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Korniloff

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Korniloff on 14 and 23 November 2017. Korniloff is a unique residential care home providing accommodation and personal care for older adults. The service is set in a converted hotel on the coast, offering spacious communal areas to make the most of the wide stunning views of the sea and Burgh Island. The service does not provide nursing care. The home uses community nurses to provide this service. The home can accommodate a maximum of 17 people but as the provider does not use two rooms as doubles, the actual capacity is 15 people. At the time of the inspection 10 people were living at Korniloff. The provider was also the registered manager who lived on site. 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 provider planned to take less of a day to day role in the running of the service in the future and a manager was also employed who ran the home with the support of a deputy manager.

At the last inspection in August 2016 the service had required improvement in some areas. These had included staffing levels, medicine administration, timely referral to health professionals and ensuring effective quality assurance audits were carried out. Risks to people's safety and their care needs were assessed during that inspection, but this information was not always transferred to care plans. At that time people's care plans were not comprehensive and were not reviewed regularly. This meant staff did not always have the most up to date information on people's needs. People had also told us they would like the opportunity to go out of the service on a regular basis, which had not been happening.

At this inspection we found the service was meeting all regulatory requirements and we did not identify any concerns with the care provided to people living at the home. The manager, who had been in post for nearly a year, had ensured that the above issues had been addressed. As the provider lived on site and they were intending to move away from day to day management, their input had become less systematic which did not always ensure actions were completed in a timely way. The manager had now arranged for more formalised regular monthly meetings with the provider and information such as maintenance management had been centralised to ensure there was not information held by the manager and also the provider which could be confusing.

People lived in a service which had been designed and adapted to meet their needs. The provider and manager had taken into consideration people's diverse care and support needs when making changes to the environment, and listened to what people needed. People lived in an environment which the provider had assessed to ensure it was safe and had taken appropriate actions. As an old style building, maintenance work was on-going. People were protected by the provider's infection control procedures, which helped to maintain a clean and hygienic service.

On the day of the inspection there was a calm and relaxed atmosphere in the home and we saw staff interacted with people in a friendly and respectful way. Staff and the manager were very knowledgeable

about people's needs and how they liked to spend their day. People were able to choose what they wanted to do, maintain their independence as much as possible and enjoyed spending time with the staff who were visible and attentive. Most people currently had a low level of need and were able to communicate well, were independently mobile and sometimes only required the assistance of one care worker. People's individual equality and diversity was respected, enabling people to be supported in the way they wanted to be.

People looked comfortable and happy to spend time in the large hotel type lounge, TV area and conservatory looking out to sea. People were encouraged and supported to maintain their independence. Most people were over 90 years old and told us they were happy living at the home. They enjoyed a more quiet morning sitting together chatting or watching TV and in the afternoons we saw people enjoying playing a game with staff. People were engaged with staff, receiving visitors, watching what was going on, pottering around the spacious communal areas or spending time in their rooms.

People and relatives said the home was a safe place for them to live. One person was able to tell us, "I've nothing to say, it's all fine. We have a nice quiet life which I like." Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns. Relatives said they would speak with staff if they had any concerns and issues would be addressed. People and relatives knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. One relative said, "I come all the time and my relative is very happy here. They are all very nice and I come for tea."

People were well cared for and people and their relatives had opportunity to be involved in planning and reviewing their care; most people chose not to be involved as they were "happy with things as they were." Staff had good knowledge about people, including their backgrounds, needs and preferences. Care plans had been updated to reflect a more person centred approach which reflected staff knowledge of people's individual needs. People were able to make choices, for example about what drink they would like, including from the 'Korniloff bar' or what clothes to choose and when to go to bed or get up.

There were regular reviews of people's health, and staff responded to changes in need. For example, care records showed examples of staff identifying changes in need and appropriate referrals to health professionals. The manager had organised a more effective way to capture health and short term needs to ensure this information was gathered in one place to inform staff. District nurses visited daily and told us they were happy with the care that was delivered. People were assisted to attend appointments with appropriate health and social care professionals to ensure they received treatment and support for their specific needs.

