Sunrise Operations Sonning Limited

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Inspection report

Sunrise of Sonning
Old Bath Road
Sonning
Berkshire
RG4 6TQ
Tel: 0118 944 4300
Website: www.sunrise-care.co.uk

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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?	Requires Improvement

Overall summary

We carried out this inspection on 8 and 10 December 2014. It was unannounced, which meant that people, staff and the provider were not aware we would be visiting.

Sunrise Operations Sonning Limited provides residential and nursing care for up to 103 older people with nursing and other care needs, including dementia care. At the time of our inspection 101 people were living in the home.

The home consisted of three floors, with individual ensuite bedrooms and shared bathrooms on all floors.

Summary of findings

The top floor, known as the reminiscence unit, cared for people with dementia needs. The first and ground floors, known as assisted living, accommodated people with personal and nursing needs, and also catered for people in the earlier stages of dementia. Communal lounges and dining rooms were available for people on the top and ground floors. Stairs and a lift provided access between floors. People had access to the garden, and a range of communal areas on the ground floor, incuding a large dining room, function rooms and a bistro area. The front door and exit from the top floor were secured, to ensure people were protected from dangers that could affect their safety. People able to leave the home or floor safely knew the codes to do so independently, or were escorted to leave as they wished.

A registered manager was not in post at the time of our inspection. This report contains the name of a manager who left the home in May 2014. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The provider had kept us informed of manager changes, and the Director of Operations told us a person would be applying with CQC shortly to take up the post of registered manager.

At our previous inspection on 4, 5 and 7 August 2014 the provider was not meeting the requirements of the law in relation to the care and welfare of people, meeting people's nutritional needs, managing medicines, requirements relating to and supporting workers, and assessing and monitoring the quality of the service. Following the inspection the provider sent us an action plan stating they would make the required improvements by 26 October 2014. During this inspection we looked to see if these improvements met the requirements of the law. We found that they had for some of the concerns identified, but not for all of them.

Risks to people's health and wellbeing had not always been identified. Where people's risks such as developing pressure ulcers had been identified, care and treatment provided did not always effectively reduce these risks. Wounds were not always managed in accordance with health professionals' guidance. Some people had experienced delays in the treatment of their wounds.

People were not always protected against the risks associated with unsafe use and management of medicines. Medicines were not always in stock when people required them. People did not always receive their medicines at the required times to manage their health and wellbeing.

The provider's arrangements to monitor the quality of care provided (including the use of feedback and learning to improve) were not always robust. Information about people had not always been updated to provide an accurate record of people's needs. Audits had not ensured all areas of improvement had been identified, or that required actions had been effectively implemented to drive and sustain these improvements.

People's safety had been protected through appropriate measures to safeguard them, such as staff training and notification of incidents.However, the provider had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff available to meet people's needs safely.

People had not been protected from the risk of unsuitable staff caring for them, as the provider's recruitment process was not sufficiently robust to meet all the requirements of the law. The provider had not always identified or investigated gaps in applicants' employment history, or verified that applicants' conduct in previous relevant employment was appropriate to ensure people's safety.

The provider followed appropriate guidance and trained staff in infection control measures. However, people, staff and visitors were at risk of infection, because staff did not always follow the guidance provided. Staff did not always take effective measures to reduce the risk of cross-contamination, such as wearing protective gloves whilst handling soiled waste.

The provider's systems did not always effectively identify people at risk of malnutrition or dehydration. People's daily intake of foods and fluids was not always effectively

Summary of findings

monitored when risks had been identified. People were provided with a range of food choices, and those identified with dietary needs were given support to eat or provided with suitable meals to meet their health needs.

People had been supported to consent to their care and treatment, and their wishes were clearly documented. However, it was not always clearly documented that this consent had been lawfully provided when others had consented to people's care provision, or that actions taken to support decisions and people's best interests were lawful. The provider was meeting the requirements of the Deprivation of Liberty Safeguards.

People were mostly cared for respectfully, and their dignity and independence were usually promoted. Most people and their relatives spoke positively about their experience in the home. People told us the managers were prompt to address any areas of concern raised, and the provider's complaints policy guided staff on the appropriate actions to take to resolve these. People were involved in decision-making in the home, such as refurbishments, meals and activities, through resident meetings and forums. A wide range of activities supported people to maintain their links with the local community, and engage in meaningful activities such as painting and gardening.

Staff received training and support to ensure they had the skills required to meet people's needs. A daily communication meeting ensured staff in all roles understood identified issues and the required actions to support people's daily needs effectively. Equipment such as fire alarms, lifts, hoists and pressure mattresses, had been maintained and serviced regularly to promote people's safety in the home.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People told us they felt safe with staff. However, they were not protected from the risk of infection because staff did not always follow the provider's infection control procedures.

