a quiet relaxing space and there were numerous items to stimulate conversations and memories for people.

The provider sought feedback from people, relatives and external professionals through the use of questionnaire surveys. These showed a high level of engagement with staff. 'Residents council meetings' were also used as an opportunity to seek the views of people and family members and these showed a high level of satisfaction with the service provided. Feedback from two meetings had included comments about the response times to call bells and this had led to a number of actions aimed at addressing the issue.

People knew how to complain or make comments about the service and the complaints procedure was displayed on the notice board in the entrance hall. People told us they had not had reason to complain but would contact a staff member if needed. One person told us, "If I needed to make a complaint, there are plenty of facilities for doing it." Another person told us, "I often see the manager; he comes round to see if everything is okay."

Records showed that complaints were used to develop and improve the service. For example, in response to one complaint, training sessions in note recording had been run to help staff improve the way they documented incidents. Another complaint had led to improvements in the way staff communicated with people and their families about the completion of body maps to record people's skin integrity.

Good

Is the service well-led?

Our findings

At the previous inspection in May 2015 we found the registered person had not protected service users, and others, against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems. The registered person sent us an action plan telling us how they would improve. At this inspection we found that action had been taken and effective quality monitoring systems were in place.

A comprehensive and robust quality assurance system was now in place that focused on continuous improvement. This included auditing key aspects of the service, such as care planning, the environment, medicines and infection control. Where changes were needed, specific actions were developed and implemented. For example, the medicines audit showed a high level of medicine administration errors, so the arrangements were simplified and this had reduced the volume of errors. Staff administering medicines also told us the introduction of red tabards reminding staff and people not to interrupt them had resulted in less interruptions resulting in fewer mistakes. The frequency of urine infections and falls had been reduced by the introduction of 'hydration points'.

In addition, the Director of Operations conducted monthly reviews of the home. These drew on the experience and data from other homes operated by the provider to help identify areas for improvement and to introduce initiatives that had been found to work well elsewhere. For example, staff from this home had spent time in a neighbouring home that had developed a positive approach to supporting people with dementia to live well. The staff member had learnt from the experience and was introducing the new approach to Sunrise Bassett.

The provider had a clear vision and set of values for the service. The registered manager summed these up as "a commitment to delivering high quality care" to people. They communicated and reinforced this ethos to staff at every opportunity. We observed that staff showed a commitment to these values in the way they supported people. When we spoke with staff, they expressed pride in the progress they had made since our last inspection and were confident in their ability to sustain the improvement.

People enjoyed living at Sunrise and told us the service was well-led. One person said of the service, "It's unbelievably well-run. If anything, there's too much management now." People were aware of who the manager was. One person said "I have seen the manager". Other people also told us they saw the manager and we observed members of the management team in all sections of the home throughout the time we were there.

There was a clear management structure in place and all staff understood their roles and responsibilities. Each member of the management team had specified responsibilities, which allowed the registered manager the time and space they needed to take an overview of the service and monitor its performance overall. A duty manager system was in place to enable staff to seek support and advice out of hours.

A staff survey earlier in the year indicated that not all staff were satisfied with the way the home was run. In response, the management had introduced a wide range of initiatives to improve engagement with staff and

their job satisfaction. They included incentives to attend staff meetings and initiatives for recognising good work, such as the "heart and soul cheque books". These were tear-off notes that any staff member could use to express their thanks and appreciation to a colleague. Managers had issued many to staff, and we saw staff had also issued some to managers. This showed mutual respect and appreciation for each other's work.

Staff spoke positively about the support they received from management. For example, a staff member told us, "Everything I do is appreciated. I enjoy my job. Every day someone says 'thank you'. The bosses appreciate what I do, which makes me do my job better. They listen to me and trust my judgement." The registered manager told us, "I'm glad staff feel appreciated. It comes from the top. If you feel valued then you value your staff; and I do." Another staff member said, "The home is better organised now. At [staff meetings] we can raise anything and make suggestions for improvement. We suggested that [non-nursing staff who administer medicines] have a radio, so they can call for support or advice, and it was accepted." Nursing staff told us they were encouraged to be more assertive by the managers. For example, they told us they were now challenging some decisions made by the GP and felt able to say 'no' to other staff when they were interrupted whilst administering medicines.

Other comments from staff included: "It's a good company to work for"; "I feel valued and appreciated. Every time I need something, I just go to [one of the managers]; they have an open door policy"; "There's good team work; at the end of the day everyone helps each other"; "We work as one big family"; and "I like working here and I am happy with the management; they are very supportive of me".

There was an open and transparent culture at the home. A monthly newsletter was produced to keep people and their families up to date with events that had taken place or were planned. It highlighted people's birthdays and forthcoming activities, together with changes to the staff team or initiatives the home were taking part in. Visitors were welcomed at any time and could stay as long as they wished. There were good working relationships with external professionals and notifications about significant events were reported to CQC as required.

There was a duty of candour policy in place which required staff to act in an open way when people came to harm. The registered manager followed this when a person fell and sustained a serious injury. They notified family members of the incident both verbally and in writing.

Positive links had been developed with the community to the benefit of people. These included: supporting a local bowling club that people living at the home could, and did, use; the hosting of a weekly dementia café, which enabled people from the community to meet and build friendships with people living in the home; and links with local faith groups who visited to sing hymns, distribute Holy Communion and run services. A local school was also planning to visit at Christmas to perform a nativity play and sing carols. A staff member told us, "The links help people mingle with the outside world and stops them living in isolation. Several [of our neighbours] come to all our events; two have built up friendships with people and now visit them."