People were supported at the end of their life to have a comfortable, pain free and dignified death. The service was not always a 'home for life' as the manager was clear about ensuring the service could continue to meet people's needs should they increase considerably or referring people to appropriate health professionals. They worked with local health professionals ensuring people received individualised palliative care and pain relief promptly. Following a recent death, staff were attending the funeral with other people living at the home and the family had shown their appreciation of the staff during end of life care.

Medicines were well managed and stored in line with national guidance.

Staff were well trained and there were good opportunities for on-going training and obtaining additional qualifications. The staff team was stable over the last year and some care staff had worked at the home for some years and knew people very well, having built up meaningful relationships. They said they enjoyed the

homely feel and felt they were well supported by the manager.

People's privacy and individual equality and diversity was respected, enabling people to be supported in the way they wanted to be and staff promoted independence. Staff pro-actively supported people to keep in touch with family and friends, inviting friends and family to coffee mornings and events regularly. The relative told us they were always made welcome and were able to visit at any time, use the quieter lounges and were offered hot drinks. People were able to see their visitors in communal areas or in private.

The manager and deputy manager showed great enthusiasm in wanting to provide the best level of care possible and valued their staff team. For example, they were purchasing vintage tea stands to offer afternoon tea parties, looking into staffing to enable a trip to the local aquarium and encouraged relatives and staff to visit with their families as people enjoyed seeing their children. Staff had adopted the same ethos and enthusiasm and this showed in the way they cared for
people in individualised ways. Staff thought about ways they could further support people, for example by offering a trip out to one person's favourite café or placing visual reminders for people who lived with short term memory along their usual route around the home.

Observations of meal times showed these to be a very positive, relaxed experience in a lovely setting, with people being supported to eat a meal of their choice where they chose to eat it.

There were now quality assurance processes in place to monitor care and plan on-going improvements, overseen by the provider. There were systems in place to share information and seek people's views about the running of the home, including relatives and stakeholders. All responses were positive from the last quality assurance questionnaire. People's views were acted upon where possible and practical and included comments such as, "I am very happy at Korniloff. I always feel I am treated with respect and my dignity is always looked after" and "Staff are easy to get on with." A relative had commented, "It's a lovely, caring, family style home" and "Always a great visitor experience with friendly staff. A real home from home for grandma. We had a cream tea and bunting and they are very welcoming and helpful."

A notice board showed events such as the monthly conservatory community coffee morning and stalls run by a local society at Korniloff. Overall, people told us there were opportunities for social engagement, people had enjoyed visits from a donkey, a visit to get sausages from a local farm and craft activities. Some people expressed they would like more to do, and to go out more. The manager had already been made aware of people's views, and had started to take action for those individuals. The manager and deputy manager were open, transparent and admitted when things had gone wrong. This demonstrated their understanding and recognition of the Duty of Candour. The Duty of Candour means that a service must act in an open and transparent way in relation to care and treatment provided when things go wrong. The manager notified the Commission of significant events which had occurred in line with their legal obligations.

We have made a recommendation during this inspection about ensuring that governance and managerial responsibilities were made clearer.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People benefitted from support from enough staff to meet their needs in a timely way.

People benefitted from a homely environment that met their diverse needs.

People were protected from the risk of harm or abuse whilst independence was promoted in a balanced way.

People were supported with their medicines in a safe way by staff who had appropriate training.

People's safety was paramount. When things went wrong, the provider learnt from mistakes and took action to make improvements.

Is the service effective?

Good

The service was effective.

People and/or their representatives were involved in their care and people were cared for in accordance with their preferences and choices. People's equality and diversity was respected.

Staff had good knowledge of each person and how to meet their needs.

Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people.

People saw health and social care professionals when they needed to. This made sure they received appropriate care and treatment.

Staff ensured people's human and legal rights were protected.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with dignity and respect, promoting independence and maintaining people's privacy.

People and/or their representatives were consulted, listened to and their views were acted upon.

Staff used their knowledge of equality, diversity and human rights to help support people with their privacy and dignity in a person centred way.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support which was responsive to their changing needs and met people's social and leisure needs.

People made choices about aspects of their day to day lives.

People and/or their representatives were involved in planning and reviewing their care if they wished.

People and/or their representatives were encouraged to share their views on the care they received and on the home more generally.

People's experiences, concerns or complaints were used to improve the service where possible and practical.

