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Cornelia Heights

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Cornelia Heights on 2 and 4 August 2017. Cornelia Heights provides accommodation for up to 23 older people with personal care needs. There were 18 people living at the home when we visited. All areas of the home were accessible via a lift or stair lifts and there was a lounge and conservatory dining room. There was also an accessible garden. Most bedrooms were used for single occupancy and some had en-suite facilities.

Since the last inspection in November 2016 improvements had been made in the management structure within the home. This had resulted in more effective running of the service and increased staff morale. There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment. However systems were not always robust. For example, where incidents or accidents had occurred it was unclear if action had been taken to identify cause and prevent recurrence and care plans and risk assessments were not always updated in a timely manner to reflect people's changing needs.

Staff and the registered manager had received training in respect of MCA and were able to demonstrate an awareness of the principles. Staff understood the need to gain consent from people, however information in relation to who can legally provide signed consent when people lacked capacity was not easily accessible to staff.

People and their families told us they felt the home was safe. Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

People were supported by staff who had received an induction into the home. Most staff had received appropriate training to enable them to meet people's individual needs. There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessments. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

People were positive about meals and the support they received to ensure they had a nutritious diet. Care plans provided information about how people wished to be cared for and staff were aware of people's

individual care needs and preferences.

People and their families were positive about the care received. The quality of staff interactions with people to be varied, but people were comfortable and relaxed in the company of the staff and felt able to ask for assistance and support when required.

People and when appropriate their families were involved in discussions about their care planning, which reflected their assessed needs. There was an opportunity for families to become involved in developing the service and they were encouraged to provide feedback on the service provided both informally and through an annual questionnaire. They were also supported to raise complaints should they wish to.

People's families told us they felt that the home was well led. They were positive about the registered manager and felt that they understood the responsibilities of their role. Staff were aware of the provider's vision and values, how these related to their work and spoke positively about the culture and management of the home.

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 and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

The registered manager had assessed individual risks to people which were managed by staff. Action was taken to reduce risks posed by the home's environment.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

People received their medicines at the right time and in the right way to meet their needs.

Is the service effective?

Requires Improvement

The service is not always effective.

There was not always an effective system and processes in place to ensure that appropriate action was taken when incidents, accidents and near misses had occurred.

Staff understood the need to gain consent from people, however information in relation to who can legally provide signed consent when people lacked capacity was not easily accessible to staff.

People were supported by staff who had received an induction into their role and staff were appropriately supported in their work. With the exception of one new staff member we saw that staff had received effective and appropriate training to meet people's needs.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Is the service caring?

Good

The service was caring.

People and their families were positive about the care received. Staff interactions with people to be varied but people were comfortable and relaxed in the company of the staff and felt able to ask for assistance and support when required.

Staff understood the importance of respecting people's choices and their privacy.

People were encouraged to maintain friendships and important relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

Care plans and activities were personalised and focused on individual needs and preferences.

The registered manager sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

At this inspection we found that improvements had been made in relation to the running and management of the service.

Further time was required to embed the changes into practice and ensure that improvements made are sustainable.

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment. However, these systems were not always robust. For example, were incidents or accidents had occurred it was unclear if action had been taken to identify cause and prevent recurrence.

There was a clear management structure in place and staff understood the roles and responsibilities of each person within the team structure.

People and their families told us they felt the service was well-led and also said they would recommend the home to their families and friends.

Cornelia Heights

Detailed findings

Background to this inspection

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

The inspection was an unannounced planned inspection and was carried out on 2 August 2017 by three inspectors and concluded on 4 August 2017 by one inspector. Previous to this inspection a focused inspection was completed in November 2016 to follow up on warning notices that had been issued to the home. You can read the report from our last focused and comprehensive inspection, by selecting the 'all reports' link for Cornelia Heights on our website at www.cqc.org.uk

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 13 people using the service and engaged with 4 others, who communicated with us verbally in a limited way. We spoke with one visitor and six family members. We observed care and support being delivered in communal areas of the home. We 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 three members of the care staff, the chef, a member of the domestic staff, the deputy manager, the registered manager and one of the providers.