Sufficient staff were not always available to meet people's identified needs safely. Recruitment procedures did not ensure applicants were of suitable character to support people safely.

People did not always receive their medicines at the time they required them. Some medicines were not available when people needed them. Medicine administration records were not always securely stored or completed.

Is the service effective?

Inadequate

The service was not effective.

People's nutritional and wound care needs were not always effectively managed. Records did not always identify when changes to their care or treatment were required.

People were not effectively or lawfully supported in decision-making when they lacked the mental capacity to make specific decisions for themselves.

Although staff training ensured they had the skills and knowledge required to support people, this had not always been applied effectively.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us their wishes were not always respected.

People enjoyed meaningful engagement with staff. Staff chatted with people with kindness, and took care to promote people's welfare, dignity and wellbeing through the support they offered.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's wishes were not always met, as staff did not always have time to support people at the times they wanted. People's individual support plans were not always updated to reflect their current needs or wishes.

People joined in with activities provided in the home, and were able to influence the choice and variety of these through residents meetings.

People knew how to raise concerns with the provider, and felt comfortable to do so. Concerns and complaints were mostly dealt with effectively.

Summary of findings

Is the service well-led?

The service was not well led.

Although the managers were visible in the home, care workers were not always aware of who to approach for senior managerial support and guidance.

Systems in place to monitor the quality of the service did not always identify where improvements were required. Actions implemented to drive identified improvements had not worked effectively, and improvements made had not always been effectively monitored to ensure actions were sustained.

Requires Improvement

Sunrise Operations Sonning Limited

Detailed findings

Background to this inspection

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

The inspection took place on 8 and 10 December 2014 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor with nursing experience and an expert by experience with knowledge of dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at previous inspection reports and notifications that we had received. A notification is information about important events which the provider is required to tell us about by law. Concerns brought to our attention regarding poor care practices, including people's nutritional support and care of their wounds and pressure areas, were used to inform our inspection. Prior to our inspection we spoke with a local authority safeguarding officer and commissioner of the service to obtain their feedback about the care provided in the home. We also spoke with health professionals including district, diabetes care and tissue viability nurses.

During our inspection we talked with six people who use the service, six relatives of these and other people, the deputy manager, and the Director of Operations. We also spoke with ten nurses and care workers, as well as the chef, activities coordinator, housekeeper and maintenance person. Some people were unable to tell us about the care and support they received. We observed the care and support these and other people received throughout the day, including activities, mealtime support and the administration of medicines, to inform our views of the home.

We 'pathway tracked' three people's care. This means we spoke with them and looked at their care plans. We then observed the support they received and reviewed daily records, to ensure they received their planned care. We reviewed another 16 people's care plans and 12 staff files, including eight recruitment files and four training files. We looked at staff training plans and the working roster for two weeks during November 2014. We also reviewed a selection of policies and procedures, and records relating to the management of the service. We considered how people's and staff's comments and quality assurance audits were used to drive improvements in the service.

Inadequate

Is the service safe?

Our findings

At our inspection in August 2014, we found people had not been supported safely in the home. Medicines had not always been managed safely. All the required pre-employment checks to ensure staff were of good character had not been completed. The provider sent us an action plan outlining the improvements they would make. They said these would be in place by 26 October 2014.

At this inspection we found the provider had not taken sufficient actions to address these concerns. Actions had been taken to address the concerns previously identified regarding medicines management during our inspection in August 2014. For example, medicines were stored securely and appropriately in treatment rooms in the home, were in date and rotated to ensure old stock was used first. Where people had been prescribed medicines to be taken 'when required', recently updated protocols informed and guided staff to give these medicines consistently when needed. However, we identified further concerns regarding medicines management during this inspection.

People told us that their medicines were not administered at the same time each day, even when this was a requirement to safely manage identified health needs. We observed that the morning medicines round was not completed on one unit until nearly 12 noon. Whilst most people who needed medicines early in the morning were given them before the round started, one person was offered their early morning medicine (prescribed four times a day for pain relief) at 11:30am, which meant that a period of over 12 hours had elapsed since their last dose. This meant this person was at risk of experiencing pain that should have been prevented. During the medicines round, people's medication administration records (MAR) were often left unattended on top of the medicines trolley, and so were accessible to unauthorised people. There was one instance where medicines had been signed for but had not been taken, as the person was elsewhere in the home at the time. This placed the person at risk of harm, as records indicated that they had received medicines that had not been administered.

All medicines for December 2014 were available for people following a recent delivery. However, when we checked the MAR for November 2014 we found four occasions when medicines were not available to people for periods of four to ten days when they needed them. Staff explained there was a process for ordering medicines before they ran out, which was supported by the home's medication policy, but this had not been followed. For example, one person had run out of medicines to manage their blood pressure. Staff had not discussed the impact this may have on the person's blood pressure with their GP.