People were supported at the end of their life to have a comfortable, pain free and dignified death.

Is the service well-led?

Good

The service was well led.

There were effective quality assurance systems in place to make sure areas for improvement were identified and addressed in a timely way.

The service took account of good practice guidelines and sought timely advice from relevant health professionals and used various resources to improve care.

There was an honest and open culture within the staff team who felt well supported by management.

Staff worked in partnership with other professionals to make sure people received appropriate support to meet their needs.

The manager kept their on-going practice and learning up to date to help develop the team and drive improvement.

Korniloff

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 23 November 2017. This was an unannounced inspection on the first day and was carried out by one adult social care inspector.

At the time of this inspection there were 10 people living at the home. During the day we spent time with all 10 people who lived at the home and one relative. We also spoke with the manager, deputy manager, five care workers and the cook. We also spent time with the registered manager/provider and a visiting health professional.

We looked at a sample of records relating to the running of the home, such as audits, quality assurance, medication records and care files relating to the care of three individuals.

Good

Is the service safe?

Our findings

At the last inspection in August 2016 the service was rated as requires improvement. This was because some aspects of the service were not safe. At that time risks to people's safety were not transferred to their care plans. This meant staff did not always have instructions on how to manage the risks. People's needs were met by ensuring there were sufficient staff on duty. However, we then recommended that staffing levels were kept under review.

During this inspection in November 2017 we found these areas had been addressed and the service was safe. People and relatives told us they felt the home was safe and they were well supported by staff. One person was able to tell us, "Oh yes, I'm fine. No worries here." Another person told us, "I've nothing to say, it's all fine. We have a nice quiet life which I like." The manager had systems in place to make sure people were protected from abuse and avoidable harm. Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns and the local contact details to report any concerns, were easily accessible. Staff were confident that any allegations made internally would be fully investigated to ensure people were protected. Any safeguarding concerns had been managed well with manager involvement and the service worked with the local authority safeguarding team. One relative said they would speak with staff if they had any concerns and issues would be addressed. They said, "I come all the time and my relative is very happy here. They are all very nice and I come for tea. You can leave without worrying. I don't worry at all." People seemed comfortable and happy to go over to staff and indicate if they needed any assistance throughout the inspection.

Staff encouraged and supported people to maintain their independence in a caring way. Care staff ensured people were assisted in a discreet way, to dress themselves and people were wearing appropriate clothes for the weather. The balance between people's safety and their freedom/choice was well managed. Staff were visible around the home and quickly noticed if anyone who needed assistance was trying to mobilise on their own without waiting for help. They watched one person head to the bathroom from a discreet distance and waited outside the bathroom to ensure the person was managing.

Risk assessments and actions for staff to take included for example, risk of pressure area skin damage, falls and nutrition. The people currently living at Korniloff had low dependency needs, requiring minimal assistance from one care worker at times. Where people required pressure relieving equipment to maintain their skin integrity, staff ensured cushions, for example, were moved with the person when they moved. There were no pressure sores at the home and no-one required monitoring of their nutritional intake. Falls audits showed very few falls, with each being assessed and audited to identify any patterns or areas where the service could further minimise falls. People were able to mobilise freely and there were spacious communal areas free from hazards. For example, the large, light conservatory sat in front of a large lounge with a TV area at one end. There were heavy doors into the hall and further dining rooms but the manager had ensured these were held open by door stopper alarms that were included on the maintenance programme. One door alarm was fixed during our inspection to enable people to continue to access bathrooms independently.

There were enough skilled and experienced staff to ensure the safety of people who lived at the home. During our inspection there was the manager, deputy manager, three care workers, the provider and cook. Staffing levels remained flexible and staff told us there had been five care workers during the day the previous week and staffing levels depended on people's level of need. Staffing could be changed if required, for example if people became particularly unwell or if a person was nearing the end of their life. All people, except one, at the time of the inspection required the assistance of one care worker. One person used a hoist to mobilise on occasions. We saw that people received care and support in a timely manner.

Staff were attentive to people's needs, knowing them well and understanding their preferred routines. For example, one person living with a level of dementia was able to enjoy pottering safely around the home chatting to staff. Staff also noticed if the person appeared to be tiring and offered tea to encourage them to rest.