We looked at care plans and associated records for seven people using the service, staff duty records, three staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

Good

Is the service safe?

Our findings

People told us and indicated they felt safe. One person said "I feel safe here". Another person told us "Safe? Oh yes it's safe. The staff are very nice". A visitor said "[name of person they were visiting] is so well cared for and safe living here". They added "They [staff] will always tell me if something has happened like if they have a fall". A family member said "I think [name of loved one] is safe. They [staff] have done everything they can to keep them safe".

People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. All staff and the registered manager knew how to identify, prevent and report abuse and had received appropriate training in safeguarding. Staff knew how to raise observed concerns and said they would have no hesitation in reporting abuse. One staff member told us "I would speak to [name of registered manager] or if the concern was about them I would go to social services or CQC." Another staff member said "I would tell the senior or the manager, I know they would sort it out". Staff were confident the registered manager would take the necessary action when concerns were raised. The registered manager explained the action they would take in relation to safeguarding issues and records confirmed appropriate action had been taken when necessary.

The registered manager had assessed the risks associated with providing care to each individual. Each person's care file contained risks assessments which identified the risks along with the actions taken to reduce these risks. Risk assessments in place included moving and repositioning, mobility, fluid and nutrition, skin integrity and falls. Staff showed that they understood people's risks and we saw that risks to people were assessed, monitored and reviewed regularly. However one person's risk assessment had not been updated in a timely way in accordance to their changing needs. This was discussed with the registered manager and it was immediately updated. Additionally, when this person's needs was discussed with staff they were all aware of their current needs and risks.

Moving and repositioning risk assessments viewed set out the way staff should support each person to move and correlated to other information in the person's care plan. Staff had been trained to support people to move safely and we observed support being provided in accordance with best practice guidance. One person was at risk of developing pressure sores. Their risk assessment described how to support them which included ensuring the use of a special cushion and pressure relief mattress to reduce the risk of damage to their skin. Pressure relief mattresses were used correctly, and people were assisted to change position to reduce the risk of pressure injury. People were supported in accordance with their risk assessments. Staff explained the risks related to individual people and what action they needed to take to mitigate these risks.

People and their families told us there was sufficient staff to meet people's needs. People's comments included, "Yes, as far as I'm concerned there is enough staff", "I ring the bell sometimes; you don't have to wait long for them [staff] to answer it" and "They usually come quickly". A family member said "I normally visit at weekends; I think there is enough staff". A visitor said "They [care staff] seem to be around when I visit". We observed short periods of time when staff were not present in the communal areas; however it was not apparent that this was impacting on people. We saw staff responded to call bells and activated

movement safety alert alarms quickly.

The registered manager told us that they used a dependency tool to support them to determine staffing levels. This dependency tool took into account the level of support people using the service required but did not consider the size or layout of the building. The registered manager told us they took account of this by listening to feedback from people and staff, regular walk rounds of the home, observing care and monitoring call bell response times. There was a duty roster system in place, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime or cover from staff employed by the provider at another home nearby. The registered manager and deputy manager were also available to provide extra support when required.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited was suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. A newer member of staff confirmed that before they started working at the home they had completed an application form and an interview had been conducted. They also told us that a DBS check had been completed and they were unable to commence employed until this had been completed.

People received their medicines safely. All the people we spoke with told us staff administered their tablets on their behalf. One person said "The carers give them to me. They know what I should have". Another person told us "If you have a headache you just ask for some tablets and they'll get them for you". Staff administering medicines had received appropriate training and had their competency assessed to ensure that medicines were given appropriately. Staff supporting people to take their medicine did so in a gentle and unhurried way and waited until their medicines had been taken before moving on. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines was required to initial the MAR chart to confirm the person had received their medicine. Each person who needed 'as required' (PRN) medicines such as, pain relief or medicine to support with anxiety had clear information in place to support staff to understand when and why these should be given.

