North Corner Residential Home

North Corner

Inspection report

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Ratings

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

Overall summary

This inspection took place on 30 June and 1 July 2015. It was unannounced. There were 14 people living at North Corner when we inspected. People cared for were all older people. They were living with a range of care needs, including diabetes, arthritis, stroke and heart conditions. Some people were also living with dementia. Many people needed support with their personal care, eating and drinking and mobility needs. The registered manager reported they provided end of life care at times. No one was receiving end of life care when we inspected.

North Corner was a large domestic-style house which had been extended to one side. It was set in its own grounds on a residential street in Lewes. Accommodation was provided over two floors in the older part of the building and ground floor only in the newer extension. A chair lift was available for part of the way to the second floor rooms. A lounge and separate dining room was provided on the ground floor.

North Corner had a registered manager. The registered manager was also the owner of North Corner. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

We found a range of areas where people were not safeguarded from risk of harm, this particularly related to where people were at risk of falling.

The provider's systems did not ensure they responded to people's needs in a consistent way. Some people's care plans were not up to date, others did not include information about people's needs that care workers told us about. Appropriate referrals to external healthcare professionals did not take place, for example where people were documented as losing weight.

North Corner was not following its own policies in relation to prescribed 'as required' medicines and secure storage of all medicines They also did not have safe systems to ensure people were administered their prescribed skin creams in a safe way.

Care workers had not received training in their responsibilities under the Mental Capacity Act 2005 or Deprivation of Liberties Safeguards. Several people who were living with dementia did not have capacity assessments in place to support them. People were not referred to the local authority under Deprivation of Liberty Safeguards when required.

The provider's systems for assessment and review of the quality of service did not work effectively across a range of areas, including environmental risks and quality of services provided. Some necessary records were not completed, for example records indicated not all staff received the training and supervision they needed.

Some practice by staff at North Corner did not ensure a respectful approach by staff to people.

Care workers had not been regularly trained in safeguarding adults who may be at risk of harm. Therefore some care workers were not aware of all of their responsibilities in this area. People felt they had raised issues about service provision, however as informal concerns and complaints were not documented, the provider could not ensure all such matters had been taken up and acted upon.

However people also reported on the caring approach of staff. We saw staff supporting people in a kindly and helpful manner.

People said there were enough staff to support them in the way they needed. Staff were recruited using safe systems, to ensure they were suitable to work at North Corner.

People were positive about the quality and choice of meals at North Corner. Meals were served in pleasing, domestic-style surroundings.

The registered manager and deputy were open to different areas about improvements in service provision. They had an established philosophy of care, particularly relating to ensuring people were cared for in a domestic, homely way. Staff knew about this philosophy. A care worker said the aim was to ensure people were "Looked after just like in their own home."

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

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

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

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

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

North Corner was not always safe.

The provider did not ensure they took appropriate steps to ensure the safety of people and protect them from risk of harm. Staff had not received recent up-dates on safeguarding people from risk of harm, so were not aware of all of their responsibilities.

The provider's system for administration of certain medicines were not safe.

Both people and staff felt there were enough staff to meet their needs. Staff were recruited using safe systems.

Is the service effective?

Inadequate

North Corner was not always effective.

Where people were living with dementia, systems were not in place to ensure requirements of the Mental Capacity Act and Deprivation of Liberties Safeguards were followed.

Referrals were not always made to relevant healthcare professionals to ensure people were appropriately supported.

Staff training and supervision were taking place, but all relevant areas had not been included.

People responded positively about meals. These took place in a supportive, domestic environment.

Is the service caring?

Requires Improvement

North Corner was not always caring.

The provider had not ensured all staff actions showed a respectful attitude towards people.

Staff always asked people's permission before supporting them and involved them in decision-making. Staff showed an understanding of supporting people in the way they wanted and respecting their choice.

Is the service responsive?

Inadequate

North Corner was not always responsive

The provider's systems for care planning did not ensure people's needs were assessed effectively and plans put in place and delivered to meet their needs. There was a lack of focussed activities relating to some people's individual needs.

Summary of findings

People gave mixed responses about raising issues of concern about the service. The provider had not received any formal complaints during the past year.

Is the service well-led?

Requires Improvement

North Corner was not always well-led.

The provider's systems for review of the service provided did not identify a range of areas, to ensure people's health, safety and welfare and improve quality of care provided. Some relevant documentation had not been completed.

The provider was open to developing new ideas about improving service provision. Staff were aware of the provider's philosophy of care to provide a homely environment for people.

North Corner

Detailed findings

Background to this inspection

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

The inspection took place on 30 June and 1 July 2015. It was unannounced. The inspection was undertaken by two inspectors.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We did not request a provider information return on this occasion. This was because of some of the information received led us to inspect at an earlier date than originally planned. However the provider sent us a wide range of different information about the how they provided services immediately after the inspection and we used this information in this report.