The home was clean and tidy and in a homely style. Care workers also had responsibility for laundry and domestic cleaning. This had been raised as a concern at the previous inspection but did not seem to be a problem. There were no offensive odours throughout the home and rooms were clean. Staff used personal protection equipment (PPE) when delivering care and changed aprons and gloves between rooms or when dealing with food. Staff had had training in infection control.

People were protected from the risk of harm or abuse because safe recruitment procedures had been followed. We looked at the recruitment records of three staff who had been recruited since the last inspection. These showed that risks of abuse to people due to unsuitable staff were minimised because the provider and manager carefully checked prospective new staff to make sure they were suitable to work at the home. These checks included seeking references from previous employers, photo identification and carrying out Disclosure and Barring Service (DBS) checks. These checks made sure the applicant had not been barred from working with vulnerable people, and did not have a criminal record that indicated they were untrustworthy. The manager was adding a recruitment checklist to the files so that they could easily check all recruitment records were completed.

All staff who gave medicines were trained by the local pharmacy and had their competency assessed before they were able to administer medication. Medication administration records detailed when the medicines were administered or refused. Medicines entering the home from the local dispensing pharmacy were recorded when received and returned. The service did not use homely remedies so all medication was prescribed individually. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. We saw medicines being given to people at different times during our inspection. Staff were competent and confident in giving people their medicines. They explained to people what their medicines were for and ensured each person had taken them before signing the medication record. One care plan noted that the person liked to take their medication when staff had left the room. They checked later with the person, who was able to make this choice, that they had taken it. Medicines were thoroughly audited by the manager who had devised a formal tool to ensure consistency. Staff contacted the GP regularly to conduct people's medication reviews. A medicine fridge was available for medicines which needed to be stored at a low temperature such as eye drops. One person was using medication which required additional secure storage and clear recording systems. We saw these were stored and records kept in line with relevant legislation.

The provider had systems in place to manage emergency situations such as fire. Each person had a personal evacuation plan (PEEPS) to enable emergency services to know how to manage people. Accidents and incidents were recorded to show they were well managed and appropriate actions taken.

When things went wrong, the manager learnt from mistakes and took action to make improvements. A previous safeguarding incident had been difficult for the provider as they had not experienced the safeguarding process. However, improvements had been made to see safeguarding as a positive process and the manager worked with staff explaining the process and working with the local safeguarding team to discuss a recent incident. ,The safeguarding team decided not to investigate the incident any further. One example of this was the manager was introducing separate health and short term needs documents in care plans so staff could easily work through these with external health professionals. This would assist with more confident communication between staff and community nurses. The manager said, "We are always willing to learn."

Good

Is the service effective?

Our findings

The service was effective. Most people were able to voice their needs or indicate what they needed support with. The manager and staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Mental capacity assessments had been carried out to determine each person's individual ability to make decisions about their lives. No-one had currently had any restrictions imposed. The manager was considering an appropriate application to the local authority to safely deprive one person of their liberty in line with the Deprivation Of Liberty Safeguards (DoLS) set out in the Mental Capacity Act 2005. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The manager understood the best interest process where decisions could be made for people lacking capacity, in consultation with other people involved in their care.

The manager kept up to date with changes in legislation to protect people and acted in accordance with changes to make sure people's legal rights were promoted. Throughout the day staff demonstrated they were familiar with people's likes and dislikes and provided support according to individual wishes. People were able to mobilise freely around the home. Some people enjoyed spending time in their rooms and this was respected. The manager had supported one person to move to a lower ground room as this enabled them to access the outside patio more easily and receive their visitors this way in private.

There were few falls at the home. Staff said they tried to promote people's independence as much as possible, ensuring people had easy access to clear spaces, mobility aids, drinks, visible staff and easily accessible bathrooms and visual signage. The manager was also planning to make collage picture frames of items/pictures people liked to further assist people in identifying their own rooms. During meal times people were encouraged to help themselves with staff saying, "Would you like this plate of food" or "You like this [person's name], would that be ok for you?"

There was a stable staff team over the last year at the home who had a good knowledge of people's needs and backgrounds. Some staff had been employed at the home for a number of years. Staff and the manager were able to tell us about how they cared for each individual to ensure they received effective care and support. For example, they told us they encouraged one person living with a level of dementia to rest, by chatting, listening to their favourite music or peeling potatoes, which they enjoyed.

