Sunrise Operations Sevenoaks Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

Sunrise Operations Sevenoaks Limited provides accommodation, nursing and personal care for up to 102 older people. There were 84 people living at the service during our inspection, the majority of whom were living with dementia. A number of people had other conditions including Parkinson's disease, epilepsy, diabetes, and sensory impairment. Some people had reduced or impaired mobility and used wheelchairs to move around. There were also people who lived independent lives, continuing to drive and come and go as they chose.

Sunrise is a large building with accommodation provided over three floors and communal areas on each floor. The third floor, known as 'the reminiscence neighbourhood' is designed to accommodate people who are living with

Summary of findings

dementia which has progressed. During our inspection 27 people were living in the reminiscence neighbourhood. The ground and first floors are known as 'the assisted living neighbourhood' and although some people on these floors were independent and active, many people were living with dementia and physical challenges. During our inspection there were 57 people living in the assisted living neighbourhood.

The service had not had a registered manager since December 2014. A registered manager is a person who has registered with the Care Quality Commission 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. Since the previous registered manager there has been interim management cover until the current manager took up post in May 2015. The current manager was in the process of submitting an application to be registered with us at the time of this inspection.

We inspected Sunrise in December 2014 and rated the service as inadequate at that inspection. The Care Quality Commission (CQC) issued five Warning Notices as the provider had not ensured people were protected from harm through the effective management of risks or making sure there were suitable and sufficient, trained and supervised staff. People's needs were not assessed or reviewed, care plans were not maintained accurately and care was not delivered in such a way as to ensure their needs were met. Action was not taken to address people's complaints and quality assurance systems were not effective in identifying and improving shortfalls in the service. The provider sent us an action plan which detailed when different areas would be addressed.

We undertook an inspection on 13 and 14 April 2015 to follow up on the actions we had asked the provider to take and that they had assured us would be taken to make the improvements needed. During that inspection we found that the provider had made significant improvements and people, their relatives and health and social care professionals we spoke with, told us about the improvements they had noticed. We rated the home as requires improvement because although improvements had been made, further improvement was required and we needed to see that where improvements had been made these would be consolidated and sustained.

At this inspection we found that many of the improvements had not been sustained.

All apart from three people told us they felt safe. However, 10 of the 13 relatives we spoke with told us of concerns they had about their family member's safety. The provider had safeguarding systems and processes in place but we found that people were not always protected from harm. The provider had not taken appropriate action to reduce risks to people's safety and staff did not consistently follow safe practices, putting both staff and people at risk of harm and injury.

Staff were not effectively deployed to meet people's needs in a timely manner. The provider had not ensured that all staff had the skills and support they needed to deliver safe, effective and responsive care. We observed times where staff did not always offer an explanation of the care they delivered or seek the agreement of people.

People were not consistently protected by safe systems for managing, recording and storing medicines. People did not have their nutrition and hydration needs effectively monitored. Although charts were used when there was a need to monitor concerns, we found that these were not always completed effectively.

People received medical assistance from healthcare professionals such as the local GP. However, staff did not consistently follow guidance regarding people's health needs. Where people were at risk of pressures sores records did not show that people received the topical medicines they had been prescribed or had been repositioned as required.

Some staff were polite and respectful in their approach to supporting people. However we also observed occasions where people who were living with advanced dementia were not treated with compassion or respect.

Care records did not consistently provide staff with up to date and accurate information that would ensure they could effectively respond to people's individual needs.

There were a variety of communication systems in place but these were not being used fully and the majority of

Summary of findings

relatives, staff and healthcare professionals told us that communication needed to improve. We found that where improvements had been made such as the reduction in falls, infections and incidents of aggression themes and trends were not explored in order to influence quality.

There was an activity programme that offered a range of events and people told us that liked the choice of activities and entertainers who visited the home. However, people who required the most care and support were not always given the support they needed to ensure they had meaningful occupation during the day.

Complaints were dealt with as individual issues rather than being used to assess if there were common themes and therefore lessons that could be learnt. Relatives we spoke with did not have confidence in the provider to respond in a favourable way when they made a complaint. We have made a recommendation about this in the main body of our report.

We did see and hear some individual examples of staff treating people with compassion and kindness. People were supported to maintain their relationships with people that mattered to them. Visitors were welcomed.

Robust recruitment processes were followed to ensure new staff were not unsuitable to work with people.

A comprehensive menu was in place that offered a wide range of choices at all meal times that were nutritionally balanced to promote good health. People who were more able had a positive dining experience and told us that on the whole they were satisfied with the meal choices available.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

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

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

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

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

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 were not protected from abuse or improper treatment as systems did not operate effectively to prevent abuse.

The provider had not taken appropriate action to identify and reduce risks to people's safety and staff did not consistently follow safe practices.

Sufficient staff were not always deployed to meet people's needs.

People were not consistently protected by safe systems for managing, recording and storing medicines.

Is the service effective?

Requires improvement

The service was not always effective.

Staff did not always have the appropriate support, supervision and skills to ensure they delivered care and treatment to people effectively.

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

People did not always receive the support required to ensure their nutrition and hydration needs were met.

People were not consistently supported with their health needs.

Is the service caring?

Requires improvement

The service was not consistently caring.

Some people living with advanced dementia were not treated with compassion, dignity and respect.

People's needs and preferences were not consistently respected.

Is the service responsive?

Requires improvement

The service was not responsive.

Care records did not provide staff with up to date and accurate information that would ensure they could effectively respond to people's individual needs.

There was an activity programme that offered a range of events. People with more complex needs were at risk of becoming socially isolated due to a lack of personalised stimulation.

A complaints process was in place that enabled people to formally raise concerns. The system was not being used as an opportunity to improve or learn lessons.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

There were quality monitoring systems in place but these were not always being used to effectively or consistently improve the quality of service people received.

Changes at the service had not been managed well and this had resulted in a demoralised workforce, poor communication and significant shortfalls in service delivery.

Sunrise Operations Sevenoaks Limited

Detailed findings

Background to this inspection

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

This inspection took place on 12, 13 and 14 October 2015 and was unannounced. The inspection team consisted of three inspectors, an inspection manager, two specialist advisers and an expert by experience attending on different days of the inspection. One of the specialist advisers was a dementia specialist, and one was a registered nurse. They advised us on aspects of nursing care and the quality of services people living with dementia received. The expert-by-experience was a person who has personal experience of using and caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and information that relatives and others had shared with us. We looked at whether we had received any notifications. A notification is information about important events which the provider is required to send us by law. We reviewed the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information when planning and undertaking the inspection. The provider also sent us some information immediately after the inspection.