We met with 10 people who lived at North Corner and observed their care, including the lunchtime meal. We spoke with four people's relatives. As some people had difficulties in verbal communication, 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 inspected the home, including the laundry, bathrooms and some people's bedrooms. We spoke with six of the care workers, a domestic worker, the cook, the handyman, the deputy manager and the registered manager. We also spoke on the phone with North Corner's administrator.

We 'pathway tracked' five of the people living at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at North Corner. One person said they felt safe because when they had fallen "I shouted and the night carer came." A person's relative told us their loved one was "Safer" at North Corner than they had been in their own home.

However we found a range of areas where people were not being safeguarded from risk of harm. Before the inspection, we had concerns raised with us about risks to people who had a tendency to fall. We saw a person had bruising to their leg. They told us they had fallen over, but could not recall anything further about their fall. We looked at the person's records. There were no recent records of the bruising, such as a body chart to record the extent of the bruising or when it had first been noted. A care worker told us the person was on medication which could cause bruising. They were unsure of when the bruising had occurred. We looked at North Corner's accident book. This showed the person had fallen on several occasions earlier in 2015. Their falls risk assessment had not been reviewed after these falls. The registered manager told us they had consulted with the person's GP about their falls and skin condition several times. The person's care plan had not been revised following these consultations to ensure the person's risk was reduced. A different person told us about a recent fall. Their records documented bruising to their hand. A care worker reported on bruising to another part of the person's body. No further documentation had been made about the extent or duration of this person's bruising. The person's fall had not been reported to their GP. We made a safeguarding referral about these people following the inspection.

North Corner had several slopes and integral steps within the building. There are well-established guidelines from national bodies on how to identify and assess risks to people from trips and slips. The provider had not followed these guidelines by ensuring environmental risk assessments were in place and action plans developed to reduce risks of trips and slips to people. For example there was a small step coming out of the lounge, and two people had rooms which were up a short flight of stairs. The registered manager said they completed individual risk assessments for people about the risk of tripping. A person whose room was up the short flight of stairs had a falls risk assessment. This was incomplete and did not take factors documented in their records relating to their medical condition and general frailty into account and did not consider if this flight of steps could be a potential risk to them. This meant the person's risk of falling had not been fully assessed. A different person who had fallen several times did not have the risks to them from tripping over the small step into the sitting room included in their risk assessment, although we saw them in the sitting room on the first day of the inspection.

The provider was not taking other actions to protect people from harm. A corridor led from the dining room to six people's rooms. The door to the laundry was directly off this corridor. The laundry door had a lock on it, so staff could access it but so the area could be kept secure to prevent harm to people. The laundry room presented a risk of harm to people because it had a large hot water cylinder and hot pipes in it, these were not covered. Some of the people living in the rooms of this corridor had history of falls and some were living with dementia. The laundry room was not locked on either of the two days of the inspection, this included after we had pointed it out to more than one member of staff. The registered manager confirmed the lock should always be engaged to protect people from risk of harm from entering the laundry. They did not know why it was routinely being left unsecured.

We looked at systems for supporting people in taking their medicines. Several people had prescribed medicines to be given 'as required' (PRN). One of these people was prescribed one tablet to be given every four to six hours. Records showed there were several occasions when the person had been given two tablets, thus exceeding the prescriber's instructions about the maximum dose they were to be given. The medicines policy stated PRN medications could only be given in accordance with a PRN protocol. The policy outlined PRN protocols needed to state, among other areas, the specific signs and symptoms medicines should be given for, and the maximum daily dosage. It also stated if a PRN medication was given, a note needed to be made of why the PRN medication was given and the effect for the person of the PRN medication. However we found none of the people prescribed PRN medication had a PRN protocol in place. This included a person who was prescribed a PRN medication which was being given twice a day on a regular basis and another

Is the service safe?

person who was being given it every morning at 8:30am. These people did not have any records to state why they needed to be given this PRN medication or its effect for them.

Several people were prescribed skin creams. One person had two skin creams in their room. They did not have any information in their records about where and how often these skin creams were to be applied. The prescription labels on both the containers had deteriorated so were no longer readable. We asked one care worker about application of these creams. They told us they applied one of the creams to the person's legs. Another care worker told us they applied the other of the creams to the person's legs. As there were no care plan or other instructions about application of these creams, people were at risk of not having their prescribed skin creams applied in accordance with their GP's prescription. This was not an isolated occurrence. Another person had a prescribed PRN skin cream in their room. There were no instructions about where their skin cream was to be applied and how often, apart from an undated instruction on their medicines administration record that the cream was 'for painful joints.' There was no information about which joints the person found painful or how often the medicine was to be applied. The person was frail and had some communication difficulties, so would not be able to always inform staff about which of their joints felt painful.

