Sunrise UK Operations Limited

Sunrise of Southbourne

Inspection report

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Date of inspection visit:
26 June 2018
02 July 2018
04 July 2018
10 July 2018
19 July 2018

Date of publication:
11 September 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Sunrise of Southbourne is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Sunrise of Southbourne is registered for 104 people. There were 97 older people living in the home at the start of our inspection. People had a variety of care and support needs related to their physical and mental health. The home was divided into two main areas with people living with dementia accommodated on a separate floor called Reminiscence.

This unannounced inspection took place on 26 June 2018 with further visits to the home on 2 July, 4 July and 10 July 2018. We continued to receive evidence from the service until 19 July 2018. This was our first inspection of the service since the provider had changed.

There was a registered manager for the service; however, they had not been overseeing the home since the end of May 2018. They resigned their post during the time that we were inspecting. 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. The previous registered manager, who knew the service well, had been appointed and had submitted their application to register with the CQC.

At this inspection we identified breaches of regulation with respect to: safe care and treatment, safeguarding adults, the deployment of staff, dignity and respect and the governance of the service including notifications. You can see what action we told the provider to take at the back of the full version of the report.

Staff understood most of risks people faced. However, these risks were not always recorded and shared consistently and as a result care staff did not always act to reduce these risks.

People did not always receive their medicines as they were prescribed.

Staff encouraged people to make decisions about their day to day lives. However, care plans had not always been reviewed to reflect changes in behaviour. This meant that that staff did not always have guidance to follow to meet emerging needs.

People described the food as good.

Care plans also did not always reflect that care was being delivered within the framework of the Mental Capacity Act 2005. This meant people were at risk of receiving care that was not in their best interests or was

overly restrictive. The failure to apply the MCA appropriately had led to Deprivation of Liberty Safeguards not being applied for a person we were told would be brought back if they left the home.

People were largely positive about the care they received from the home and told us the staff were kind. We observed that most care was delivered respectfully and with kindness but we also saw that some care practices did not promote dignity and that people were sometimes treated disrespectfully.

People told us they felt safe. Staff knew how to identify physical abuse and told us they would whistle blow if it was necessary. One person had not been protected appropriately because the safeguarding process had not been implemented effectively.

Quality assurance systems had not been effective in identifying the issues identified during our inspection and notifications that the provider was required to make to the CQC had not been made.

Care staff were consistent in their knowledge of people's on-going care needs and spoke confidently about the support people needed to meet most of these needs.

Staff told us they felt supported in their roles and had taken training that provided them with the necessary knowledge and skills. There was a plan in place to ensure staff received refresher training as deemed necessary by the provider and enhanced training in dementia was being delivered to staff working with people who lived in the Reminiscence part of the home.

People had support and care from staff who had been safely recruited. Staff had not always been deployed effectively to meet people's needs. This had included not deploying night staff who were trained to give medicines. We were assured that this would be addressed immediately.

People were engaged with activities including individual and group activities. There was work being done to develop the opportunities available to people living with dementia. Most people and relatives felt that they were listened to and their views were considered and acted upon.

The environment was clean and maintained efficiently. An unlocked door to an area where soiled laundry was kept was addressed immediately.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People did not always receive their medicines as prescribed and risks were not managed, monitored and communicated effectively.

Safeguarding practices were not always followed effectively.

People felt safe and there were enough staff to meet their needs although they had not always been deployed safely.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not all have a clear understanding of the MCA.

People told us they had access to healthcare when they needed it.

People's needs had been assessed and they were cared for by staff who mostly understood these needs.

Is the service caring?

Requires Improvement

The service was mostly caring but people were sometimes treated in ways that did not promote their dignity.

Staff developed relationships with people and took the time to get to know them individually.

People and their relatives were listened to and felt involved in making decisions about their day to day care.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care reviews did not always reflect changes in people's experiences.

People, and relatives, were confident they were listened to and knew how to complain if they felt it necessary. People enjoyed a range of activities this was being developed for the people living with dementia.

People were cared for with compassion at the end of their lives.

Is the service well-led?

Requires Improvement

The service had been through a period of unsettled leadership. A manager had been reinstated.

People, relatives and staff had confidence in the management and spoke highly of the support they received. There were systems in place to monitor and improve quality including seeking the views of people and relatives. These had not been effective in highlighting the concerns identified during our inspection.