People had not been protected against the risks associated with unsafe use and management of medicines. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

People told us there were not always sufficient staff available to meet their needs safely. We observed lunch time on the reminiscence unit. One person had been served their lunch in their room at 12.10pm. We heard them calling for help at 1pm, and found them sat in light clothing with the window open. They appeared cold and distressed, and their lunch was untouched. It was not documented whether this person was able to use their call bell to request attention, or if staff visited them regularly when in their room to check on their safety or wellbeing. Staff seemed unaware of this person's need for support until we brought this to their attention. This placed the person at risk of harm from malnutrition and social isolation. Once staff were aware of this person's situation, they were offered an alternative meal choice, and the window in their room was closed.

For people dining together on the reminiscence unit, there were not sufficient staff to meet everyone's needs promptly. The meal arrived on the unit at 11.45 on a heated trolley, but some people requiring support to eat their meal did not start their meal until 1pm. Meal temperatures were checked before serving to ensure they were hot, and meals were re-heated as necessary. However, we noted some late servings appeared dry and unappetising. Many people did not eat much or any of the main meal served. The lack of staff to support people promptly with their meals affected their safety, as it placed them at risk of malnutrition.

Rotas for two weeks in November indicated that staff allocated to administer medicines were also required to provide care and support for people. This was to ensure staffing levels were sufficient to meet people's identified needs. This meant that whilst they administered people's medicines, fewer care staff were available to meet people's care or support needs. People told us that there were not always sufficient staff to help them to rise or dress in the mornings at the time they wished. This meant that some

Is the service safe?

people were unable to breakfast in the dining room, and so limited their choice of meal at breakfast time. Staff informed us that at times they struggled to meet people's needs promptly, and a health professional told us it was not unusual for them to find their patients undressed and still in bed when they visited to attend to their health needs. We found care workers were often too busy to engage with people during activity sessions. They relied on the activity coordinator to ensure people were encouraged to participate in planned individual or group activities. This demonstrated that there were not always sufficient staff available to meet people's needs or wishes.

Rotas and an internal review of staffing demonstrated that there was a reliance on agency care workers and nurses to meet rostered hours. Staff told us agency staff did not always have sufficient knowledge of people's needs to ensure they were supported safely. One person told us they were "Not happy with agency staff as they do not know you"'. This meant people may not receive the care or support they require promptly, and that staff supporting them may not have sufficient understanding of people's needs to meet these safely.

People's health, safety and welfare had not been protected, as the provider had not taken steps to ensure sufficient staffing was available at all times to meet people's identified needs. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

At our inspection in August 2014 we found that the provider had not completed all the checks required when recruiting staff to ensure they were of good character. At this inspection, we looked at the recruitment files of staff employed between September and November 2014. These contained some of the information required in accordance with the law, such as proof of identity, criminal record checks, and verification of declared qualifications. However, not all the gaps in applicants' employment histories had been identified or explained. Where applicants had declared previous employment in health or social care positions, verification of good conduct in these positions, or explanations of why this information could not be obtained, had not been documented. Good conduct references were not always provided on headed paper, and the information documented did not record whether the provider had verified its authenticity. This meant people may be placed at risk of harm from staff who were not of good character.

People had not been protected from risks related to unsafe recruitment procedures. This was a continued breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

Relatives and staff told us that, although the home was clean, infection control practices were not always effective. A nurse stated "We have had a lot of infections here". There had been two outbreaks of norovirus since our previous inspection.The nurse explained that staff did not always follow infection control protocols, such as wearing personal protective clothing, including aprons and gloves, when this was required. They felt this may have contributed to recent outbreaks of norovirus in the home. We observed several instances of poor infection control practice by staff. For example, we observed one care worker supported five different people with personal care without wearing a protective apron over their uniform. Later the same day they assisted people with their meals whilst wearing the same uniform and no cover to protect people from cross-infection. Other staff were observed sorting or carrying soiled linen without wearing protective clothing. They told us they knew the measures they should take to protect themselves and others from infection, but had not followed the provider's protocol. This placed people, staff and others at risk of health-care associated infection because of poor infection control practices.

People, staff and visitors were at risk of infection due to unsafe practices. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

People told us they felt safe in the home. Staff were aware of signs of abuse, had completed safeguarding training, and understood the provider's safeguarding procedure and actions to escalate concerns. The local authority's procedure for safeguarding people at risk of harm was displayed for staff reference.

People's safety in the home was promoted through regular checks and tests of equipment such as fire extinguishers and alarms, servicing of lifts and the gas boiler, and water tests to ensure legionella disease was prevented. Actions required to promote safety had been completed in accordance with professional external advice. The maintenance person explained how, and certificates demonstrated that, systems ensured checks were completed in accordance with the provider's and

Inadequate

Is the service safe?

manufacturer's guidance. A disaster plan was displayed in staff offices to ensure all staff understood the actions to take in the event of foreseeable disasters, such as fire or health-associated illness.