During our inspection we spoke with 13 people and seven relatives about their experiences of using the home. We spoke with six relatives by telephone after the inspection as they requested that we contact them to hear their experiences.

We also spoke with the director of operations, the manager, the previous interim manager, the deputy manager, the dining services coordinator, and the current and previous reminiscence co-ordinators. We spoke with the assisted living co-ordinator, the life enrichment manager, four nurses, housekeeping staff, activities staff and five health professionals including a GP. We formally spoke with 11 care staff during the inspection but we also spoke with and observed other care staff during the three days.

We examined records which included people's individual care and medicines records, activity records, six staff files, staff rotas and staff training records. We sampled policies and procedures and examined the provider's quality monitoring systems. We looked around the premises and spent time observing the support provided to people within communal areas of the home.

Inadequate

Is the service safe?

Our findings

Of the 13 people we spoke with 10 told us that they felt safe. One person told us, “Yes. I leave my door open all the time, I can go out, down the road, there are no restrictions” and another said, “Yes, I don’t think I’m not safe.” Of the 13 relatives spoken with 10 told us they had concerns regarding safety.

Prior to our inspection we spoke to Kent County Council who informed us that there were four safeguarding’s which had been investigated, concluded and substantiated as abuse since our last inspection. Of those that had been concluded one concerned a case of harm as a result of neglect. Another case concerned harm due to incorrect medicines being administered. The third and fourth cases concerned incidents where people had been hit or grabbed by other people living in the home exhibiting behaviours that challenged. As a result of each of these cases the home had reviewed systems and procedures in order to safeguard people and to learn from events.

There were safeguarding policies and procedures in place at the home and staff received training on safeguarding during their induction. We spoke with 10 staff about their understanding of the how to protect people from abuse and harm. All understood their responsibilities to report concerns. The three Registered Nurses we spoke with said that they would investigate the matter and that this would need to be reported through safeguarding and the Local Authority which is the correct procedure. Three of the staff said although they would report concerns they did not know where the policy was or who to report to outside their immediate area of work despite this information being on display at the home.

We found that despite the registered provider having safeguarding systems and processes in place these were not always robustly used to protect people from harm. One person’s care file showed that there had been multiple incidents where the person had become distressed and agitated. We asked staff to show us what strategies and actions had been put in place following each incident. We were told these had been archived. This meant they had been stored away and were not easily accessible to staff who were providing care for this person. Although the incidents were still on file and the person was known to display behaviours that challenged, there were no clear records of strategies for staff to follow to prevent harm to the person or other people. We spoke to an agency member of staff who told us the person was "Known for being aggressive". Having worked at Sunrise eight times the staff member could not recall being given specific guidance on how to work with the person. They told us they found they usually worked well with the person by "Not making a fuss and letting him make his own decisions". One permanent member of staff told us they felt that due to their experience they were able to respond more effectively to the person but that less experience care staff may struggle. Although people who knew individuals well may have had the skills to support people who became distressed and agitated, care records did not provide staff with the guidance they required to ensure people were kept safe from harm.

Records showed that in August and September six out of nine incidents where people suffered bruising and skins tears were unwitnessed or unexplained. Two skin tears occurred whilst staff assisted people with moving. One incident form from August 2015 it stated ‘Skin tear occurred during transfer accidentally by wheelchair unavoidable at time of incident’. In another incident form from August 2015 it stated ‘As I was taking (X) out of his room in his wheelchair he caught his right arm on the open door causing a skin tear- seen by nurse on duty now has a dressing on it’. No further details were recorded and no investigation undertaken to look at how the incident could have been avoided. Records from the clinical supervision meeting in August 2015 described the only reason for the prevalence of skin tears as being frailty and old age, with no further clinical analysis as to why they had occurred or if they could be prevented.

During our inspection we saw that one person had an injury on their forearm which was not documented in their care plan. We were told by their relative that the injury occurred whilst the person was being transferred using the hoist. Another person's care records showed they had sustained a large 5cm open wound to their hand. Although photographs were on file, there was no incident report to show how they had sustained the injury. When inspectors asked staff they were unable to provide an explanation.

We found that four people living in the reminiscence neighbourhood exhibited behaviours that challenged others. Three of the people’s records included clear guidance that would assist staff to understand the person’s distress and how to prevent it or de-escalate situations and

one did not. During the inspection one health professional expressed the view that incidents between people who lived at the home were not managed well and that there appeared to be a lack of learning from incidents.

The above evidence shows that people were not protected from abuse or improper treatment as systems did not operate effectively to recognise and prevent abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After our inspection we were supplied with a root cause analysis tool that we were informed was being implemented at the time of our inspection. The tool was a numerical analysis of events and did not include evidence of clinical investigation and possible preventative measures.

Since our last inspection in April four relatives and Kent County Council safeguarding team informed us of possessions that had gone missing in the home. The home had cooperated fully and worked with the police. The investigation identified that a number of people chose to place personal items in unsecured locations. As a result, people and their relatives were reminded to use the locked storage facilities at the home and for the need to have insurance for items of value. This showed that the registered provider advised people in order to help ensure their possessions were kept safe and secure.

Whilst people's care files included risk assessment we found that these did not always contain enough information for staff to safely care for people. One person was living with Parkinson's disease and we observed they were unsteady on their feet. We also saw that they sometimes dropped things as they had involuntary movements that were associated with Parkinson's. We visited this person in their bedroom and saw that their room was cluttered with many things across the floor that put them at risk of tripping or falling. The person had a small kitchenette that included a kettle and toaster to promote their independence and we saw that the sink area was also cluttered with washing up as well as out of date food on the work surface. Topical medicines were on display and these had no names or dates on them. The medicines were immediately removed when we pointed these out. We looked through the person's care file and saw that the risk was recorded but did not include measures or actions staff should undertake to minimise the potential risks. A nurse told us the bedroom was tidied frequently but quickly became untidy again. The staff had an assignment sheet that highlighted key support tasks for this person which stated 'Makes room very untidy'. There had not been any accidents involving the person in their room but there was a lack of documented guidance for staff as to how they should manage this potential risk. After our inspection we were informed the person had capacity and it was their choice to have items on the floor of their room as it gave them a sense of security.

People who had fallen were assessed and provided with lowered beds, crash mats and falls mats that would raise an alarm that alerted staff should they fall. We looked at the falls mat list for those people living in the reminiscence neighbourhood and we found that this did not match the information staff were given on the assignment sheets. The list on the wall showed that 14 people used falls mats; the assignment sheet showed that 11 people used falls mats. Therefore information was not accurate about the numbers of people who used falls mats and staff did not have accurate information about people that might require assistance should they fall.