There were suitable systems in place to ensure the safe storage and disposal of medicines. There was a medicine stock management system in place and we saw that all medicine in stock was accounted for. Systems were in place to ensure prescribed topical creams were applied where and when required and this was supported by the use of body maps which highlighted the areas people required the cream to be applied. The dates that topical creams containers were opened were recorded which also including the date these should be discarded. This helped to ensure people did not have creams applied beyond the safe to use by date.

The providers and staff actively managed and reduced environmental risks. For example, staff were aware of the procedures to follow in the event of a fire and regular tests of fire safety systems and equipment were conducted to make sure they were working effectively. The home was clean and free from offensive odours. Families and visitors described the home as being clean and well maintained. There was a clear and detailed cleaning schedule in place which both domestic staff and care staff worked to; staff understood their responsibilities in relation to the cleaning schedule. The registered manager told us that as well as completing regular audits on the cleanliness of the home they completed a 'daily walk around' to ensure the

home was clean and tidy. A member of the housekeeping team confirmed this.

Requires Improvement

Is the service effective?

Our findings

People and their families told us they felt the service was effective and staff understood people's needs and had the skills to meet them. A family member said "It's like home, it's a comfortable environment and [our loved one] is in the right place. It's perfect for them". Another family member told us "It's homely, we [family] have visited a lot of care homes and this is one of the better ones". A person said "It's very good here, I am happy with everything".

There was not always an effective system or processes in place to ensure that appropriate action was taken when incidents, accidents and near misses had occurred. We saw that incidents, accidents and near misses had not always been recorded robustly. This meant that the provider or management team may not be able to identify any actions necessary to help reduce the risk of further incidents. For example, where body maps were in place for people, which highlighted observed concerns in relation to the person's skin (such as bruising); there was no record that an investigation had been completed by the management team. Additionally where a repeated incident had occurred it was unclear if action had been taken to identify cause and prevent recurrence. This was discussed with the registered and deputy manager on day one of the inspection who agreed to review the recording processes to ensure that it demonstrated what actions had been taken. By day two of the inspection we saw that some action had been taken to address the issues raised.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests.

However, we saw that for one person who lacked the capacity to give informed consent to care and treatment their consent form had been signed by a family member. At the time of the inspection the registered manager told us that this family member did not have Lasting Power of Attorney (LPA) for health and welfare in place for their loved one. This meant the family member did not have the legal authority to consent to care on behalf of the person. This was discussed with the registered manager on day one of the inspection who agreed to review the consent forms. On day two of the inspection we saw that appropriate action had been taken.

Following the inspection additional information was received from the provider which highlighted that this family member did have a LPA in place. However this does reflect that the provider had failed to ensure the care plan was up to date and that the information in relation to the LPA was not previously accessible to staff or the registered manager as they were unaware that the LPA existed at the time of the inspection.

People and their families told us that staff sought verbal consent before providing care or support, such as offering to provide support to help them mobilise or supporting with personal care. We observed staff seeking consent from people using simple questions and giving them time to respond. Staff told us how they offered choices and sought consent before providing care. One staff member said "We ask them, if they said no we don't do it but try later or try a different staff member." A person said "They [staff] tell me what they want to do. They don't make me do anything that I don't want to do". We heard staff seeking verbal consent from people throughout our inspection.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards. The registered manager had applied for a DoLS authorisation for some people at the home and these authorisations were monitored on a regular basis to ensure they were still relevant, necessary and reapplied for before there expiry date to ensure that restrictions posed remained lawful. The registered manager told us that one of the DoLS authorised had additional conditions attributed to them and was aware of these. Staff were aware of which people were subject to the DoLS authorisation and the restrictions imposed.

People were supported by staff who had received an induction into their role, which should include a period of shadowing a more experienced member of staff who assessed their suitability to work on their own and the provider's mandatory training. However, one new staff member told us that since being at the home no formal training had been received, but said they did receive the essential training required to care for people in their previous post. This was discussed with the registered manager who was unable to confirm if this staff member had completed or received up to date essential training when they started working at the home or received training which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. It aims to ensure workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. The registered manager agreed that they would review their processes to ensure that all new staff were appropriately trained.