Inadequate

Is the service effective?

Our findings

At our inspection in August 2014, we found people had not been supported safely to ensure pressure ulcer risks were identified promptly or pressure ulcers were effectively managed to promote healing. Pressure ulcer development had not been prevented, and actions had not been effectively implemented to prevent reoccurrence. Some people had been at risk of malnutrition or dehydration, because their dietary and fluid intake had not been sufficiently monitored to identify and address risks. Where risks had been identified, actions taken did not effectively demonstrate that people at risk were protected from health issues arising from poor food and fluid intake, such as the development of pressure ulcers. The provider sent us an action plan outlining the improvements they would make. They said these would be in place by 14 October 2014.

At this inspection we found the provider had not taken all the actions required to address these concerns. A district nurse told us that although actions to manage skin care had improved, they did not feel people received effective care or treatment to prevent the risk of developing pressure ulcers. Records documented that regular checks and treatment were not provided in accordance with the provider's or health professionals' instructions. For example, records of dressing changes showed that these did not always occur on the days they were due. There were delays of two to seven days from the date a dressing change should have been made for one person. For another person, charts recording regular re-positioning documented gaps of nine hours between position changes on two occasions. Delays to planned care meant that there may have been delays to pressure ulcer healing. It also placed people at risk of developing infections or sores due to inappropriate pressure and wound care.

People's welfare and safety were not protected against the risks of receiving inappropriate or unsafe care or treatment. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

Staff had not been alerted to factors affecting people's health because records were not always accurately completed or updated. Although the use of health-monitoring tools and records, such as the Malnutrition Universal Screening Tool (MUST), had been improved to identify and address risks, they were not always completed accurately. MUST is used to monitor risks to people's nutritional health such as malnutrition or obesity. This placed people at risk of developing health issues such as diabetes or pressure ulcers. For example, one person's care plan guidance informed staff of how to provide skin care to protect the person from developing pressure ulcers. Daily notes did not record sufficient detail on the person's skin condition, whether their weight was stable or reducing, or if they had an increased dietary and fluid intake to promote their skin integrity. This meant that risks affecting their health had not been effectively monitored, and so placed the person at risk of ill health, including the development of pressure ulcers.

Charts to record the actions taken by staff to promote people's health and wellbeing did not evidence that effective actions had been taken. People unable to re-position themselves required regular support to re-position, to reduce the pressure on vulnerable skin areas. We noted omissions in the completion of one person's re-positioning chart. This placed them at risk of developing a pressure ulcer. Equipment to support skin integrity, such as pressure-relieving mattresses, were used for some people. Pressure-relieving mattresses are set at the correct pressure for each individual to ensure that vulnerable areas of the body are supported safely. We noted that one person's pressure mattress setting had not been recorded for three days. This meant there was a risk that the setting would not effectively reduce the risk of them developing pressure ulcers.

People identified at risk of malnutrition or dehydration required their daily food and fluid intake to be recorded, to ensure that they received sufficient food and fluid to prevent ill health. We noted gaps in recordings in four people's food and fluid charts. This meant that staff were not aware whether these people had sufficient food or fluids to promote their good health, or whether they were at an increased risk of malnutrition or dehydration. People's food and fluid intake were not always totalled each day. This meant staff were not aware if people had reached or exceeded the required balance to promote their health and wellbeing. An insufficient intake placed people at risk of malnutrition or dehydration. An excessive intake may place people at risk of obesity or fluid retention. These conditions increased people's health risks, such as the development of pressure ulcers, reduced movement, or organ failure. One person's chart demonstrated that they had exceeded their maximum fluid intake over three days,

Is the service effective?

and another person's records demonstrated poor fluid intake. This placed people at risk of harm, as staff were not able to monitor or assess whether they received care and treatment that effectively met their health needs.

A care worker stated that they did not feel people's individual support plans (ISPs) were sufficiently updated to reflect their current dietary needs. Comments in people's daily notes, such as 'Has had plenty to eat and drink', 'Offered a three course meal' and 'Hardly any breakfast eaten' in people's daily notes did not effectively record the amounts eaten or drunk by the individuals.The lack of detailed information in people's daily notes meant that changes to their daily intake may not have been identified promptly. This placed people at risk of malnutrition or dehydration.