Sunrise of Southbourne

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 the 26 June 2018 and 2, 4 and 10 July 2018. Our first visit was unannounced. The inspection team was made up of two inspectors, a pharmacy inspector, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service. This included notifications the service had sent us, information received from other parties and the Provider Information Return (PIR). The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we observed care practices and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 19 people living in the home, five relatives, 24 members of staff, the manager and a representative of the provider. We also looked at records, including medicines' administration records related to 23 people's care, and reviewed records relating to the running of the service. This included five staff records, quality monitoring audits, the minutes of meetings and accident and incident records. We received requested information throughout the inspection. Following the inspection, we asked the manager to send us further documentation including information relating to: quality assurance processes, recruitment procedures and people's care. We received this information as agreed on 17 July 2018 and further clarification on 19 July 2018.

We also spoke with social care professionals and health professionals who had worked with the service.

Requires Improvement

Is the service safe?

Our findings

Staff were able to describe with confidence most risks people faced and people's views were taken into account in risk management. However, we found that some risks people faced were not managed effectively.

Some people, whose lives were impacted by dementia, could become physically aggressive when they were upset, anxious or confused. Whilst we saw one person had detailed guidance in place to support them when they were distressed, the information recorded on other people's care plans was insufficient to allow staff to respond effectively. One person had been distressed during personal care in mid-June 2018. This had resulted in three members of staff being needed to keep the person safe. There hadn't been any review of their care plan since this incident and no reference added to the care plan of the person behaving in the way they did.

Failure to record risk indicators and potential impacts put people and the staff supporting them at risk. For example, the information about another person, who had been known to kick and punch when distressed and had been sexually forward with a member of staff, was not in their care plan. Although some of the more experienced members of the team were aware of this, one member of staff working with this person was not able to describe how they would know if this person was getting distressed or what might happen if they were.

Some risk plans were not being followed. We observed a person moving furniture unsupervised in another person's bedroom. This person was identified as being at risk of falls and needing stand by assistance when walking. Their care plan stated: "You will need to aware of my whereabouts at all times." Their care plan also stated: "Ensure my glasses are clean and available for use to help me see clearly". We noted they did not have their glasses on and asked staff about this. Staff looked in the person's room and acknowledged they did not know where their glasses were. The person was at risk because they were not being supported safely when moving.

Another person's risks were not fully assessed or managed. The person's safety plan detailed 'Ensure my footwear is supportive and in good repair'. However, the person was wearing ill-fitting slipper socks/slippers and when they walked down the corridor they only had one of those on. We spoke with a member of staff about this and they told us they had raised footwear with the person's family on several occasions.

One person was being seen by district nurses due to pressure sores that had been identified on 3 July 2018. Their care plan stated: "I need repositioning in bed every 2 hours to protect my skin integrity, by 2 carers." Care records relating to repositioning and care entries did not reflect that this care was being provided. We were then shown a short-term care plan dated 3 July, which had not been scanned onto the computerised system. This referred to a "four hourly turning chart", although there was no information recorded explaining why this change was being applied. Care records reflected that four-hourly support to move had not been achieved on three occasions.

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Medicines were not always being managed safely at the home. There was a risk of unauthorised access to the medicines' storage areas. One of the key codes to one of the medicine storage rooms had only been changed twice in the past ten years. Keys for some medicines' cabinets were not held by a designated member of staff as per provider's policy.

Staff did not always record date open on liquid medicines which were in use. This meant it would be difficult to ascertain the shelf life of these medicines as per manufacturer's instructions.

We looked at MARs for 13 people. We found no gaps in MARs, which provided assurance that people received their medicines as prescribed. However, one person had been given another person's medicines for eight days in the previous week. Whilst this had been picked up during an audit this meant the systems in place had not been effective when the medicine was received. It is also meant staff had not checked the medicine correctly when administering the medicine.

When we initially looked for guidance about the risks associated with some medicines we could not find it with help from care staff. Care staff working with people who took these medicines did not know the risks associated with them. It was found that an error was made when adding this information to the system. This was rectified during the inspection

People did not always receive their medicines as prescribed and people were at risk of not receiving safe care and treatment because staff did not record and communicate their needs.

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

Some people took their medicines themselves and stored them in their own rooms. Staff members helped order medicines from pharmacy and supported them if they had queries relating to medicines. The home had a medicine management policy in place. Staff received medicines management training and were checked to make sure they handled medicines safely. The provider had carried out regular medicine audits.