During our inspection two relatives expressed the view that mats did not offer sufficient protection or reduce the risk of injury if their family member fell. The home had a bedrails policy in place which confirmed bed rails were only used as a last resort when all other options had been considered. This is in line with national guidance and good practice as bedrails pose risks of entrapment and injury. We looked at incident reports from September concerning skin tears. These showed that two people who were assessed as at risk of falls and who had mats in place sustained skin tears as a result of falling from their bed. Further consideration had not been given for the use of bed rails despite the two people sustaining skin tears. As a result, the home was unable to demonstrate that risk management was always safe for the two people concerned.

People's care plans included an assessment of mobility as well as a moving and handling review. Both the resident review and risk assessments and individual service plans stated 'If a hoist or sling is used, detail the type of hoist and the make and size of the sling used'. However we found this was not always completed and no information regarding the make or size of sling was recorded in three people's files. This meant staff did not have information they required to ensure they practiced safe care when assisting people to move.

Inadequate

Is the service safe?

Prior to our inspection we had been made aware by two people's relatives of concerns they had regarding unsafe moving and handling practice. One relative told us that they had witnessed people being moved in wheelchairs without footplates being used and another relative described how they had witnessed one person lifted from behind by a member of staff. During this inspection, despite staff having completed moving and handling training we observed moving and handling practices which placed people and staff at risk of injury. We saw people being moved in wheelchairs that only had one footplate, with both feet placed on the one plate. On another occasion we observed a staff member approach a person and begin to wheel their wheelchair. We noted the person's feet were still on the ground which is against good practice as it puts the person at risk of injury when the wheelchair is moving. The member of staff did not help the person to put their feet on the footplate until we reminded them to do so.

On another occasion we saw two staff, one of whom was from an agency and another who was a permanent and longstanding member of staff, work together to physically lift a frail person out of their chair and into their wheelchair. We intervened and asked the staff about the correct moving and handling guidelines for that person. The staff told us that a hoist should have been used. We checked the training and competency for the two staff members involved which showed that their training was in date. Although the staff knew they were required to use a hoist, they had not followed safe practice and had put the person at risk of harm and injury. Immediate action was taken by the manager when we drew this to their attention in order to safeguard people from the risk of injury.

Medicines were not always being managed safely. During this inspection we observed as nurses administered medicines and saw that these were being administered correctly in the assisted living neighbourhood. However in the reminiscence neighbourhood we saw a nurse dispense medicine into their own hand without wearing gloves before administering the medicine to the person which is not good practice.

We also found a number of concerns regarding medicine records and safe storage of medicines. We looked at one person's Medicine Administration Record sheet (MAR) for September 2015, and there were two days where a medicine which is used for the treatment of Parkinson's disease, was not signed as having been administered. This medicine needs to be given at specific times and the MAR gave no indication as to whether it had been delayed or given at all. On another MAR sheet, Thyroxine was signed for as given yet the number of remaining tablets did not correspond with it having been given. Another person's MAR sheet had paracetamol to be given when required, however as the amount given was not always indicted, this made checking the person received the correct dose difficult.

The medicines policy referred to Oxygen needing to be secured to the wall and that a warning sign needed to be displayed. We found that Oxygen cylinders were stored in the clinical room and the door was without a warning sign and the cylinders were not secured and were instead free standing. This does not follow the provider's own safety guidance and posed a potential risk of harm to staff or others.

One person's relative told us they had concerns regarding the administration of topical medicines as they had looked at their loved one's records and found gaps in administration. We looked at the use of topical medicines and found that records did not always evidence that people were receiving these as prescribed. We also found that some were without names and some did not include the dates of opening or expiry. When we visited one person's bedroom the deputy manager removed a number of creams where this applied.

We were shown the homely remedies sheet signed by the GP on the12 August 2015. This included the types of homely remedy, dose, duration, and any contraindications approved by the GP. However although there was a separate record for homely remedies we found that there had not been a stock check and balance recorded since 15 August 2015.

The provider was having difficulty with the supplier of people's medicines and although senior staff had made repeated attempts to rectify issues we found that the room where medicine returns were stored was very untidy with 13 large sacks of medicines waiting to be returned. Where the floor area was covered there was little room for staff to enter and use the room for its purpose. We also found that there were sharps bins that were on the floor that did not have their dates of opening and closing recorded as they should have. One registered nurse explained that these were accumulating, as it could not be clarified who was responsible for taking them. The book that recorded

Is the service safe?

medicines that were destroyed or returned to the pharmacy was not comprehensively completed. After our inspection we were informed that arrangements had been made with an appropriate specialist for the removal of these items.

The medicines policy had been reviewed in 30 September 2014 and was comprehensive in its content covering training needed before staff could administer medicines, information on administration and disposal as well as ordering and action to take when medicine errors occurred. There were three staff signature lists confirming staff had read and understood the policy. However, our evidence demonstrates that the policy was not being followed at all times.

The above evidence demonstrates that care was not provided in a safe way to people and people were not consistently protected by safe systems for managing, recording and storing medicines. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three relatives expressed the view that at times there were not sufficient numbers of staff to meet people's needs promptly. Three staff told us that since our last inspection the numbers of nurses on duty had fallen. Rotas confirmed that the number of nursing hours had reduced since 1st June 2015. However, we were informed this was because an additional nurse had been allocated whilst the deputy manager was on leave that was not required when they returned to work. When we inspected in April 2015 there were 78 people living in Sunrise, 38 of whom required nursing and during this inspection there were 84 people living at sunrise, 39 of whom required nursing. The provider used a scoring system to work out the level of care that people required and the amount of hours of care needed. We were informed that based on the assessed needs of individuals the staff levels were appropriate to meet the needs and numbers of people who lived at the home. Despite staff levels being maintained on the majority of shifts to the assessed levels determined by the provider six staff and two health professionals expressed the view that at times, staff levels impacted on the care and support that people received. In the reminiscence neighbourhood, one staff member told us, "Around lunchtimes there is not adequate staff, the deputy manager has helped at lunchtimes…." Another staff member told us, "I don't think there are enough staff and where they are overworked; they don't show patience towards residents". One staff member told us, "Every day is different, sometimes you are fully staffed and sometimes we are two down but we come together as a team".