With the exception of the one new staff member highlighted above we saw that staff had received effective and appropriate training to meet people's needs. People and their families told us they felt that the staff were well trained and were confident in the staff's abilities. One person said "I'm very confident in the staff". A family member told us "The staff really do know what they are doing". The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. Staff had access to other training focused on the specific needs of people using the service, such as, dementia awareness and the mental capacity act. Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, how they supported people who were living with a cognitive impairment to make choices and how to use moving and handling equipment effectively.

People were cared for by staff who were appropriately supported in their work. The registered manager had recently implemented new arrangements for supervision to ensure that this was more effective and robust in meeting staff and management requirements. New supervision recording forms had been put in place and the supervision responsibility was now shared between the registered manager, deputy manager and head of care. This helped to ensure that supervision could be provided to staff more consistently. Supervisions provide an opportunity for the management team to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. The management team also

worked some care shifts, which they said enabled them to directly supervise how staff provided care for people. Staff who had worked at the home for in excess of a year had received an appraisal.

People were provided with enough to eat and drink, however during lunch time staff did not ask or encourage people to move from their lounge chairs to the dining room. This meant the lunch time meal was not a particularly social event and did not encourage people to interact with each other.

All the people we spoke with were positive about the quality and availability of food. One person said of their breakfast, "Superb job, don't know who cooked it but they did a very good job of it". At lunch time a person said of their meal "Exceptional- really good". A family member told us "[name of loved one] is quite happy with the food, they certainly get enough to eat and drink". Another family member told us "The food seems very good, [our loved one] enjoys the food". Fluids and snacks were offered throughout the day and evening, including homemade cakes, biscuits and fresh fruit and meals were appropriately spaced and flexible to meet people's needs. People and staff also confirmed that drinks and snacks could be provided at any time. One person said "I was awake one night and they [night staff] asked me if I wanted anything [to eat or drink].

The kitchen staff were aware of people's likes and dislikes, allergies and preferences. For example, when talking to the chef they were able to tell us people's individual requirements, included who preferred white and brown bread; foods to avoid for individual people and people's specific dietary needs. At lunch time we saw that one person who was vegetarian had a non-meat meal and where people required their meals at a soft or pureed consistency this was provided.

Staff were aware of people's needs and abilities and offered support when appropriate. For example, one person needed full assistance with their meal and they were supported in a caring and unhurried way. Where people required encouragement to eat we saw that staff did not take over and people's independence was supported with the provision of specialist cups, appropriate cutlery and the use of plate guards. People was offered a choice of two main meals at lunch time, however, people confirmed that the chef would provide them with an alternative of their choice if they didn't like what was offered.

When people's food and fluid intake was reduced or poor this was closely monitored by the staff supported by the use of individual food and fluid intake charts. These were reviewed frequently and where issues and concerns were highlighted appropriate action was taken. Action included, requesting guidance from health professionals and making changes to the menu. People had nutrition care plans in place, which included information about people's food and drinks preferences, allergies, levels of support needed and special dietary requirements.

People received the personal care they required. A visitor told us they were happy with the way the person they were visiting's personal care needs were met. They said, "They [person] always looks clean and dressed nicely, they [staff] always see to that". Staff recorded the personal care they provided to people including if people had declined offered care such as a shower or bath. These records showed people were supported to meet their personal and other care needs.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. A person told us "They [staff] would arrange the doctor for me". Staff described how they supported people which reflected the information in people's care plans. Where needed, equipment to safely reposition people such as slide sheets were available individually for people. People's care records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in

detail.

Some measures had been taken in respect of the environment to consider the needs of people living with dementia. For example, signs on toilet doors to make them easily identifiable and colour contrasts for hand rails. Overall the home is an adapted building and not purpose built so some parts were less suitable for people, due to slopes and steps. This was considered by the registered manager prior to people being admitted to the home. Bedrooms varied in size but overall were suitable for their occupants. People visited in bedrooms had access to a call bell system to allow them to request assistance and support where required.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people who, with their families were positive about the care received at Cornelia Heights. A person said, "They [staff] are very good, I have no complaints at all. They always speak nicely to me". Another person told us that the staff were, "Nice, all nice here". A third person said "The staff are lovely, very kind and so helpful". A family member told us "All the staff are very kind".