There was a system in place to report and investigate medicine errors and incidents. We observed staff give medicines to people in the morning. Staff gained permission, were polite and caring while giving people their medicines. They signed for each medicine on the Medicine Administration Record (MAR) after giving them. The method of taking medicines from the treatment room to people took a long time. Staff informed us the morning medicine round could take four and a half hours to complete, with the afternoon medicine round starting shortly after. To remove risks associated with medicines that requires a specified time between doses staff had created a log to record times the medicines were given. Staff had recorded allergy status, photograph and room numbers for people to help give medicines safely.

Some people at the home were given their medicines disguised in food or drink. Records showed an assessment, involving the person's GP, had decided it was in their best interest to give medicines in this way. Pharmacist advice had been sought to check the medicine was safe to be crushed and would be effective when mixed with certain foods.

People told us they felt safe and relatives also largely shared this view. One person told us: "I certainly feel safe." Another person told us: "I do feel safe here, I did not feel safe at home but here we are protected" Some people could not communicate with words about their experience of care. They appeared relaxed around staff indicating their comfort and ease. However, we found that the recording of incidents and the oversight of safeguarding processes were not robust and this put people at risk.

For example, an allegation of verbal abuse was made on 10 May 2018. The member of staff involved was suspended on 4 June 2018 and the safeguarding authority were notified on 14 June 2018. The delays were explained by a member of staff with responsibility for managing the allegation being off sick.

In another instance, a complaint that highlighted that a person had not received their pain relief as prescribed as there had not been enough medicines trained staff available in the building to do this. This had been responded to as a complaint and the person had been satisfied by the response provided. This failure to give pain relief as prescribed had not been identified as a potential safeguarding and no external agencies had been notified of the event.

We also identified that staff did not have a clear understanding of how to identify potential abuse and appropriate action had not been taken to safeguard a person.

We asked for clarification about whether a number of incidents had been raised with the safeguarding authority. We were told that some of these incidents did not need to be notified and that staff had been given guidance in the use of language. For example, one record referred to a person being 'punched' by another resident. The director of operations explained that this had been investigated and the member of staff had clarified it was a "playful tap" and had not resulted in any adverse outcomes. There was no record of these investigations to support the decision not to report to external authorities.

We were told that other incidents had been reported. We checked with the safeguarding authority and they had not been made aware of an incident in April 2018 that resulted in a person being bruised. The manager told us that they had reported a similar incident in June 2018. Another of these incidents involving a 'physical altercation' had not been reported. The manager informed us that when checked this incident had not resulted in any injuries and both parties had been "reassured and diverted promptly."

There were policies in place to support good safeguarding practice. Staff had all received training in how to follow the safeguarding process and could describe how they would report suspected abuse. However, we received mixed feedback about how this training would be implemented. One member of the team was very clear that they would report any concerns highlighting that they were here for the people first and foremost. Another member of staff told us the team would report incidents: "If we think it will cause harm to themselves or others physically." Another senior member of care staff discussed how to determine if an incident is notifiable and was not aware that language used in an incident form would indicate potential abuse.

There was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always deployed in a way that met people's identified needs. We highlighted that there were two nights per month on a regular rota where no medicines trained staff were available in the building. People living in the home were assessed as needing support with medicines. We spoke with senior staff and they told us that they did not always ensure medicines trained staff at night and that if a person was prescribed medicine at this time staff would stay late or come in early. We asked about PRN medicines and they told us this would require the on call to be called in. Following the inspection, we were provided with evidence that a second member of medicines trained staff had reached the home and supported in the giving of a medicine requiring two staff members within eight minutes. This was not, however, a sufficient response as some people living with dementia required medicines trained staff to assess their need for medicines and people requesting medicine would have to wait whilst the on call woke and made it to the home safely.

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

We also heard from staff and observed that people living in the Reminiscence part of the home did not always have its full complement of staff and that agency staff were being booked regularly. For example, over a four week period half the staff providing support on Sundays were from agencies. We saw staffing deployment impact on the oversight of people.

There were enough staff on duty in the Assisted Living part of the home. Although people told us that staff were sometimes busy, and we saw this was the case, staff also had time to chat with people. Feedback from people was taken and used to consider deployment. For example, changes had been made to how lunch times were being supported to promote a timely and safe service was provided.

Staffing levels were determined with a dependency tool that reflected the support people needed. The service also employed housekeeping, kitchen, administrative, concierge and maintenance staff to help ensure the service ran effectively. These staff were actively involved with people living in the home and communicated with the care team.