We looked at the minutes from the residents' meetings held in September 2015 and found that one resident expressed concerns that it had taken up to 50 minutes for call bells to be answered. The manager agreed with the person that this was not acceptable and offered assurances that she would discuss this with the staff concerned. During our inspection we asked to see the call bell logs from the three days preceding our inspection. These showed that there were times when calls had not been answered for over 45 minutes which meant that people may not always have received timely care. One person told us of an occasion when "last time it took them 20 minutes to answer". We spent over an hour in the assisted living area lounge during which time people were brought into the lounge in wheelchairs. The only time we observed staff coming into the lounge was when they were assisting people to come in or out of the area. We did not witness any person receiving unsafe care due to the lack of staff presence. We observed lunchtime in the reminiscence neighbourhood. We observed that there were times during the lunch that people were sitting for long periods with no food and did not have staff easily and readily assisting them when they required help. We observed some people waiting for 20 minutes between courses.

The above evidence shows that were insufficient numbers of staff were deployed to meet people's needs at the times they required. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our inspection we have been provided with evidence that call bell response times are being monitored and actions taken when these are not responded to within acceptable timeframes.

We looked at six staff files, four of whom were new staff and two of whom had been at Sunrise for two and five years. All files included appropriate pre- employment checks which showed the provider had taken action to ensure that newly employed permanent staff were as far as possible both suitable and safe to work with people living at the home.

Requires improvement

Is the service effective?

Our findings

People who were able to speak told us they were supported to have sufficient amounts to eat and drink. One person said, "I think it's good, it's not home cooking" and "Sometimes it's good but you get a great pile of meat" and "I would actually like more choices than we get" and "It's too rich, wish there was more home cooking…plainer".

A comprehensive menu was in place that offered a wide range of choices at all meal times that were nutritionally balanced to promote good health. People were offered choice and we saw that specific dietary needs were catered for. Those people who were more independent appeared to have a pleasurable experience in the assisted living dining room. People were chatting to each other and interacting with staff. We observed one person leaving the table, taking their own bottle of wine and another person thanking them for sharing it.

Where people had more complex nutritional needs, more advanced dementia and found verbal communication difficult, there were problems which put them at risk of not receiving the nutrition and hydration they needed. During lunch in the reminiscence neighbourhood we saw on one occasion that staff began to clear things away at which point a visitor told staff that their family member was yet to receive their main meal. Although staff subsequently served them a meal, they had not noticed that this person had not received one because they were not effectively supporting and monitoring people.

On another occasion we saw an instance when staff did not identify visual clues given by a person that indicated they would like more food at lunch time in the reminiscence neighbourhood. This person had finished their main meal and taken their empty plate up to the hot trolley. The person was looking at the food in the trolley and their behaviours indicated they wanted more. The staff member took their plate from them, thanked them and asked them to sit down as they would be given pudding. The person looked around the room, and approached other people sitting at tables, trying to take a piece of toast from the plate of one person before being handed another person's plate of food. At this point the staff member redirected the person to their seat where they were given food to eat. Although the person's body language, conversation and general demeanour indicated they were still hungry and wanted more, the care staff did not identify this need.

Four relatives told us of times where they felt their family members had not received adequate support to eat or drink and our observation of the lunchtime experience in the reminiscence neighbourhood confirmed people living with dementia did not always experience a positive dining experience.

Management told us that charts were used when there was a need to monitor what and how much people ate or drank. We saw that these were designed for short term use where people were at risk of malnutrition or dehydration due to acute illness or deteriorating health. We looked at the three day food intake chart for one person whose weight had fallen. The person's care file stated they needed physical assistance to eat and that they should receive 'High calorie snacks and drinks' and 'Three meals day, full portions and snacks three times a day'. We looked at their chart for the 18 September and found it was not effectively completed. On day one it had three entries that recorded the person as having eaten 'Ready break, Puree and Yoghurt with double cream.' On day two the only food this person was recorded as having eaten was described as 'Puree with the amount consumed as a quarter of that served. On the third day there was no food recorded. On the 21st September a new three day chart for this person was started and again it was not effectively completed with two entries for one day and no further entries made. Although the food intake chart had a section where concerns about the amount of intake could be recorded and actions taken, this was left empty. This showed that this person's nutrition was not being effectively monitored. We looked at a three day fluid chart for this person and found that this had only been monitored for two days and that the person's fluid intake was not totalled every 24 hours for staff to clearly understand whether the person was hydrated.

Another person's food chart for 10 October 2015 had only two entries at 12.30pm, 'Soup and a Pudding'. The fluid chart for 10 October had no 24 hour total and when we totalled the person's fluid intake for that day it was only 300 mls. Another chart we saw included jelly recorded on both the food and fluid charts for this one person, who had approximately 500mls intake recorded. We were informed that a nutritionist had said it was appropriate for jelly to be recorded on both as it was a fluid as well as a food. Having totalled up both people's fluids there were days when both individuals were drinking under one litre of fluids a day. This is considerably lower than the amount recommended

in the Royal College of Nursing (RCN) guidelines for older people. These recommend; 'A conservative estimate for older adults is that daily intake of fluids should not be less than 1.6 litres per day'. This showed that systems were not being used in full to ensure potential risks associated with malnutrition and dehydration were reduced.

We looked at the care records for one person whose weight records from May 2014 showed them weighing approximately 66 kg. Their most recent resident review and risk assessment was dated April 2015 and showed their weight had fallen to 61.3 kg. However this record stated that there was no weight loss. It stated 'Sometimes food will need to be cut especially meat as I have difficulties to chew hard food'. In June 2015 there was a handwritten note on the person's individual service plan that stated they required a referral to Speech and Language Therapy (SALT) as were coughing when drinking and were at 'Increased risk of chest infections.' We saw that a letter from SALT dated July 2015 made recommendations to use thickener in the person's drinks and to monitor their fluid intake should they not like thickened fluids. Their wellness visit was dated 28 July 2015 and their weight had further fallen by another 2kg. We asked the nursing and kitchen staff to show us records of this person having tried thickened fluids but they were unable to provide any. One staff member told us that the person did not like their drinks thickened. We asked to see the person's fluid charts that would show them having tried this and how it had affected their fluid intake. They were unable to provide any records to show the SALT recommendations had been followed, they told us, "I know what you are looking for and I know we should have recorded it but no there isn't anything".

The above evidence shows that some people did not have their nutrition and hydration needs effectively monitored. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Half of the people who lived at the home that we spoke with said that staff were knowledgeable and trained sufficiently to carry out their roles. One person told us about their specific medical needs and how these could be difficult to manage but "They (staff) are excellent". Another person said, "They're not bad". Three people said that at times staff did not know their needs. One said, "A few are, yesterday was dreadful, I had a strange girl for everything I had, they didn't know what they were doing. I didn't know any of them".