We observed staff interactions with people to be varied. At times staff were seen to be attentive and engaging with people in a kind, caring and positive manner and we heard friendly banter between the staff and people. For example, a staff member was seen spending time with a person sorting out some music they wanted from a laptop; the person was very pleased when music was found. Additionally, housekeeping staff choose to spend their tea break with people, chatting pleasantly to them and offered them drinks and things to do that the person had a particular interest in. However, for some periods of the day staff were not present in the communal areas of the home and when they entered the lounge did not always acknowledge people. We also observed one staff member approach a person, move a table and begin to move the person who was in a wheeled chair without any explanation or warning. At lunch time one person said to a member of staff that, the pudding was too much (amount). This staff member explained what it was and said, "Eat what you can". The person was clearly put off by the amount and told the staff member "it's too big". Soon after another staff member came by and asked person why they were not eating their pudding, this staff member offered to get a smaller one which they did and the person then started to eat this.

People were treated with dignity and respect and appeared relaxed and comfortable in the company of the staff and confident to approach them. One person who spent time in their room said "They [staff] will always pop in and out for a chat. They listen and we get on well". Another person told us, "I just ask if I want something, they [staff] will get it". Staff understood the importance of respecting people's choice. People all confirmed they were offered choices about meals, where they spent time and what they did. Choices were offered in line with people's care plans and preferred communication style. Throughout people's care plans there were comments about providing choices to people in relation to their care. One care plan stated, 'Respect [name of persons] wishes to remain in bed clothes when they are having a day in bed'. A family member told us "They [staff] get [loved one] up early, which is what they like and they always give them a choice about what time they go to bed".

People's privacy was respected when they were supported with personal care. We observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited for a response before entering. Staff were able to describe the practical steps they took to preserve people's dignity and privacy when providing personal care. One staff member said "I make sure the doors are closed and no one can see into the room (when providing personal care)". There were two shared rooms in the home; these were set up with a fixed partition between sections which helped to promote people's privacy during personal care. People confirmed staff respected privacy and always shut bedroom doors when any care provided. Confidential care records were kept securely and only accessed by staff authorised to view them.

People were encouraged to be as independent as possible. A person told us, "The [staff] will help me if I need them". Care plans specified what people could do for themselves and what they needed help with. For example, one stated 'I usually walk independently but at times would prefer to use my stick'. Another said 'I will need assistance with dressing but I am able to choose my own clothes'. We saw a staff member assisting a person to the bathroom; the staff member provided good verbal guidance and prompts and did not rush the person. Where appropriate, adjustments had been made to the environment to support people to remain independent, including handrails.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identified people who were important to the person. All of the families we spoke with confirmed that the registered manager and staff supported their relatives to maintain their relationships. One family member said "We [family] are made welcome and staff are happy for us to visit whenever we like". People's bedrooms were individualised and reflected people's interests and preferences. One person had recently had extra television channels added in their bedroom to enable them to watch more sports and another person had reported that they had poor television signal in their room and this was addressed. The bedrooms were personalised with photographs, pictures and other possessions of the person's choosing.

Good

Is the service responsive?

Our findings

People and their families told us they felt the staff were responsive to their needs. One person said "I'm very confident that the staff would do something if I wasn't well". A family member told us "They [staff] are always quick at getting the doctor in if [loved one] is unwell, and will phone me". Another family member said "I am quite impressed, staff respond very quickly to the call bell. I know they will act quickly when needed".

People experienced care that was personalised and staff demonstrated a good awareness and understanding of people's individual needs. People and their families told us that they felt staff knew them well and understood their needs. One person said "They [staff] know how I like things doing". Care plans were individualised and detailed with people's preferences, such as sleeping arrangements, their backgrounds, likes and dislikes and social needs. These care plans also included specific individual information to ensure medical needs were responded to in a timely way. For example, for one person, who occasionally demonstrated behaviours that some people may find challenging, there was clear and informative guidance to staff in relation to signs to look for, individualised distraction techniques to try and actions to take.