For one person, their totalled daily fluid intake was so low that it placed them at risk of dehydration. Their care plan did not record any actions taken to promote their health, although the deputy manager was able to demonstrate that the GP had been informed, and referral to a dietician had been arranged. This meant that this person's care records did not reflect the care they required. This placed the person at risk of harm, as staff may not be informed of the required actions to promote their health and wellbeing

People were not protected against the risks of unsafe or inappropriate care or treatment because records did not effectively record their care or treatment needs. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

People were not protected from the risks of inadequate nutrition and dehydration, as the provider did not always provide a choice of suitable food, or support people to eat and drink sufficient amounts where necessary. Although people on the reminiscence unit were offered plated meals to choose their preference, on the first day of our inspection both options looked similar. Therefore people may not have been able to differentiate between the choices offered. There was no other format available for people to indicate their preferences, such as pictures of reference. This meant people were unaware of other options available. We observed that three people did not eat the meal they chose, and several others only ate small amounts. Most people ate their pudding in preference to the main course, and staff told us this was not unusual. This may place people at risk of not receiving a healthy balanced diet to meet their specific nutritional needs.

People were not protected from the risks of inadequate nutrition or dehydration. This was a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

On the second day of our inspection the deputy manager explained the arrangements they had put in place to improve people's dining experience, including changing staff working practices on the reminiscence unit to ensure people received required support promptly. The chef was working with care staff to ensure daily records could accurately document portion sizes eaten or left.

People had not been supported to consent to their care and treatment. Documents did not explain how the person's consent had been obtained if they were unable or unwilling to sign their consent. Records did not detail the reason or process for decisions taken when people had been assessed as unable to make a specific decision about their care or welfare. For example, we did not see evidence of mental capacity assessments or the best interest decision-making process for the use of call bells or bed rails where this was appropriate. A best interest decision is made by professionals, care workers, relatives or others with professional skills and knowledge of the individual, to ensure a decision the person lacks mental capacity to make themselves is taken in accordance with their best interests and known preferences.

Where documents had been signed by a relative rather than the individual, they did not include an explanation of why the individual was unable to sign themselves. It was not documented whether the person signing had power of attorney for care and welfare, or any other indication of why this was an appropriate or lawful signatory. Where it had been identified that people had varying mental capacity, there was no evidence to suggest that they had been involved in the decision-making process, or that their views had been taken into consideration.

People were not effectively supported to consent to their care and treatment. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

People were able to move around their units freely, and were able to move between units and into the local community if they wished. Where people had their liberty restricted to ensure their safety, for example through the use of door keypads, Deprivation of Liberty Safeguards

Inadequate

Is the service effective?

(DoLS) had been submitted to ensure these restrictions were lawful. DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive a person of their liberty where this is a necessity to promote their safety. This meant appropriate procedures were in place to support people requiring DoLS restrictions to maintain their safety. Staff were undergoing training in Mental Capacity Act 2005 (MCA) and DoLS to ensure they understood lawful processes to support people.

At our previous inspection in August 2014 we had found staff were not supported to achieve all their required training, or to attend regular supervisory meetings. At this inspection we found these concerns had been addressed. Records demonstrated, and staff confirmed, that essential training had been completed and updated in accordance with the provider's training requirements. Competency checks ensured staff had the required skills to safely support people, for example with medicines administration and mobilising people safely. This meant that people were supported by staff with the skills required to meet their care and treatment needs.

Additional training for staff had been scheduled in role-specific topics, such as wound and catheter care for nurses, and allergy awareness for catering staff. New staff were supported through a structured induction programme that 'buddied' them with an experienced member of staff to monitor their progress. They shadowed experienced staff and were observed to ensure they could support people safely before working alone. This meant that people's care and treatment was provided by staff with the skills and knowledge required to support them safely.

Staff told us, and records confirmed, that supervisory meetings were held in accordance with the provider's requirements. All the staff spoke positively about their supervisory meetings. One care worker told us "I can see the difference. They listen now".

Hospital referral forms had been prepared in readiness to ensure important information, such as people's medicines, medical history and health needs were documented should a person require emergency admission to hospital. Care plans recorded liaison and referral to health professionals when actions or symptoms indicated a need for medical intervention, for example to review falls, refer people to a memory clinic, or for audiology tests to check their hearing. This meant people were supported by health professionals to promote their health and welfare when a need for this had been identified.

Requires Improvement

Is the service caring?

Our findings

Most of the people we spoke with were complimentary about the care they received. Comments included "I am very happy here, the staff are always cheery and bright, they are great and do a good job", and "The staff are lovely and very kind". A relative told us "I cannot praise the home highly enough, staff are always kind and friendly".

However, feedback from a committee meeting held in November 2014 noted that staff did not always knock on people's doors or wait to be invited in. One person told us their preference for seating in the dining room was not always accommodated by staff, and they were sometimes told to sit in an area that was convenient for the staff member rather than met their preference. This meant that people's privacy and wishes were not always respected.

During our inspection we observed instances of staff treating people with dignity and respect. We observed that people recognised regular staff, and appeared to have a good rapport with them. We observed the maintenance person treated a person with respect when attending to repairs in their room. They knocked on the person's door and waited to be invited in. This suggested that people did not experience a consistent level of respect or privacy in the home.