Since our last inspection there had been a significant turnover of staff and the provider had been proactive in their recruitment. Two health care professionals, two members of staff and two relatives expressed the view that the turnover of staff had affected continuity of care that people received. We were informed that whilst permanent staff were recruited the home had been supported by agency staff and that whenever possible the same agency staff were used in order to ensure effective care.

The provider had formal induction, training, supervision and appraisal systems in place but half of the staff that we spoke with expressed the view that they would like further support. One staff member said, "Most people (staff) are sent off to do their training on e-learning and some struggle". One new staff member told us, "I could do with a lot more support, it's such a big home and there is so much to learn, the lead will tell me to go and see a person but I don't know who these people are". Staff said that they received supervision but that the frequency of this varied and records confirmed this.

Records confirmed that agency staff received information about the home and people when first coming to work there. However, during our inspection we observed interactions and practice that showed that not all agency staff understood the needs of people they were supporting. On one occasion, we saw an agency staff member say to a person who used a walking aid, "I'm going to take this away and you are going to walk normally". This person's assignment sheet clearly stated they used a walking aid. On another occasion we observed that an agency member of staff was serving an unpleasant looking green puree to a person at lunch time. On questioning the staff member they told us they did not know what they were serving but had mixed all the pureed food together. The senior carer on duty informed us this should not have happened and she would speak to the staff member. We also witnessed examples of unsafe moving and handling that showed that where staff had completed training they were not always using skills or the learning from the training to deliver safe or effective care.

The above evidence shows that all staff, including agency staff were not sufficiently skilled to care for people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had an induction and training programme in place that included subjects such as moving and handling,

Is the service effective?

fire safety, infection control, COSHH, health and safety, food hygiene, dementia, safeguarding, bedrails and MCA and DoLS. We asked the management to supply evidence of staff training and we were shown two staff training matrices detailing what training had been completed and what was planned. These were not up to date and therefore did not demonstrate that sufficient numbers of staff had been provided with training that helped equipment them with the skills and knowledge to meet people's needs.

After our inspection we were supplied with documentary evidence that confirmed that all staff had completed their initial training and the majority of staff had completed refresher training. We were also supplied with documentary evidence that confirmed that a qualified first aider was allocated to every shift and that wound care training was provided to all nurses in 2015. In addition to this, we were also informed that the provider employed a nutritionist who provided training to 26 staff in 2015. Also that as part of their basic training, nurses completed pressure area care, epilepsy and diabetes training and that non-emergency matters would be referred to the specialist diabetic nurse, tissue viability service or GP.

Those people who were able to speak with us told us they could make their own decisions regarding their day to day care. For example, choosing from the menu, what time they went to bed and what they wore. Our observations found that those people who were able to express their wishes and communicate verbally with staff received the care they required and preferred. For people living with more advanced dementia's and other physical illness or disability staff did not always offer up explanation or seek their consent to care. One staff member told us, "I don't understand mental capacity, old people with dementia, we talk to them, have patience listening to what they are saying". We observed multiple times where people were wheeled in their wheelchairs without explanation or agreement being sought. For example, we observed a staff member pushing a person in their wheelchair out of the dining area, along the corridor and back to the dining area without asking were they wanted to go.

On another occasion we observed two people sitting together in the main lounge of the reminiscence neighbourhood enjoying a western film on the TV. At 12.30 they were taken to the dining room for lunch without any discussion or consultation. The staff did not enquire whether they wanted to finish watching the film and eat later or whether they would like their food brought to them so they could continue watching whilst eating. Although these two people were engaged in a meaningful activity this was disrupted by the routine of the home and they were moved without consent being sought.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. This legislation sets out how to proceed when people do not have capacity to make specific decisions and what guidelines must be followed to ensure people's freedoms are not restricted. It provides a process by which a person can be deprived of their liberty in their own best interests when they do not have capacity to make certain decisions and there is no other way to look after the person safely.

We asked the co-ordinator of the reminiscence neighbourhood about their understanding of mental capacity and deprivation of liberty. We were told, "All residents have been assessed using a mental capacity assessment. All residents have a deprivation of liberty safeguards referral completed". We found that although applications for DoLS were comprehensive, there were some occasions when mental capacity assessments were not in place where other records indicated people did not have the capacity to consent. For example, three people had a 'Do Not Attempt CPR' record in place which had been authorised by a GP in line with legal requirement but decision specific assessments relating to these were not in place.

We observed one example where a person was restricted without their consent. The person's assignment sheet said 'X uses her wheelchair to get about and uses her feet to move around the community'. We saw a member of staff wheel this person in their wheelchair to the lounge of the assisted living area. When the person was left alone they lifted the footplates from the wheelchair with their feet and moved their chair using a shuffling motion into the dining area. The person then proceeded to shuffle their way back to the lounge. As they approached the area where an inspector was sitting, a member of staff came over to the person and said, "So you want to go back to your club?" she replied "Yes". He then said, "Later" and moved her back to where she had been originally positioned in the lounge. He then told her that he was "Putting the brake on" as she had "To stay there for now", no explanation as to why was

Is the service effective?

given. This restriction imposed on the person did not consider their ability to make individual decisions for themselves as required under the Mental Capacity Act (2005) Code of Practice.

Staff did not always act in accordance with the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People that were able to speak with us told us that their healthcare needs were being met and that they could see a doctor, dentist or chiropodist when they needed to. One person told us, "I have an immune problem and had a virus infection, very high temperature and received marvellous care, they insisted I was attended to by the Doctor" and "The Chiropodist comes round every couple of months". Three relatives of people and two healthcare professionals expressed the view that improvements could be made in relation to the management of complex needs and the health needs of people who were living with advanced dementia.

During this inspection we looked at the care plan for one individual who was at risk of pressure sores. Their care plan stated 'I must be repositioned through the night (every four hours) to ensure that my skin remains intact and I am not at risk of any pressure damage'. We asked to see the records that showed this was taking place but staff were unable to supply any. We looked at the persons topical medicine application records which stated they required a barrier cream to be applied twice daily. We found that on only one day out of the previous eleven day period was the cream applied twice. On five days out of eleven days there was no record that this topical medicine had been applied and on five out of eleven days it was only applied once.

We looked at another person's Topical Medicine Application record that stated they required cream to be applied to their pressure areas two to three times daily and found that the last entry was the 02 October 2015 and that between 25 August 2015 and the 02 October 2015 records showed that the cream had been only been applied a total of 15 times during the 39 day period.