The service had an appropriate recruitment procedure. Recruitment checks were in place and demonstrated that people employed had satisfactory skills and knowledge needed to care for people. Staff files did not all contain appropriate checks, such as a record of any gaps in employment, two references and a Disclosure and Barring Service (DBS) check. We asked for this information to be sent and it was provided.

Staff received training in safety processes and practices such as moving and handling, fire safety and infection control and we saw they used appropriate protective clothing when supporting people with personal care or cleaning. People's rooms and communal areas were cleaned throughout our inspection. We noted that a room holding high risk laundry items was accessible to people in the Reminiscence part of the home. This was addressed immediately by the maintenance staff.

Accident and incident reports were all reviewed and actions taken as necessary although we noted that some incidents had been omitted from the organisational tracker. The majority of records were included and we saw that this led to improvements for people. These had included records of medical assistance being sought for people and additional input being sought. This process was being developed to further meet the needs of people. For example, a senior member of staff described how falls monitoring was being developed to give better analysis of times. Staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses.

Equipment owned or used by the registered provider, such as specialist beds and hoists, were suitably maintained. Effective systems were in place to ensure equipment was regularly serviced and repaired as necessary.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff demonstrated an understanding of the principle of gaining consent before they carried out personal care. They told us they checked with people before providing any care and explained what they were doing. When people refused care they understood how this was to be approached and shared information with their colleagues. We saw that most people were offered choices such as where they wanted to sit and whether to get involved with activities.

However, we found mixed evidence with regard to how people's care was framed by the MCA. We discussed with a senior member of staff how a decision had been made to introduce a system of oversight to what someone ate that was being trialled. The person was not aware of this oversight. No assessment had been made of the person's capacity to make a decision about this oversight. If the person had this capacity the oversight was being imposed without consent. and if they didn't that this restrictive practice was being implemented without the framework of the MCA. After the inspection we were told that this monitoring did not go ahead without the person's consent.

We looked to see how people who had been given the legal right to make decisions about their loved one's care through the Power of Attorney process were involved in people's care. We were told by the Operations director that the normal process would be for the care plan consent to be signed by those with POA for Health and welfare unless conditions prevented this. The system was not in evidence during our inspection however we were provided with information evidencing that consent had been sought appropriately.

Care plans generally and then more restrictive specific practices such the use of photos, sharing confidential personal information, medicines administration must be considered within the framework provided by the MCA. This ensures that people's rights are protected and that where they have given authority to others that this is respected.

This failure to follow the MCA meant that a DoLS had not been applied for appropriately. One person had a DoLS that had recently expired. We discussed recent records which described 'absconding' and asked if the person was free to leave. They told us that the person would be brought back if they left. A DoLS provides oversight to the care of those who are not free to leave the place where they are receiving care. The

supervisory authority were aware that this DoLS had expired and had told the home that it was not for urgent review. However, the home should have applied for a further DoLS as the person was being deprived of their liberty illegally.

DoLS are sometimes authorised with conditions. This means that the person can be deprived of their liberty in the home but these conditions must be met. We looked at the DoLS conditions for three people. Two of these were not being met fully. One person had a condition which required that they had access to baking. We reviewed their activity records and saw that this had not been recorded as done or offered for 30 days. Their care plan did not refer to this condition. Their activity plan dated April 2018 did include this information; however we were told by the operations director that these activity plans had not been introduced at the time of our inspection. Another person's conditions referred to the development of a rummage box. The condition required that this reflect memories and that staff know where the box is stored. Two members of staff who worked with this person regularly told us they did not know where this was. We were sent information about a life skills station that reflected the person's interests. This was not understood by staff and did not reflect the personal aspect of the DoLS condition. A condition to record ABC behaviour charts was also not met. ABC charts detail the antecedent, behaviour and what happened to resolve it. We were told staff were using a different method of recording, however the records we were given did not detail all this information. We could not locate the DoLS for a third person and this was found in an email sent to the home by the DoLS team. It was not possible for staff to check if they were meeting the condition on this DoLS as they had not had sight of it.

There was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff had the skills they needed to support them. One person told us: "The staff are capable and obliging." Another person said: "We expect a lot of them but they always come up to the post." A relative told us: "The quality of care is due to the quality of staff. Sunrise staff are never impatient." Staff told us they felt supported by their colleagues, the manager and the operations manager. They commented that they had access to training to support them in their roles. One member of staff commented: "Sunrise gives opportunities for training including management training" We spoke with a representative from the provider who had been doing development and support work on the Reminiscence floor. They detailed training that was scheduled to enhance understanding of dementia for the staff team.