One care worker told us "People's care plans are very large and complicated so I only use the daily assignment sheets and get to know people's needs". The assignment sheets contained limited information about each individual, such as the time they wished to get up or went to bed, their support needs for moving, and meal preferences, needs and allergies. Care workers told us these were not always updated to reflect people's current needs and wishes. One person told us they had not been supported to get up at the time they wished. This demonstrated that people's needs and wishes were not always met, especially if staff did not know the individual well.

Care workers were allocated to named individuals on a daily basis. One care worker described how they introduced themselves to people at the start of each shift, and ensured they were aware of each person's current needs and wishes, so that they could support them as they wanted. This included supporting daily decision-making, such as ordering meals in advance to ensure their choice was available. People's comments to us suggested that this was not a consistent experience. For example, some people told us meal choices were limited when they dined.

We observed many instances of thoughtfulness and compassion between staff and people in their care. For example, we observed staff slowed their pace in communal corridors to walk with people, and supported people to eat at their pace. When supporting people with medicines, staff provided assurance, and spoke kindly with people. When one person walking in the home appeared breathless, staff suggested they took the lift rather than the stairs to get downstairs. When the person refused, the staff member stopped the task they were engaged in to accompany the person down the stairs, to ensure they were not at risk of falling.

People's views were welcomed through informal individual feedback and planned meetings, such as the monthly residents committee. A comments book located at the dining room entrance had been used by people to provide positive feedback on meals they had enjoyed, or to raise informal complaints if the meal had not met their expectations. The chef responded to comments in the book, and met with people individually on a monthly basis to discuss menu options and preferences. There was a regular food forum meeting for people to share their comments and suggestions with catering staff. Minutes from a committee meeting held in November 2014 noted discussion of the norovirus outbreak, plans for refurbishment of the home, and availability of flu vaccinations. This demonstrated that people had opportunities to discuss areas of importance to them, and influence the care and support they received.

Requires Improvement

Is the service responsive?

Our findings

People told us staff were not always responsive to their needs. They told us of some delays to the answering of call bells by staff. One person was concerned that their spouse had not been supported to get up and dressed at 9.40am. Staff and health professionals told us this was not an unusual experience for people. This meant that people's wishes to rise at a specified time were not always met.

The activity coordinator led activities on the reminiscence unit. The deputy manager told us they were encouraging care staff to also take a lead to offer more variety. Staff told us they knew people well, and understood their activity choices, including those who did not wish to join in group activities. They told us they respected people's choices, but gave them "Lots of encouragement" to join in. Staff did not record when they visited people who were unable to, or chose not to leave their rooms to join in with group activities. This meant there was no process available for staff to consider how often people were engaged in meaningful or social activity. This meant there was a risk of social isolation for some people.

People were satisfied with the range of activities offered. One person told us "There are plenty of activities, we can join in or not as we wish". We observed events provided on each floor of the home, including word games, one to one pampering sessions, a holy communinion service and an outing to a local amenity. An events plan was displayed in communal areas to ensure people had the opportunity to join in. These included travel outside of the home, for example to local shops, pubs and the theatre.

People's care needs were assessed prior to and on admission to the home, and a care plan was developed to record their needs, preferences, likes and wishes. The care plan was then reviewed monthly, and updated as necessary. A care worker told us they followed guidance in people's individual support plan (ISP) to understand people's needs and preferences. However, ISPs did not always reflect people's current care needs. For example, we noted one ISP recorded that the person did not have any hearing problems or aids. Notes from a recent family meeting documented that the person required their ears syringing, and that care workers did not always ensure that their hearing aid was in place. This meant there was a risk that this person may not be supported to be able to hear well. Care workers told us that ISPs were not always updated to reflect people's changing needs or wishes. Agency staff did not always know people well. This meant there was a risk that care and support would not be provided as the person wished or required.

People told us they knew how to raise complaints or concerns. One person told us "If I have any complaint I would not be afraid to say it. They ask us at intervals if we are happy or if we have any complaints". Although relatives were not aware of the complaints process, they told us concerns had usually been addressed promptly when raised. However, one relative told us that their concerns had not been satisfactorily addressed, and told us of the process they were using to escalate their complaint externally.

The complaints process was explained in the residents handbook, made available to each person on arrival in the home and available throughout the home for reference. The provider's complaints policy documented the process to investigate and resolve concerns internally, or externally with the ombudsman if necessary. The complaints file did not record any formal complaints raised since our last inspection in August 2014. Four informal complaints, regarding meals, had been logged and responded to. The issues identified had also been discussed at the following residents meeting to ensure it had been resolved to people's satisfaction. Compliments were logged. Complaints and compliments were reviewed monthly as part of the provider's 'quality of life indicator' audit.