In another person's care plan it was documented that their blood sugar should be tested twice a day as they were diabetic. The blood sugar monitoring form for this person showed that they did not always have their blood monitored twice a day. It stated that nursing care should be provided by a Sunrise registered nurse and a community diabetic nurse. There were no records in the person's multi-disciplinary team records or care file of any support received from the community diabetic nurse and there were no contact details in the file.

In one person's individualised medicines service plan, there were no details of medicines taken other than warfarin. The person was an insulin controlled diabetic however there was no mention of insulin in the medicines service plan. Their plan said the person could request medicines when they needed them however it did not state which medicines.

The above evidence shows that some people did not always receive safe care and treatment that effectively met their health needs. This was a breach of regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

People who were able to told staff treated them with kindness and respect. One person said, "I'm as happy as I can be anywhere…yes very happy" and "Since my wife died I'm not 'happy' but I'm comfortable and content". Another person told us, "The carers are delightful. They do anything you ask" and "They are like friends". And another said, "Yes, if I go out and want to wear a tie they do my collar up for me". Another two people who were sitting in a dining room said they had no complaints and the staff were kind to them.

We found that people who were living with advanced dementia were not always treated with kindness and respect. We observed one member of staff who was in a person's room having just supported them with personal care. The door was open and the person was continually calling out. The member of staff was ignoring their calls. We knocked on the door and entered and asked the member of staff what the person was asking for? They responded, "I don't know". They then approached the person and started to wheel their wheelchair without any explanation of where they were going. We noted the person's feet were still on the ground and the member of staff did not help the person to put their feet on the footplate until we reminded them to do so. They then moved the person's feet, again without any explanation or interaction and when the person called out "Ow" again the member of staff gave no reassurance or apology. In this instance the staff showed no care or compassion towards a person living with dementia or understanding of what they should do to communicate properly or provide effective and safe care.

During lunchtime we observed one particular table in the assisted living dining room where one person was calling out "Carer, Carer". The three people sitting at this table appeared to require greater levels of support than others seated in this area that were more independent. Afterwards we spoke with a member of staff who described this as "The feeding table". When we asked how people's nutritional needs were supported we were told by another member of staff, "In reminiscence we have finger food for the walkers". They were trying to describe people's need to have food outside of meal times and when people were up at night and may have chosen to walk around. Another member of staff suggested that we use the staff toilet in the reminiscence neighbourhood and not the resident's toilet, as the staff toilets were "Nicer". These references showed a lack of basic respect and compassion for people with specific needs due to their advancing dementia.

After our inspection we were informed that there were no designated staff toilets in the reminiscence neighbourhood and the action of the member of staff was not one agreed and authorised by the provider.

We saw staff supporting people with their breakfast and staff did not always interact with people when providing assistance with eating and drinking. On one occasion we saw a staff member assisting a person to eat, without explanation they stopped and left the person to wait a few minutes whilst they began assisting another person with their meal. The staff member then informed their colleague in front of three other people seated at the table that one person had a urinary tract infection. This did not demonstrate respect for people and their privacy.

On another occasion in the reminiscence neighbourhood we observed one staff member assisting two people to eat their pureed meal at the same time. While assisting these two people the staff member was also calling out instructions to other members of staff. This approach did not demonstrate respect.

At 12.50 during one lunchtime we saw another staff member supporting someone to eat their lunch without any acknowledgement or engagement of the person they were supporting. However when another member of staff approached the staff member they began a conversation. The staff member did not excuse themselves from assisting the person and instead simply stopped supporting them whilst they talked to the other member of staff for six minutes before returning to assist the person with their lunch. At 13.05 the member of staff was interrupted again by two other staff with whom they engaged in conversation whilst still raising the spoon to the person's mouth. This showed that people's needs were not prioritised and that people were not always treated with respect.

We found that some people's preferences regarding their care were not always respected. We observed an agency staff member enter a person's bedroom without knocking or waiting for acknowledgement to enter. The agency staff member exited the bedroom & told us, "(X) is not ready to get up, he's fighting". We looked at the assignment sheet to see what this person's needs were and it said staff were to

Requires improvement

Is the service caring?

'Allow him to wake naturally – do not wake him'. The agency staff member confirmed to us that had attempted to wake the person. Therefore they had not respected the person's wishes.

One person's assignment sheet stated that they required female carers only. We observed that this person was hoisted from a wheelchair to a tilted chair by one male staff member and one female. Although gently done, there was very little reassurance and no eye contact with the person. The male staff member tidied the persons blouse and cardigan however the person's individual service plan stated 'I do not want male carers to assist me, female carers only'. This person's preferences and wishes were not respected in this instance.

The above evidence shows that staff did not always show compassion and people were not consistently treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014**.**

Although we saw many examples of poor interaction we also saw times when staff did demonstrate compassion and care. Whilst we were speaking with one staff member, they noticed that a person had spilt their drink on their lap and floor. The staff member immediately responded to the person by offering assistance and explaining what they were going to do. The staff member summoned assistance to clean the drink off the floor and to help provide support to the person as they required two staff. This staff member showed care and respect for people.

On another occasion whilst we were talking to one person in their room, a carer knocked on the door and asked if they could quickly empty the bin. Another knocked before entering and politely requested the person place their order for room service. On these occasions staff demonstrated politeness and respect.

We saw two staff helping a person to walk safely down a corridor, as they passed another group of staff and an inspector one member of staff said how nice they looked that morning. The person stopped replied and had a joke with that member of staff. The staff member showed knowledge of the person and a kind, caring, appropriately humorous approach.

People who were able to speak with us told us they could make their own choices. One person told us, "I choose to go to bed early" and another said, "Of course, I'm perfectly capable. I have set times, breakfast at 8.30, help to dress at 9.30". A member of staff told us that one person preferred to come down for their meals every lunch time but preferred supper in their room.

Requires improvement

Is the service responsive?

Our findings

People that were able to speak with us said that staff responded to their needs and provided the care they needed. One person told us, "I damaged my back and one of the night carers washed my feet" and "When I need extra attention I can get it". One person told us, "The carers are delightful. They do anything you ask, even put mascara on for me".

Information supplied by the provider in their PIR stated, 'People receive personalised care that is responsive to their needs via their ISP (Individual Service Plan) and an individualised activities programme'. During this inspection we looked at care records and found that these did not consistently provide staff with up to date and accurate information to ensure people's needs were responded to. One person who was an insulin dependent diabetic had been assessed on 24 September 2015 and their medical history referenced that they had dementia. Their blood sugar monitoring charts recorded some very high blood sugar levels and this showed that their diabetes was unstable. However there were no records provided that gave detailed information on how this person's unstable diabetes was to be managed. There were also no records to give guidance to staff on how this person's dementia presented and what actions staff should take. After our inspection we were provided with documentary evidence that confirmed that a GP reviewed the person's blood sugar levels on 06 October and did not make any changes to their medicines for the management of diabetes.