Newer staff had also had the opportunity to undertake induction training. If staff needed to undertake the Care Certificate this was available. The Care Certificate is designed to help ensure care staff that are new to working in care have initial training that gives them an understanding of good working practice within the care sector. Agency staff undertook an induction process when working in the home. We were not able to locate records of this process for staff who had worked recently. Senior care staff were confident this had been done but were not sure where documentation had been stored.

People were supported with most of their day to day health needs in conjunction with health care professionals. We saw liaison took place with people's GP's to ensure the most appropriate treatment and we received feedback from a GP that communication with the service was improving and that they were confident in the decisions made by the staff about calling them in or waiting for the weekly visits they made to the home. Records showed that people had regular contact from a range of health professionals such as: nurses, GP's, physiotherapists and consultants.

We also saw that a person had been referred to the dentist after they damaged a tooth. We asked about access to the dentist for people who would be unable to request this for themselves. Most people living in

the Reminiscence part of the home had not seen a dentist in the year prior to our inspection. The manager sent us information assuring us that appointments were made if people needed dental input. At the time of our visit a private company had been scheduled to do check-ups but had cancelled the appointments. A new arrangement had not yet been made.

The physical environment was used in a way that supported people to maintain relationships and spend their time meaningfully. People in all parts of the home used communal areas and their bedrooms; there were also quiet places throughout the home for people to meet with friends and family. There was access to secure outdoor spaces where seating and planting provided a pleasant environment. During our inspection the garden was enjoyed by people living in both parts of Sunrise of Southbourne. Within the Reminiscence floor areas had been created to provide focal points of interest based on the life experiences of people living there. There was also an outdoor balcony area that provided easy access to the outdoors and the sensory experience of plants. A sensory room was also being developed; this was starting to be used by people when we visited. Alongside the sensory room we saw an activities room that was in use during our visits. People were able to take part in a range of activities in this space. We also saw people enjoying making use of a specialist projector and able designed to engage people with dementia in a wide variety of activities.

Before moving into the service people had their needs assessed across a wide range of areas. This assessment process identified initial support needs. The process ensured that within the framework of needs catered for by the home, people were protected from discrimination from initial contact onwards. This meant people were protected from discrimination on the grounds of their gender, race, sexuality, disability or age.

The use of technology and equipment to assist with the delivery of effective care, and promote people's independence was being developed. A system had been in place to alert staff if people left the building. This had not been as effective as hoped and an alternative was being sourced. There was a call bell system which people could use to alert staff if they needed them. The provider had introduced an electronic care planning system. This was being developed at the time of our visits. Information and recording options were being added to make the system person centred and accurate.

People were asked about what they liked to eat as part of their assessment process and this included any dietary, cultural or religious needs.

People had varied experiences of mealtimes. People who had specialist pureed diets had this nicely presented using separate shaped food moulds. This was so people's pureed meals looked like the foods they were. There was a relaxed atmosphere during the meal. Staff sat at the tables, chatted with and ate with people. People were given both verbal and visual choices of the meals. Staff gave people plenty of time to look and smell the meals before they made their choice. During the inspection the weather was very warm and staff offered people lots of drinks and ice lollies to keep them hydrated. There were drink and snack stations so people could help themselves for food and drink when they wanted it.

People commented positively on the food although a number of comments were made about the accessibility of some condiments and vegetable options. These options were available if requested. For people living with dementia or for those who did not like to ask for different food this meant that a regular set menu was available to them designed by the provider organisation rather than based on people's preferences. One person observed that opening sachets of condiments was difficult and two people commented that salad dressing was not always available despite an agreement to this being made after a request was made at the resident's forum meeting.

When people needed additional monitoring or staff support we identified mixed evidence. Most people had been weighed appropriately and their food intake was monitored adequately but we saw one person who had lost weight and was meant to be weighed weekly after a GP visit. This had not taken place fortnight since their care plan was updated with this care need. Another person had been identified as being at risk because they did not want to eat or drink enough to maintain their health. Referrals had been made to health professionals over the months prior to our inspection. We noted that records indicated they had declined the majority of meals offered over a period of five days in June 2018 and this had not been flagged up as a concern to ensure additional prompting within daily management meetings. We discussed this person's access to food and saw that further options for snacks were being explored and additional input had been sought from their GP.