Some people living at Cornelia Heights had care needs that required close monitoring such as, diabetes, specialist nutritionals needs or skin conditions. Where appropriate risk assessments and care plans were supported by the use of support tools and monitoring charts to allow staff to pick up on and respond to people's changing needs quickly. Although care plans and risk assessments were detailed and person centred we found that these had not always been updated in a timely way. For example, one person was predominately cared for in bed however this was not reflected in their care plan or risk assessment. This was discussed with both the registered and deputy manager on day one of the inspection. By day two of the inspection the care plan and risk assessment had been updated.

Staff were kept up to date about people's needs through handover meetings which were held at the start of every shift. Information was provided to staff during these meeting which included information about changes in people's emotional and physical health needs and where people had declined assistance with personal care. During this handover meeting staff shared ideas and knowledge of how best to provide support to individual people.

Care and support were planned proactively and in partnership with people, their families and healthcare professionals where appropriate. The registered manager told us that they completed assessments of people before they moved to the home to ensure their needs could be appropriately met. They also said "I don't just consider their needs but also think about the people we already have living at the home and the staff skills". A family member confirmed that their loved one was assessed by the registered manager before they moved to the home. The family member said "They [registered manager] asked questions about everything in relation to [loved ones] needs. They also asked about their interests".

Families told us that they were fully involved in the development and reviews of care plans. A family member

said "They [management team] will often talk to me about [my loved ones] care. A second family member told us "I can talk to staff about the care at any time". Within people's care files there was a relative communication sheet. This showed that family members were involved and informed of any changes in their loved one's health and wellbeing. One family member said "We always get a phone call if [our loved one] is unwell".

People received appropriate mental and physical stimulation and had access to activities that were important to them. There was an activities coordinator in place who provided activities on an individual bases and in groups. Activities included games, armchair exercises, reminiscence, painting and manicures. The registered manager explained that they also purchased activities staff from external providers which included, arts and craft and music. People reported enjoying the activities and also spoke positively about a musician who had entertained them recently. People were provided with the opportunity to go on occasional outings, for example into the local town or to the local library.

People told us there was enough for them to do and were happy with the activities provided. One person said "I don't get bored" and another person told us "I am content (with the choice of activities)". A family member said "There is enough for [loved one] to do". Staff were knowledgeable about people's right to choose the types of activities they liked to do, and respected their choice. Activities were discussed during the residents meetings to give people the opportunity to comment on past activities and share ideas about things that they could do in the future.

Cornelia Heights had developed some links with the local community. For example, Local school children visited the home and spend time talking to people, completing activities with them and sharing stories. Representatives from the local church visited monthly to provide a church service to those who wished to attend.

The management team sought feedback from people's families on an informal basis when they met with them at the home, during telephone contact and via email correspondence. People and their families felt able to approach the management team and staff at any time. One person said "They [management team and staff] will come and see that I am alright". A family member told us "I'm really impressed; they [management team] always talk to us and get our views". Residents meetings were held approximately every two months to discuss all aspects of care, update people on any changes in the home and to get people's view on the service provided. During these meetings people and their families were given the opportunity to talk about any concerns or issues they had and to share ideas about the development of the service.

The registered manager and provider also sought formal feedback through the use of quality assurance survey questionnaires sent yearly to people, their families and professionals. We looked at the outcome records from the latest survey completed in January 2017 and most responses to this survey were positive. Where concerns or issues were raised, we saw that action had been taken. For example, in the completed survey two people highlighted that they felt there were not enough additional services or treatments arranged in respect to their personal care. This resulted in increased and more regular visits from the hairdresser and chiropodist.