Staff listened to what people wanted. One person liked to be independent in the bathroom but sometimes didn't manage so well. Staff discreetly offered support, respecting when the person said they could manage themselves and checking from a distance later. Staff went on regular shopping trips, asking people if they would like anything. They knew who particularly liked pizza and ice cream for example and the kitchen was full of items particular people enjoyed. A relative spoke positively of the staff who worked in the home. They said they were all friendly and they were assured their relative was well cared for.

People's consent to care had been sought and recorded in their care plans and staff were heard to verbally ask people for their consent prior to supporting them, for example before assisting them with their lunch or with their medicines. For example, one person liked a lot of snacks. They had discussed how to manage this themselves to promote health and wellbeing and the person told us they were happy to keep snacks in the office which staff gave to them when they asked rather than have the temptation to eat them all at once.

Staff told us there were opportunities for on-going training and for obtaining additional qualifications. The manager had recognised that it was difficult to ensure regular night staff were available for training and had discussed this with the staff to ensure they were booked in for training at a suitable time whilst emphasising the importance of attending. Most of the staff were qualified or working towards the relevant national vocational qualification (NVQ). The provider, who was often the 'sleep-in' staff member on nights as they lived on site, was working towards updating their training too. Training, which the provider felt was mandatory was detailed in each staff member's file and the manager was devising a training matrix which would make it easier to gain an overview of staff training. Training included safeguarding, comprehensive practical manual handling, fire, infection control, health and safety and food hygiene. Some staff had also completed training to support them to meet people's individual needs such as catheter care, dementia care and diabetes. Some staff were undertaking a 12 week mental health awareness course. As a result, staff had recognised that one person new to the service did not like too much noise and if distressed became calm if left alone and they had added this to the care plan.

New staff completed an induction pack. Their induction also included working with more experienced staff for a period, until they felt confident to work independently. Staff said they liked working at the home and felt they could say if there was an area of training they were interested in. For example, the manager was looking into gaining training from a local hospice on end of life care. Policies and procedures were accessible to staff. The manager told us how they tried to ensure they recruited good quality staff through the interview and induction/probation process.

Staff received regular one to one supervision sessions. This enabled staff to discuss career and training needs, any issues and for the manager and deputy to assess competency using a set format. Staff felt supported by the manager and deputy manager and enjoyed the homely, relaxed feel.

Staff had good knowledge in identifying people's changing needs and providing appropriate care. People had access to health care professionals to meet their specific needs. Records showed people attended appointments with GPs, dentists, chiropodists, district nurses and speech and language therapists. Staff made sure people saw the relevant professional if they were unwell and there were lots of recorded examples. For example, one person regularly saw a heart specialist. Staff said they had a good relationship with local GP surgery and the district nurses. A district nurse visited every day, one told us they had a good relationship with the manager who acted as people's advocate. They said they and the manager both appreciated each other. A new health document was welcomed by staff, as all health and short term needs would be in one place rather than through people's daily record. Body maps were used to identify and monitor areas requiring topical creams or with bruises. We heard staff asking people, "Have you had your cream applied [person's name], how are your legs feeling?"

Each person had their nutritional needs assessed and met. The home monitored people's weight in line with their nutritional assessment. Care plans included a nationally recognised nutritional assessment tools to ensure staff knew who was at risk and what action to take. No-one currently was at particular risk of losing weight. Everyone we spoke with was happy with the food and drinks provided in the home. Comments included, "I love the food. The cook is really good. Lovely not to have to cook ourselves. What more can you ask?" We took lunch with the seven people eating in the dining room. The cook and staff knew what people

liked to eat including their favourite foods and dislikes, which were detailed in an easily accessible folder. This information was very detailed showing a person centred approach. For example, care staff sometimes worked in the kitchen and foods included staff specialities such as [Staff name's] brownies or chocolate and marmalade cake. Staff were getting to know a new person and had included they loved a fry up. Finding out about people's needs was a team effort.