The Food Standard Agency had inspected standards of hygiene and safety in June 2018 and had awarded the home a rating of five. This meant they had achieved high standards of hygiene and food safety.

Requires Improvement

Is the service caring?

Our findings

Throughout our inspection there was a calm atmosphere in all parts of the home. We observed care staff, housekeeping staff and managers interacting with people in a caring, respectful and compassionate manner. However, we also saw examples of care and communication that were not respectful and did not promote people's dignity. A member of staff called a colleague in front of a person and new visitors to the home to check they were "allowed" to go out. This was not done discreetly and the person was able to make this decision for themselves. Another member of staff called up through the entrance lobby of the home saying that someone had not booked themselves "as a wheelchair". This use of people's support needs as a personal descriptor was also evident in care plans where statements such as "I am a falls risk", rather than identifying that the person was at risk of falling, were made. The way language is used to describe people matters because it influences how staff think and act.

Care practices did not always promote dignity. One person's care plan stated that they should be assisted to go to the toilet every three hours to ensure that their care needs were met in privacy. We saw that this didn't happen and then we needed to call staff when we found that they had been incontinent and were undressing themselves in the corridor.

People received personal telephone calls in the dining area. This meant other people and staff could overhear their private conversations. Staff did not always consider that people were having private telephone conversations. For example, one person was on the telephone and staff used the coffee machine that was located next to the phone and this meant the person could not hear. We identified this to a senior member of staff who intervened.

Staff used walkie talkies to communicate with each other. We could easily hear staff discussing people's personal information and their visitors being discussed. This did not respect people's rights to privacy.

We also observed three pairs of glasses, a hearing aid and a set of dentures on the window sill of an office in the Reminiscence part of the home. We asked who these belonged to and were told by a senior member of the team that they did not know. On another occasion whilst looking for a pair of glasses for a person, a member of staff found their dentures under the bed. They commented that not all staff put them to soak and then cleaned them before putting them into the person's mouth in the lounge in front of other people including a new member of staff. These personal care practices did not respect people's equipment or their dignity. We spoke with the area manager about this and they told us that people would be ordered new glasses if these were lost.

There was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt cared for by staff. We heard comments such as: "The staff are lovely." and "The staff are kind and courteous." We read a compliment sent by a person who had stayed for a period of rest, they praised the home saying: "Thank you for making me feel so welcome your kindness was amazing". The relatives we

spoke with said they could visit the service at any time and always felt welcome. One relative spoke of their experience: "The Staff are respectful, always smiling, they treat her with dignity".

Staff told us they enjoyed their work and enjoyed spending time with the people living in the home. They spoke with care, compassion and enthusiasm for their work. They all described their motivation for their work being the people living in the home making comments such as: "I love it. I have got 100 plus extra grandmas and grandads." They also spoke with respect for their colleagues, making comments such as: "There is genuine warmth." We observed this warmth in many interactions that we saw during the course of our visits. For example, some staff were creative and skilled in working with people living with dementia and knew people well. For example, one staff member sat with one person who was reluctant to eat and drink. To encourage the person to eat the staff member ate the same food as the person and encouraged the person to 'mirror' them. This was successful and the person ate their food.

People were encouraged to use all the communal areas in the house. People using the communal lounge were relaxed in each other's company. We saw that staff took time to sit and talk with people in the lounges and visiting people in their rooms. Some conversations were light hearted and this familiarity was clearly appreciated by people. We spoke with staff about people who could no longer communicate easily with words due to the impact of dementia. Staff explained how a combination of their facial expressions, movements and noises communicated how they felt and what they might need.

People's bedrooms and suites were personalised with belongings, such as furniture, photographs and ornaments. People were encouraged to make decisions about their appearances, for example what jewellery and make up they chose to wear. People appeared well cared for throughout our visits and staff supported them with their personal appearance.

Care plans reflected what people needed to retain their independence and the impact of staff support was evident throughout our inspection. People were supported with their mobility. Staff were not rushed and could describe what people could undertake themselves and the individual support they needed. For example, one person's care plan highlighted that they may not ask for help when they needed it and required staff awareness. Another person's care plan identified how their independence was maintained and supported.

People's personal relationships were supported. Most relatives told us that their relationships were supported and that they were made to feel very welcome, couples lived in the home and their support reflected support for them as individuals and as couples. Senior staff identified that expression of sexuality was supported by the provider's policies required staff to work in ways that respected people's human rights and promoted equality and that staff had all received training on this.