People knew how to complain and there was a suitable complaints procedure in place. There was information about how to complain available for people and visitors in the home's hallway and within the service user guide provided to people and their families. People were also reminded how to complain during resident and relative meetings. All the people we spoke to said that they had never made a complaint, but would feel comfortable raising a concern or complaint if they needed to. One person told us

"I have no complaints". A family member said "I would complain to [name of registered manager] if I needed to, but there is nothing to complain about, it's all very good".

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in November 2016 we found there was clear evidence of tension between the management team and the providers which impacted on the running of the service and staff morale. People and their families had also told us they felt the service was not well-led. At this inspection we found that improvements had been made. However further improvements were still required in relation to having effective systems and processes in place for the management of incidents accidents and near misses such as bruises, skin injuries and choking incidents; ensuring that all new staff had received effective and appropriate training and updating of care plans and risk assessments in a timely manner. Additionally the service required further time to embed the changes into practice and ensure that improvements made are sustainable.

There was now a clear management structure in place, which consisted of a registered manager, deputy manager, head of care, senior care staff and care staff. Each member of the management team had specific responsibilities to ensure the effective running of the service. Staff understood the roles and responsibilities of each person within the team structure. Staff were positive about the registered manager and the running of the home. A staff member commented on the changes in the management team in recent months and said that "things are much better now". They added "things had previously been difficult as staff had not worked well as a team but this is improving". A second staff member said "The atmosphere in the home is much better, people and staff seem happier".

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. The provider carried out their own quality assurance process and provided documentary feedback of their findings to the registered manager. The registered manager carried out regular audits which included infection control, the cleanliness of the home, medicines management, care plans and accidents and incidents. However, as highlighted above these processes were not always robust in identifying actions required or taken. For example, care plans and risk assessments were not always updated in a timely manner and there was not always an effective system and processes in place to ensure that appropriate action was taken when incidents, accidents and near misses had occurred.

People and their families told us they felt the service was well-led and also said they would recommend the home to their families and friends. One family member said "I have no concerns at all. I would recommend the home; its homely, the staff are very friendly and approachable". Another family member told us "The home is organised and run very well". They added, "This is the best home we have been to in terms of the attention from the staff". A person said "I'm really happy here; I have been here a long time so it must be alright". People and their families knew who the registered manager was and most were able to name them. One person said "The manager? That's [name of manager]. She's nice". Another person said they knew the manager and would ask to speak to her if they needed to. The visitor said "If I had any problems I would go to [name of registered manager]. I'm sure they would sort it out". Most people also knew the registered providers and confirmed they spoke with them when they were in the home.

The providers were fully engaged in running the service and their vision and values were built around

providing people with care that was specifically tailored to people's wishes and needs, promoting independence and treating people with respect. The registered manager told us they "want people to live in a happy home; all people to be well cared for in a safe environment and to have happy staff". Staff were aware of the provider's and registered managers vision and values and how they related to their work. Regular staff meetings provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision.

The registered manager told us they were aware of, and kept under review, the day to day culture in the service, including the attitudes and behaviour of the staff. This was done through observations of care provision and working alongside staff. Where concerns were noted these were addressed by the registered or deputy manager immediately (if required), during one to one meetings with staff and during staff meetings. Observations and feedback from staff showed the home had an open culture. Staff confirmed they were able to raise issues and make suggestions about the way the service was provided and these were taken seriously and discussed. Staff were confident that the management team would act if issues or concerns were raised with them. Staff comments included, "I feel able to raise anything with the manager if I need to", "I am able to approach the registered manager with any issues or concerns I have, they will always listen" and "the registered manager is really helpful, I would be comfortable raising concerns with them as I know they would do something".

The provider had suitable arrangements in place to support the staff and the registered manager. The registered manager had regular meetings with the provider, which also formed part of their quality assurance process. The registered manager told us that support was available to them from the provider; by the staff team at Cornelia Heights and that they were able to request additional support from the registered manager of another location owned by provider.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary. There was a duty of candour policy in place, this required staff to be open with people and relatives when accidents or incidents occurred. The registered manager was able to describe the actions they would take to adhere to the duty of candour policy.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed within the reception area of the home to allow easy access to people, families and visitors.