In another person's care record we saw that the person was diabetic and was at risk of choking and had received a visit from a speech and language therapist to give guidance on their diet. The guidance stated that the person's food should be cut up small however they could have a normal diet. In their care plan it stated that their diet was soft. There was no further assessment in the care records to show why the person was receiving a soft diet. After our inspection we were provided with documentary evidence of a SALT assessment which recommended the person have thin, puree consistency food.

Three staff told us that care records were not up to date. We discussed the omissions in records with the manager. She told us, "The inspection has brought up some surprises; I thought we were in a better place with the care plans than we are". Whilst the previous interim manager told us the provider was revising the documentation in order that they became, "More meaningful". Since our last inspection care plans had been redesigned however we found that the quality and consistency of information varied and was not always accurate and up to date.

The above evidence shows that accurate, complete and up to date information was not always in place for people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

After our inspection we were informed that a second project was being launched to development care plans further.

The home had a activity programme in place that included a range of in house and external entertainers, seven days per week. These included crosswords, keep fit, scrabble, flower arranging and cooking. The home also employed dedicated activity staff to facilitate activities and events. People who were able told us that they enjoyed the activities that were provided. Comments included, "I'm re-living my life, writing my memoirs. I read the paper, play scrabble twice a week" "Scrabble, gardening club, crosswords – there's always something on" . During our inspection we saw that 28 people were sitting watching an entertainer sing and another group of people doing crosswords.

Whilst we found that people who were more able participated in activities and events people living with advanced dementia did not have the same opportunities. Four relatives, two health care professionals and three members of staff expressed the view that people who were living with advanced dementia were not supported to participate in activities that would stimulate and entertain and our observations during the inspection support the comments made by people.

One member of staff was seen to hand tactile objects to people with dementia. One staff member told us, "All this is pretend, for example management and staff are doing things they don't normally do". We observed an activity where an agency member of staff asked people to name countries starting with letters of the alphabet. Although one person was able to participate fully and one or two people offered suggestions, there were four or five people

Is the service responsive?

who appeared to be asleep in their chairs. This activity relied on recall and was not an appropriate activity for people in the later stages of dementia and therefore excluded some of people in the room.

We spoke to the new reminiscence neighbourhood co-ordinator about how people spent their days. The co-ordinator told us, "There isn't enough activities; I've not seen a lot of activities. I want to work closely with (x) the life enrichment activities lead more, and train staff to get more involved with activities".

We looked at one person's care plan and it said 'I enjoy one to one contact and like to be able to build up a relationship with carers, this will encourage me to become more responsive and interact. Please encourage me so that I can socialise with other residents and staff'. The person's care plan also said, 'I enjoy having one to one time with a carer and to reminisce, I also like to listen to classical music. Going through old pictures cheers me up'. However their activity record stated '(X) is not able to take part in activities. There is very little response when encouraging (X) to take part, but she seems content to watch or just be among people'. We looked at this person's activity records and found that since our last inspection in April 2015 there were only three recorded activities for this person, one in August, one in September and one whilst we were inspecting. The home held sessions that included classical music appreciation but there was no record of this person having taken part. Another person's activity records showed no recorded activity since January 2015.

The above evidence shows that some people with more complex needs were at risk of becoming socially isolated with little activity to stimulate or interest them. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

All of the people who were able to speak with us apart from one said they knew how to complain. One person said, "I have no cause to complain but if I did I would speak to the staff straight away" and another said, "I don't need to complain but I can if something went wrong". A third person said, "I'd go to the general manager or the deputy manager, they're very approachable".

The complaints process was easily available to those who were able to read and express their views. It was also available in alternative formats upon request. The provider offered a number of ways in which people and their relatives could share their views about the care and service provided. There was a compliments book accessible for people and relatives to use and we saw that this had been used on two occasions since our last inspection. The provider also held a resident council meeting where people living at sunrise were informed about aspects of the home and the running of the business. These meetings also provided an opportunity for people to raise issues and ask questions. Since April 2015 four meetings had been held and attendance varied from four individuals to a maximum of 15. Relatives meetings were also held, although in the reminiscence neighbourhood where people were living with more advanced dementia and were less able to self-advocate, these had not taken place since July 2015.

We saw that there was a complaints procedure which was prominently displayed in the front reception area. This was also included in the written information people received when they moved into the home. We found that although people had opportunities to express their views and contribute feedback, many people living with dementia relied on relatives and representatives to act on their behalf. Eight relatives told us that they felt complaints were not well received. Four relatives said they feared that there could be repercussions from making a complaint. Whilst these comments are people's individual opinions they show that in spite of the availability of the complaints procedure, some people did not feel they could freely complain.

Where we found people or relatives had made complaints in writing these, and the response to them, had been recorded. On occasions relatives had met with the management and again the meetings and outcomes of investigations had been recorded and letters sent to the complainants. The manager told us they did not use the provider's electronic monitoring system to analyse complaints to see if there were any recurring themes or if lessons could be learnt to improve the care. The manager said, "If someone has a moan we ask if they want to make a complaint. Some people just keep complaining..."

It is recommended that the registered person reviews it processes and implements changes that will promote an open and transparent blame free complaints system that all people have confidence in.

People were supported to maintain links with their family, friends and the wider community. Some people held

Requires improvement

Is the service responsive?

regular get-togethers with friends living outside of the home and the home supplied refreshments. Relatives told us they felt able to visit at any time and there were plenty of areas within the home for visiting.

Inadequate

Is the service well-led?

Our findings

Three of the six people who we were able to speak with spoke positively about management of the home and three did not. One person said the home had a "Super atmosphere" and a second person said the general manager and deputy manager were "Very approachable". A third person expressed the view that the new general manager was not approachable. Six relatives expressed the view that management of the home needed to improve. Three healthcare professionals said that there had been a lack of management oversight at the home and that this coupled with the high turnover of staff had affected the quality of service some people received.

Over half of the staff that we spoke with said that communication needed to improve. Three staff said that management of the home was affecting moral. One member of staff said, "We have talked about better communication lots of times but it doesn't make any difference" and another staff member told us, "We need good direction where the leads know how to direct people properly". The manager told us, "Challenges are with the staff, understanding their accountability….we are constantly fighting, people aren't doing what they need to". One senior member of staff said that the nurses were not always being accountable for their practices and passed things on between them which meant some care got missed. For example when a referral was needed to a speech and language therapist due to someone having difficulty swallowing, the nurses did not make sure that one of them took responsibility for checking this had taken place and there was a long delay in the referral being made.