Requires Improvement

Is the service responsive?

Our findings

Most people spoke positively about the care and made comments such as: "They meet my needs. Oh yes definitely."

Documentation did not support the effective review of people's care. Care plans had been reviewed and covered a range of areas including mobility, communication and nutrition and hydration. They were individualised with some information about people's likes and dislikes and referred to people who were important in people's lives. Some reviews had not been effective and this meant that care plans did not always reflect people's current needs. This was particularly apparent with reference to how people spent their time. For example, one person's care plan commented that they valued their newspaper but they had not wanted this for some months. Care reviews had not identified this.

Recording of activities did not reflect information known about people. Assessments of people's interests and activities had been undertaken for some people living with dementia. These assessments had been undertaken using a specialist tool (PAL) The Pool Activity Level is a framework for care settings across the UK. It is recommended in the National Clinical Practice guidelines for dementia (NICE 2006) This instrument matches residents to activities that provide emotional and therapeutic benefits. We saw that some of these had been completed in February, March and April 2018. Some residents had participated in the next stage and had had an individual programme developed. However, these had not translated into people's care plans or care delivery at the time of our visit. For example, one person was listed as enjoying baking, however, we received information following the inspection to indicate that at the time of the assessment this was not accurate. Another person was recorded as benefitting from having the "Daily Sparkle" read with them and this was not recorded in their care plan nor were they recorded as doing it in their delivery records of the previous 30 days. We spoke with the Director of Operations who told us that this was due to roll out in phased stages but this had not started at the time of inspection. It was not possible to review people's involvement and enjoyment of activities.

Staff did not maintain, accurate, complete and contemporaneous records. Care delivery record keeping was not accurate and did not assist the review of people's care. For example, one person who had lost weight had a care plan indicating they should be having additional snacks. Sometimes snacks were recorded at times other than meal records. However, records of meals declined and snacks offered sometimes matched and it was not possible to determine if these were additional snacks or meal alternatives. Another person's care plan indicated that they had received personal care at a time they hadn't this made it impossible to review how effective the support they were receiving was.

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

People living in the assisted living part of the home told us they enjoyed the activities available to them. One person told us: "I do participate in Activities, I like to join in the singing and listening to music" another person told us: "I enjoy the Music but not so much the Quizzes, they sometimes take me out in the Mini-Bus"

Staff appreciated the impact that meaningful activity had on people. One member of staff described with pride how providing classical music had brought a smile to the face of a person who was not responsive to most interactions. The activities coordinator reflected on the skills within the activities team saying: "My team are all lovely- they are all different with different skills to ensure person centred care." They told us they used life story work to inform the activities available and explained they also "speak to families because some people cannot speak for themselves". We also saw that people enjoyed access to a well stocked garden with a play area for children visiting relatives or friends in the home. The home had a strong commitment to 'bringing the outside in' and had a seaside themed terrace in Reminiscence where residents can independently access the outdoors. Shortly after our inspection visits we received information that people were starting to have access to a trishaw two days a week as part of the Cycling Without Age initiative.

Staff did not always respond to people when they needed support. One person when they repeatedly called out "Hello" and "Oh dear". At times this was because there were not any staff available. This person's positive behaviour support plan included that staff should gently distract the person, offer them chocolate and validate their feelings. We did not see this happening. In addition, the plan did not detail how to distract the person or acknowledge that distraction may leave them with feelings of being frustrated because they were not being responded to. There was little staff interaction with people before lunch who were sat in a small seating area within the Reminiscence part of the home. This was away from where staff were doing activities. In the afternoon of our first visit, one person, who was living with dementia, spilt their drink over their clothing. Staff were busy supporting people elsewhere so we intervened and found a staff member to inform them that the person had spilt their drink over themselves.

The home was established within the local community and enjoyed support from local businesses and links with local schools. The home had been the first to establish a safe place to people affected by dementia who needed emergency support and continued this role within the community. They were also competitors in the Bournemouth in Bloom competition. Spiritual needs were reflected in the day to day life of the home. We received feedback about this during our visits from the Older Persons Director from a local Church. They told us: "We work with Sunrise to provide the residents spiritual support whilst they are at Sunrise. It is a joy to spend time with the residents both in Assisted Living and Reminiscence. The staff are very supportive of this ministry and encourage the residents to attend where appropriate. They support our team to enable a variety of different activities to happen including Bible Study, Sunday Service, Songs of Praise and Messy Vintage (a creative session). The staff also let me know if a resident needs some individual support. This is a lovely caring home, with a great ethos that supports the residents in all aspects of their lives."