People's independence was promoted. Rooms were personalised to reflect people's tastes and interests. This included a memory box or pictures displayed outside rooms to enable people to identify their own rooms with ease. Visitors were welcomed throughout the day and evening, and private function rooms were available for hire. During our inspection one person celebrated a birthday with their family in one of the function rooms. Pets were welcomed to visit, and some people kept their pets at the home, which provided them with comfort.

People were encouraged to share their views, for example through the residents committee, dining forum group and an annual opinion survey. Feedback sought from relatives ensured that the views of those unable to participate in surveys or meetings were represented. This meant people had the opportunity to raise any concerns or changes as they wanted. An action plan dated November 2014 identified the actions planned to address issues raised

Requires Improvement

Is the service responsive?

from the most recent opinion survey held earlier in 2014. The activities programme for December 2014 reflected changes implemented to meet people's requests, such as the introduction of cooking sessions, and plans for the manager to attend more social functions in the home. Informal feedback was welcomed via comments books, and each person had a monthly meeting with heads of department, such as maintenance, catering and housekeeping, as well as a nurse.

One relative told us "I have been involved in my relative's care plan but it is huge and hard to follow". Information shared with CQC by relatives prior to our inspection suggested that they had not always been informed of changes to people's care needs. All the relatives we spoke with during the inspection told us they were kept up to date and involved in people's care plans where this was appropriate. One relative said "They phone me and discuss any issues". Records documented regular meetings with people, and their relatives if they wished, to review their care needs and wishes. Notes from one person's meetings documented how issues raised in September 2014 had been reviewed during monthly family meetings, and were documented as resolved to the family's satisfaction in November 2014.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in August 2014 the provider did not have effective quality assurance systems in place to ensure that continuous improvements were made and sustained in the home. The provider sent us an action plan outlining the improvements they would make. They said these would be in place by 26 October 2014.

At this inspection we found the service had not taken sufficient actions to address these concerns. Although some of the audits implemented by the provider were effective in monitoring the quality of the service, not all the systems had been operated effectively to drive and sustain improvements. Actions identified to reduce harmful risks to people had not always been completed. Actions taken were not always monitored to ensure they effectively reduced risks or improved people's health and wellbeing. For example, the manager had completed monthly audits reviewing areas of care and treatment including skin pressure area damage, medicines management, food and fluid care and falls. Where issues had been identified, an action plan documented how the provider planned to resolve these issues. Actions included referral to the GP when one person was losing weight, and support from the tissue viability nurse to promote healing of pressure ulcers for a person requiring pressure area care. However, we found continuing concerns regarding pressure and wound care. Actions to promote wound healing were not always effectively implemented, and systems to identify when people were at risk of malnutrition and dehydration did not always protect people from harm. This demonstrated that the audit process was not an effective assurance system to reduce identified risks to people's care and welfare.

Some audits, for example for dining and catering, demonstrated actions had been taken to address issues identified, such as improving food storage and waste management. However, the provider had identified that other audits, such as the manager's monthly internal audits, required actions that had not been completed to resolve issues identified. A report following the Director of Operations visit on 11 and 12 November 2014 had identified some improvements made on the manager's current audit action plan, but also identified areas of continuing concern. For example, they had identified that one person had not been referred to a dietician despite a large weight loss over a four month period. Care plans had not been updated to reflect some people's changing care needs, such as a requirement for increased support with mobility around the home and eating. This meant that people may be at risk of harm, as staff may not be informed of the care or support they needed to promote their safety.

Other internal audits conducted by managers in the home and the provider's management team had identified concerns. For example, care plan audits had identified where there was a lack of monitoring of behaviours that challenged the service or posed risks to people or staff. Daily checks of charts identified when food and fluid and re-positioning charts had not been completed. Actions had been implemented to address these identified concerns, such as reminders, support and disciplinary measures to encourage staff to complete all required documentation. However, there was no evidence of a robust or effective system in place that demonstrated that responses to address issues were embedded or sustained within the home. This placed people at risk of harm.

People were not protected from risks to their health and safety through the implementation of effective systems to assess and monitor the quality of the services delivered. This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

A registered manager had not been in post since May 2014. At the time of our inspection the deputy manager was managing the home, as the general manager was unwell. People and their relatives spoke positively about the managers in the home. One person described the manager as "Pretty good, and very friendly", and two relatives told us the home was well organised. Others did not voice their opinions to us. The deputy manager told us managers were on site daily, and that a manager was on call throughout the night. This meant that staff could access management guidance whenever it was required.