There was a varied menu but in reality people were able to choose exactly what they fancied to eat at the time. Many people were having different meals or for example, potato done different ways, which they enjoyed. It was a very personalised service and people were able to use condiments as they wished and sat at well-presented tables. At the time of the inspection people were enjoying loaded potatoes and salad, ham and mash and vegetables followed by sponge and custard. There was a lovely dining room, off the kitchen, which afforded views across the bay.

People were offered their choice of drinks. People were not rushed but food was served in a timely way. There was friendly banter between people, including staff gently prompting one person to remember to eat by singing. This helped to make mealtimes pleasant, sociable events which also encouraged good nutritional intake. People were offered seconds and regular snacks throughout the day, including homemade cakes.

People had the equipment and environment they required to meet their needs. There were grab rails, assisted bath and hand rails around the home to enable people to move around independently. There was a stair lift to assist people with all levels of mobility to access all areas of the home, including the garden and patio and people had individual walking aids, wheelchairs or adapted seating to support their mobility. There was one hoist and two stand-aids available if needed. Only one person required a hoist and this was mainly at night due to intermittent specific behaviours.

The premises were an older style building which required on-going maintenance. The provider was aware of the issues we pointed out, such as some drafty windows and the need for a new bath chair but some of the issues were on their maintenance programme and others on the manager's list. This could be confusing and not ensure timely completion. By the second day of inspection, the manager and provider had ensured all issues had been completed from one of the lists, for example a window had been made more secure, a new hydraulic bath chair ordered and door stop alarms replaced. Room checks were made more formal using a set format and the manager told us how some rooms had had the divan and bedside cupboard replaced. There was on-going investment in the service. Some of the décor and furniture was tired and outdated or mismatched but this was being addressed slowly and there remained a clean, homely feel. For example, there were new sofas in the conservatory, carpet had been replaced, new furniture added and a new call bell. People said they were happy with the environment.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff. Staff had good knowledge of each person and spoke about people in a compassionate, caring way. They were attentive, passing time with people and relatives. A relative told us how they always felt welcomed and all staff were able to give them an update on their loved one. Large name badges showing staff roles were helpful and the manager was ensuring all staff had a clear name badge.

Rooms were very personalised. A relative said they could decorate them as people wished. One person had been supported to decorate their room reflecting their love of a particular film. Staff said they often were on the lookout for items the person may like. People's craft activities were displayed proudly in the conservatory. Some rooms opened out into the garden and, the maintenance programme identified areas that could be made safer and more pleasant to enable people to access the garden independently for the warmer weather.

Laundry was managed by night and day staff and the provider and was well organised with people's clothes well cared for and folded neatly, showing that staff cared about people. Staff knew people, so well they knew their clothes on sight.

Care plans contained people's preferences which gave staff a basis to work with. Staff said they could update care plans as they learnt more about people and they liked the new person centred focus in the care plans. They knew what people liked to do, their preferred routines and topics for starting conversations. Tea and biscuits were offered throughout the day including to relatives. We saw staff interacting with people in a caring and professional way. Staff also enjoyed their work and told us, "The care is really good. We were over reporting before, recording care every hour for everyone. We didn't need to do this, so now we can focus on providing care. The records were hard to use before but they are better and we have always known how to care." They told us they worked as a team for example with the district nurse to ensure one person at the end of their life had their bed moved so they could see out of the window.

The manager had opened up a hotel style bar and this was stocked with sweets and snacks and drinks people liked. The manager said they had plans to include a coffee bar and the relative we met said they always came for the coffee mornings. The manager said, "It's a lovely home, we are tidying things up, it's an old building but it has a homely feel." Staff enjoyed organising people's birthday celebrations. They had recently organised a birthday lunch for one person and said they tried to make it as special as they could, involving family who lived nearby.

People's privacy, independence and dignity was promoted. Staff used their knowledge of equality, diversity and human rights to help support people with their privacy and dignity in a person centred way. People were not discriminated against. People's care plans were descriptive and followed by staff. The manager told us how proud they were of how staff had supported one person who was blind. They had ensured the person was included, telling the person where and who the staff member was, holding their hand and describing the route they were taking, for example. Independence was very important as people had low

needs, only requiring one care worker for support sometimes. People were able to move around the home as they wished and care plans reflected this. For example, "I walk with a frame but slowly, I do ok and I need assistance with the chair lift and someone to take my frame downstairs for me, ensure I have a glass of juice next to me and in my room at night" and "I will ask if I need assistance although I struggle with my memory, remind me to keep my feet up in a chair."