Communication needs were identified at assessment before people moved into the service. These were recorded in the care plan and this meant staff had information about people's needs.

There was a system in place for receiving and investigating complaints. People and relatives confirmed they knew how to make a complaint. One person told us: "If I had a problem I would talk to the Manager, I have not had a problem here" and "If I had a concern I would talk to the Senior Staff or Manager." Complaints raised had been addressed in a transparent manner and within the timescales laid out in the provider's policy. Where learning needs were identified we heard this had been acted on with individual staff members. Two relatives expressed concerns that issues highlighted as concerns were not always addressed consistently and sustainably leading to the need to reiterate information.

We received positive feedback from a relative of a person who had recently died in the home. They told us: "They were kind, gentle and understanding of the nature of end of life. I was very impressed." We also saw

feedback from a relative sent to the home that echoed this sentiment: "We are so thankful for the amazing end of life care that mother received." Staff told us they were proud of providing good care for people at the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

The home had been through a period of unsettled leadership. Following a restructuring a new general manager had been appointed and had become registered with CQC in April 2018. They were no longer actively managing the service when we inspected and resigned their post during this time. The previous manager was reappointed to the general manager role and they were present in the home on the second day of our inspection. They began the process of registering with the CQC on the same day. There were indications from both staff and relatives that this had been a difficult time with observations made about the workplace feeling 'political' and there being 'obfuscation' between different managers.

People, staff and relatives were positive about the registered manager who had just left but also told us they were pleased to see the previous manager back. People told us: "Management seems very capable to us, it is well run".

In the absence of a registered manager the provider had maintained oversight of the service through a quality assurance process that included regular provider visits to the home. This visit included a review of two people's care and we saw at this had identified the need to review some risk assessments related to falling and nutritional intake. We also saw that issues about consent, behavioural care needs, risk management and person centred care had been added to the service improvement plan following the Bournemouth Borough Council monitoring report in May 2018. The manager and senior staff also undertook audits. The director of operations identified that they believed they had been aware of the concerns we identified during the inspection. However, we found that internal processes had not been robust in ensuring the care people received reflected the fundamental standards and that statutory obligations were met.

Systems in place had also not been effective in ensuring timely responses to changes in people's needs or to ensure their safety. For example, managers did not discuss that a person's record indicated they had not eaten for more than three days at their daily huddle. Senior staff had not identified the delay in responding to an allegation of verbal abuse.

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

The service had a clear management structure with senior staff working within the home and the manager reporting to their line manager from the provider organisation. The registered persons had not, however, ensured that all relevant legal requirements had been complied with. We noted five incidents of alleged abuse that had not been notified to the CQC prior to us highlighting this. We discussed the importance of these notifications and were sent them retrospectively. We have not been able to check the sustainability of changes made to ensure notifications are made in a timely manner.

There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The manager and provider representatives were visible within the service so were aware of day to day issues

brought to their attention by staff. People recognises these staff and approached them comfortably. We saw that people's views were considered as part of oversight and development within the home. A suggestion box, an annual survey, complaints and ideas and concerns raised at the monthly resident's council all fed into the service improvement plan. Staff spoke highly of their colleagues and told us they were all motivated to do the best for people. The staff team was continuing to develop and we heard form staff that they were confident that this would happen.

Records were stored securely and there were systems in place to ensure data security breaches were minimised. Staff had individual access to computer based records and points of contact with the electronic system around the home. Rooms containing records were locked when not occupied by staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 Registration Regulations 2009 Notifications of other incidents CQC had not been notified of allegations of abuse in a timely manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with respect and care practice did not always promote dignity. There was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive their medicines as prescribed and people were at risk of not receiving safe care and treatment because staff did not record and communicate their needs.

There was a breach of Regulation 12 (1) (2) (b) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse because systems were not operated robustly. People were deprived of their liberty without conditions being met. There was a breach of Regulation 13 (1) (2)(3) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems had not been effective in identifying the failure to ensure safe care and treatment to people. Records held about people's care were not accurate or complete. Regulation 17 (1) (2) (a) (b) (c) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing Suitably skilled and experienced staff were not deployed in response to people's assessed

needs.

Regulation 18 (1)