Nursing staff need to receive clinical supervision to ensure their standards of work meet the expectation of the provider and The Nursing and Midwifery Council's Code. We looked at the clinical supervision of the nursing staff records and found that these did not contain clinical governance discussions about improving nursing standards. Instead they covered areas such as information sharing about the home and problems with the medicines system. A senior member of staff told us they felt nurses needed more direct supervision whilst they carried out their duties. We were told that senior management were already aware that nurses were not adequately supervised. The clinical lead nurse told us, "I do help the nurses occasionally and then I can role model the right care, I last did this two weeks ago with one nurse". On one day during the inspection a meeting was held with the nurses to discuss issues of clinical supervision.

Two members of staff and one health professional told us that where shifts were 14 and a half hours this led to inconsistencies as information was not always passed on. One said, "Staff are working against the clock and after fourteen and a half hours information doesn't get shared…..We don't see each other for communicating and the communication gap is not addressed in the paperwork". We were informed that the provider was looking to introduce shorter shift patterns. There were a number of systems in place to aid communication. These included handover sheets, daily logs, huddle meetings where heads of departments and lead nurses met daily and assignment sheets all of which we were informed were tools used to ensure staff had sufficient support and information to provide care to people. Despite these, the majority of staff commented that information and communication systems were not working. One member of staff said, "At handover the care staff don't stay, so the nurse gives the handover but may not have caught up with care staff before they leave".

Since our last inspection in April 2015 a new general manager has been recruited and commenced work at the home in May 2015 after completing a handover from the interim general manager. The general manager is supported by a deputy manager who is also the nurse clinical lead, an assisted living co-ordinator and reminiscence co-ordinators and heads of departments for areas that include activities, maintenance and housekeeping. During this inspection we asked the manager to show us how they had sustained previous improvements and to provide examples of how quality assurance processes had identified any further issues and how these had subsequently led to improvement. The manager told us that as she had only been at the home six months she was yet to understand and undertake all quality assurance processes. She said, "They (head office) keep asking me for things and I don't understand what they are asking me for". And, "I will admit we are being very reactive at the moment as there's an awful lot of historical stuff that we are dealing with. We need to get to a place where we are acting proactively- in order to do this we need stability of the team".

Inadequate

Is the service well-led?

A quality assurance system was in place that included audits of service provision, analysis of data and obtaining the views of people. The manager told us that a quality indicator report was completed and items that required improvement were put onto a community development plan. We saw that the quality indicator report for September contained statistical data for areas that included falls, admissions to hospital and pressure sores. Improvements had been made in all areas since March 2015. For example, there had been a reduction in falls from 22 to 10 and infections from 14 to 6. We asked the manager how they analysed information about accidents and incidents to find out if there were any common themes or patterns to these and to make sure that lessons were learnt. They said they had not done this and just dealt with each incident as it occurred. The quality indicator report contained statistical data about numbers of events and did not include information about themes or patterns. The community development plan was linked to CQC domains of safe, effective, caring, responsive and well led. The plan detailed 32 actions, 12 of which had been completed, 14 were on-going and six had not been dealt with by the date originally stated with a new date put in place.

During this inspection we found evidence that incident reports were not always completed in full when people sustained injuries, people's care records did not contain information that staff would need in order to meet their needs safely and that some staff did not always assist people to move safely in wheelchairs. We also found that at times call bells were not responded to for 45 minutes, MAR sheets were not always signed when people received medicines and food and fluid charts were not always being completed in full. In addition we found that some staff did not treat people with respect, that some people living with advanced dementia were not supported to join in activities and that complaints were not analysed to see if there were any recurring themes. Also that that the frequency of formal supervision, including clinical supervision for nurses varied. Therefore, although improvements to some aspects of the service had taken place the provider's quality assurance system had not ensured all people received a consistent quality service.

We asked to see how people's feedback had informed change and the manager showed us surveys that been undertaken by staff, people and their relatives. The staff survey had taken place in May 2015 but as it covered all Sunrise homes including those abroad, the results had not been shared with the manager until September 2015. The manager was unsure of the findings and what the figures on the spread sheets meant. When we looked at the provider's analysis it showed that in most categories, staff in the Sevenoaks home felt things had deteriorated. For example when asked 'Does Sunrise leadership act in the best interest of our residents' only 54% of staff responded favourably which was fall of 11% from the previous year. The overall favourable responses to all survey categories saw deterioration in each area. The percentage of staff responding favourably to questions regarding leadership, resident care, empowerment and performance and recognition had all dropped from that of the previous year. In July 2015 Sunrise had undertaken a survey of people and their relatives and as yet the manager had not analysed its findings. 28 out of 79 people had responded and these too showed that there had been a drop in overall satisfaction. At the time of our inspection the findings from the surveys had not been reflected in actions to drive improvements within the quality monitoring systems at the home.

When we spoke with staff they did not understand what the values and goals were of the organisation they worked for or of this particular home. One staff said there were some corporate messages displayed around the home. Staff said that when they had one to one supervision with their manager they sometimes discussed what was expected of them but that supervision did not take place regularly. We saw a record of staff supervision which confirmed what the staff had told us. Supervisions were not regular and when they did take place they were lacking detail about the standards of work expected, whether staff felt able to complete their role and whether they had the training they required to do so. A senior member of staff told us that senior staff in different departments were responsible for supervising the staff in their areas but that quality checks were not carried out to ensure these happened as frequently as they should. This meant that staff did not always have an opportunity to receive feedback on their work in a motivating and constructive way or allow them to understand the values or culture of the provider they were employed by.

The evidence above show that there were systems and processes in place but they were not always being used

Inadequate

Is the service well-led?

effectively to assess, monitor and improve the quality of service to people. This was a breach of Regulation 17 of the health and Social Care Act 2008 (regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Some people with more complex needs were at risk of becoming socially isolated with little activity to stimulate or interest them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Staff did not always show compassion and people were not consistently treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Staff did not always act in accordance with the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care was not provided in a safe way to people and people were not consistently protected by safe systems for managing, recording and storing medicines.

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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse or improper treatment as systems did not operate effectively to recognise and prevent abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Some people did not have their nutrition and hydration needs effectively monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Accurate, complete and up to date information was not always in place for people. Systems and processes were not always being used effectively to assess, monitor and improve the quality of service to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were insufficient numbers of staff deployed to meet people's needs at the times they required. All staff, including agency staff were not sufficiently skilled to care for people.