Staff acted as advocates for people and built good relationships with them. People told us the staff were all lovely. Some people appreciated being able to be quiet and do their own thing. Staff recognised this, especially for one person who had recently been poorly. When the person was in their room, staff popped in to check they were ok or to offer tea. The manager told us how they had worked with one person to try to encourage their relationship with their family. For another person they were looking into taking them on a trip to see where they used to live and work.

There was a good rapport between people; they chatted happily between themselves and with staff. A group of people liked to meet every morning in the lounge for coffee and a chat. They all told us they were happy with everything. When staff assisted people they explained what they were doing first and reassured people. Staff commented on how nice people's hair looked and some people had enjoyed having their nails painted recently.

The home had no offensive lingering odours and staff ensured people were assisted to the bathrooms discreetly to maintain their continence. Most people were able to remain independent and staff only assisted them when they wanted support, respecting their wishes.

Good

Is the service responsive?

Our findings

At the last inspection in August 2016 the service was rated as requires improvement. This was because some aspects of the service were not responsive. At that time people's care plans were not comprehensive and were not reviewed regularly. Meaningful activities were not always available. During this inspection in November 2017 we found these areas had bee addressed. People were able to enjoy chats and time with staff. When we arrived on both days people were enjoying a late breakfast, chatting with staff, napping or pottering around the home. Most people were over 90 years old and said they enjoyed a quieter morning looking at the stunning views. During the morning people had coffee and cake, visitors or an alcoholic beverage. There were activities offered including visits from external entertainers, visits from an animal sanctuary, playing musical instruments and children. The manager said one person living with dementia particularly enjoyed visits from staff members' children and they encouraged these visits, saying "It's lovely to see them light up." During our inspection some people were playing hangman with staff, other people were enjoying watching the large screen TV or could choose from a range of DVDs.

There had also been visits to the beach and a farm. The staff also organised craft activities such as making pots and decorations. Sometimes people took part in armchair aerobics. One person particularly told us they would like to go out more. The manager had included this as part of their care plan and was arranging for staff to have time to take this person out on their own. For example, in the past they had enjoyed visiting their favourite café but would like to do this more.

Each month a local society visited the home for a coffee morning with stalls and a raffle in the conservatory. People could access the large, bright conservatory from the lounge and use the CD player or binoculars. Activities were not formally documented which meant the manager could not monitor individuals to ensure their social and engagement needs were met. They started doing this by the second day of our inspection so they could now see, for example, how often people were going out or enjoying events. For example, they were purchasing vintage tea stands to offer afternoon tea parties and looking into staffing to enable a trip to the local aquarium.

People received care and support that was responsive to their personal care needs because staff had good knowledge of the people who lived at the home. Staff were able to tell us detailed information about how people liked to be supported and what was important to them. People who wished to move to the home had their needs assessed to ensure the home was able to meet their needs and expectations. Staff considered the needs of other people who lived at the home before offering a place to someone. Each new care plan had detailed information about what people liked so staff could meet people's individual needs. For example, one person liked to go up to their room to use their computer at a certain time. There were clear details about when and why people may ask for assistance, for example, "I can be fussy with food, if I say no I will often have something later" and "I wear [particular clothes] as they are easy for me to get up and down".

Bedtime plans showed how people liked to sleep and contained details such as leave the bedside light on, preferred routines, whether they could or would use a call bell and any continence needs. Staffing at night

included a regular named waking care worker and the provider or another care worker who was on call, on site. The provider said as the home focussed on caring for people with low needs this had worked well and it was rare that the waking care worker called for assistance. No people required assistance from two staff, except if there was a fall. One person sometimes put themselves on the floor and the provider said they would be called if this was at night as per the care plan. The manager and provider had not documented when the on-call staff member was called during the night on the rota and were starting to do this to monitor that there were enough staff at all times. The provider said the night staff arrangements were always on review depending on people's needs.

Staff at the home responded to people's changing needs. For example, staff recognised when people were not eating so well, were not themselves or had a sore place on their skin. No-one at the home had any pressure sores at the time of our inspection. The manager had recognised the paper work was not previously well organised and was repetitive. We found all the information staff needed was there. We spoke to all staff who were very knowledgeable about people's needs including the kitchen staff. The manager had nearly completed all the new care plans to reflect staff knowledge and ensure people's needs were documented fully.