Although staff told us they felt well supported, this was usually in reference to their direct line manager. For care workers, this referred to the team leader. For nurses, this referred to the deputy manager. Several staff commented on the number of managers in the home, and ongoing changes to the management structure. They told us that although managers were always available through the 'on call' system, they did not always understand who to turn to for advice. This meant people may be at risk of inconsistent care, as staff sought advice from a range of sources. Nurses spoke positively about the deputy manager, and one nurse

Requires Improvement

Is the service well-led?

told us the deputy was "Proactive and supportive, gets communication channels open, and takes comments on board", but care workers did not appear to have the same level of management direction or support. There was potential for staff to have an over-reliance on the deputy manager for support, creating a risk when this manager was not available.

The provider's mission statement was displayed in the home, and on brochures and leaflets, including residents and staff handbooks. This included core values such as respect, freedom of choice, celebrating individuality and encouraging independence. People, relatives and staff did not uniformly feel that the home lived up to these standards. Some people and relatives spoke positively about the home. One relative said "I think the home is brilliant and the care very good. When my relative was diagnosed with dementia I was offered a five day pathways course and also offered counselling. I did not take it up but it was good to have it offered". Whilst staff displayed core values such as respect and freedom of choice during our inspection, some people and staff told us they felt the provider's emphasis was on profit rather than people's care. This meant that they did not believe the provider demonstrated these same core values.

A daily team leader meeting discussed immediate issues identified and actions required, such as preparation for a new admission to the home, planned events and functions, health professionals and other visitors expected on site, and staffing levels. This ensured that all staff were aware of the actions required of their teams. Staff told us this was cascaded to teams by the team leader, and we noted the minutes from these meetings were displayed in staff offices. This ensured that issues were addressed promptly, and that communication was shared effectively.

Staff told us communication between managers, nurses and care workers was improving, and one nurse told us "It's easy to voice your opinions". They told us they felt supported and empowered to contribute to the effectiveness of care management through the training offered to nurses. They told us the deputy manager listened to their comments to improve people's health and welfare. For example, one nurse explained how they had been supported to take a lead in promoting wound care. Care workers did not describe the same level of empowerment or tell us they were felt able to influence the service provided to people.

Comments cards and a suggestion box provided opportunities for staff to bring ideas or concerns to the manager's attention. Staff were encouraged to make positive changes through rewards for suggestions or actions that improved people's care experience or the smooth-running of the home. Completed cards had been collated by the provider, and the deputy manager explained how some suggestions had been considered, for example requiring staff to sign out walkie talkies used to communicate between staff teams. This helped staff to alert team members when people required additional support, and ensured equipment did not go missing. This meant that staff were supported to consider and deliver care that improved people's experience in the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People's health, safety and welfare had not been safeguarded, as the provider had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitable qualified, skilled and experienced staff employed to carry out the regulated activities. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers People had not been protected from risk, as the provider did not operate an effective recruitment procedure to ensure applicants were of good character, or that satisfactory evidence of conduct in previous employment whilst working with children or adults at risk, or in health and social care employment, was verified. Regulation 21 (a)(i)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People, staff and visitors were at risk of infection, because the provider had not protected them through the implementation of effective systems to prevent and control the spread of health care associated infections. Regulation 12 (1)(a)(b)(c)(2)(a)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People were not protected from the risks of inadequate nutrition and dehydration, as the provider did not always provide a choice of suitable and nutritious food, or support people to eat and drink sufficient amounts where necessary. Regulation 14 (1)(a)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment People were not supported to consent to care and treatment through suitable arrangements in place to obtain and act in accordance with their consent, the consent of others lawfully able to consent on their behalf, or through the establishment of, and actions supporting, people's best interests. Regulation 18 (1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not protected from harm, because the provider did not ensure that records were accurately documented or maintained to identify and meet each person's care or treatment needs, or in relation to persons employed by the service. Regulation 20 (1)(a)(b)(i)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider failed to ensure appropriate steps were in place for the recording, safe storage and safe administration of medicines. They failed to ensure that service users were protected against the risks associated with unsafe use and management of medicines. Regulation 13

The enforcement action we took:
We issued the provider with a Warning Notice telling them they are required to become compliant with regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 by 27 February 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider failed to ensure that service users were protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to identify, assess and manage risks relating to the health, welfare and safety of service users. Regulation 10(1)(b)(2)(a)(b)(iii)(v)(c)(i)

The enforcement action we took:
We issued the provider with a Warning Notice telling them they are required to become compliant with regulation 10(1)(b)(2)(a)(b)(iii)(v)(c)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 by 27 February 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider failed to take proper steps to ensure that each service user is protected against the risks of

This section is primarily information for the provider

Enforcement actions

receiving care that is inappropriate or unsafe, by means of planning and delivering care in such a way as to meet the service user's individual needs, and to ensure their welfare and safety. Regulation 9(1)(b)(i) and (ii)

The enforcement action we took:

We issued the provider with a Warning Notice telling them they are required to become compliant with regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 by 27 February 2015.