There were regular reviews of people's health. The manager was completing a 'hospital passport' for each person. This was intended to be given to external health professionals/paramedics so they would know how to respond to people's care for consistently. One person was being supported to be as independent as possible and now they were preparing to look at moving out to supported living accommodation with the support of Korniloff staff. The provider had continued to invest in equipment they needed to use the bathroom despite them possibly moving on, as the person really enjoyed a bath.

People said they were involved in discussing their needs and wishes if they were able and people's relatives also contributed. Most people told us they were happy and did not want to be involved further in their care plans. Relatives said their loved one was happy and had their needs met and they did not need to be more involved but they could talk to the staff if they needed to. People and their representatives knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. There had not been any formal complaints made in the last 12 months.

Good

Is the service well-led?

Our findings

At the last inspection the service was rated as requires improvement. This was because at that time there were no effective quality assurance system in place to monitor care and plan on going improvements and not all records were well maintained. During this inspection in November 2017 we found these areas had been addressed. The provider had been the registered manager at the home for many years and was now looking to take less of a day to day role in running the home. The new manager had been in post for nearly a year, supported by the deputy manager. The team were clearly motivated to ensure people were well cared for and they and all the staff had good knowledge about individuals' needs. As the provider lived on site it had become unclear as to who was taking on which management roles. The provider oversight was sometimes random with unstructured discussions, which could be confusing as to managerial responsibilities. For example, to ensure the maintenance programme for the large, older style building was kept in one place and jobs completed in order of priority and to clarify what the manager could do without informing the provider first. We recommended that governance arrangements and responsibilities were made clearer.

The manager and deputy manager worked well together and staff said they felt well supported and part of a team. There was a lovely, relaxed feel to the home with people able to spend the day as they wished. For example, the office had an open door policy and was right next to the communal areas with windows to the lounge. People, staff, health professionals and relatives were all able to pop in for a chat, private or informal and share biscuits and sweets.

People and relatives spoken with during the inspection described the management of the home as open and approachable. People were comfortable and relaxed with the management team who clearly knew them and their family well. A relative said they were happy to talk to management and all the staff at any time and could not fault the care. Relatives of one person who had passed away recently had asked for staff to attend the funeral and donations were for Korniloff. This showed they had valued the support and care their loved one had received.

The managers and staff showed enthusiasm in wanting to provide the best level of care possible and this showed in the individualised way they cared for people and their families. There were systems in place to share information and seek people's views about the running of the home. A recent quality assurance survey had been completed. Comments were all very positive. People's views were acted upon where possible and practical. They included comments such as, "I am very happy at Korniloff. I always feel I am treated with respect and my dignity is always looked after" and "Staff are easy to get on with." A relative had commented, "It's a lovely, caring, family style home" and "Always a great visitor experience with friendly staff. A real home from home for grandma. We had a cream tea and bunting and they are very welcoming and helpful."

The managers kept up to date with current good practice by attending training courses and linking with appropriate professionals in the area. One staff member said, "Nice here, the manager is very good. We are like a family." The manager said in the PIR, "The staff are a very important asset and I include them in discussion appropriate to their job role about the service. Keeping staff informed and included keeps a

happy team and one that will flourish. I mentor and develop training pathways so we are able to deliver person centred, high quality care." Staff received regular supervision support and were regularly listened to and consulted. For example, staff had requested further information about using fire extinguishers and the manager had laminated information near each extinguisher. They had also requested some new bed linen which the provider was sourcing and suggested that people had their care plan photos taken after their hairdresser visits so they looked their best.

There were effective quality assurance systems in place to monitor care and plan on-going improvements. The manager had introduced more formal documents to ensure audits followed a set criteria such as room checks and the care plan reviews and medication audit. There was a monthly falls audit. There were very few falls but each one was analysed to ensure any patterns were identified and actions taken to minimise risk in the future. All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them. For example, where people had fallen individual risk assessments were reviewed and preventative measures taken. This demonstrated the home had a culture of continuous improvement in the quality of care provided.

The home had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.