The lack of assessment and care planning in relation to risks to people's health and safety and proper and safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed people who sat in the day room had periods of time when there were no staff with them, so staff could see if people needed support or assistance. This was a risk in a home where people may be susceptible to falls, because if a person fell over, staff would not be available to quickly support them. However people said they felt there were enough staff on duty to support them. A person told us "They're quite good at coming" when they needed them. A person said "If I ring my bell, they come as quick as they can." Another person said they did not like to use their call bell and called out when they needed help. They said the staff "Come quickly" when they did this. A person's relative told us staff were "Always in attendance when [the person's name] needs to move." The registered manager reported they had a stable team of staff, some of whom had been in post for many years. They said staff supported each other to fill in for occasions when other staff were off sick or on annual leave, so there was no reduction in staffing numbers. The registered manager said they "Very, very rarely use agency staff," because of this.

All the care workers we spoke with were aware they should report any concerns that a person may be at risk of abuse to the manager or person in charge. One care worker told us, "I would let my manager know if I suspected something was going on". Some care workers were not aware they could also refer such matters to external agencies such as the local adult safeguarding team and such referrals could be made anonymously if necessary. After the inspection, the provider sent us their training plan. This showed out of eleven staff, only one had received training during the past year in safeguarding adults who may be at risk, three staff had been trained two years ago and seven staff did not have records of specific safeguarding training. Not all staff were aware of all of their responsibilities for safeguarding people who may be at risk.

North Corner did have other systems to ensure people were protected from harm. There were records to show the temperature of bath water was checked to protect people from risk of scalding. The chair lift was regularly serviced to ensure its safety. The registered manager had identified that people did not have personal evacuation plans in the event of a fire and was in the process of drawing these up. There were clear systems for ordering medicines, which the manager was undertaking when we inspected. The manager was methodical in the ordering processes, ensuring medicines were ordered so people did not run out, and also preventing overstocking. There were clear records of medicines sent back to the pharmacy for destruction.

Appropriate checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).This meant appropriate recruitment checks had been undertaken to ensure as far as possible staff were of suitable character to work with people. There were also copies of other relevant documentation, including job descriptions, character references and interview records in staff files.

Inadequate

Is the service effective?

Our findings

People said they thought staff provided effective care and were trained in their roles. One person said care workers were "Really good at knowing how to look after me." A person's relative said "I think they're doing their best to look after [the person's name]" and another relative said there were "Lots of times there are different training meetings going on."

However staff had received no training or updates the Mental Capacity Act 2005 and the Deprivation of Liberties Safeguards (DoLS). The 2014 Supreme Court ruling in relation to Deprivation of Liberty Safeguards and the Mental Capacity Act (2005) stated that all people who lack the capacity to make decisions about their care and residence, are subject to continuous supervision, and lack the option to leave their care setting, are deprived of their liberty. The provider's policy did not contain any mention of the ruling and its implications for people living at North Corner or how decisions made about mental capacity assessments should be recorded.

The registered manager told us about a person who was living with dementia and received services from the community psychiatric nurses. This person did not have a mental capacity assessment to support them in decision-making. One of the care workers was not aware of their role in relation to supporting this person if they had difficulties with their capacity and was unaware they were living with dementia. A different person told us "I want to go home" and they didn't know why they were staying where they were. The deputy manager supported the person when they said this to us by reminding them of where they were and why they were there. The deputy manager reported the person was living with dementia and tended to make such remarks regularly. The person did not have a mental capacity assessment relating to their admission to North Corner and no assessment had been made of if they were being deprived of their liberty as they were able to go out of North Corner as they wanted to. We asked if the person had been referred to the local authority for consideration under DoLS. The registered manager confirmed they had not.

The provider was not acting in accordance with the 2005 Mental Capacity Act. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not ensuring referrals were made to relevant healthcare professionals to support people. One of the people we met with had thickening agent in their room, the prescription label showed it had been prescribed in 2014. Thickening agent is used to support people with swallowing difficulties to enable them to drink fluids safely, for example following a stroke. The deputy manager confirmed the person had experienced a stroke in the past. We asked three care workers about when they used this agent for the person. One care worker told us the thickening agent was not used, it had been prescribed in case the person needed it. A different care worker told us the person used thickening agent when they needed it, and this varied. A third care worker told us they used it for the person once or twice a week. The person did not have a care plan about use of the thickening agent or the indications for its use. There was no evidence a relevant professional such as the Speech and Language Therapist had been consulted about the use of thickening agent for this person. This means the person's hydration needs and comfort when drinking were not being appropriately supported by North Corner's systems

Three people had records which indicated they were losing weight. This included a person whose records showed they had lost seven kilos in five months. None of these people had their nutritional risk assessments up-dated following recorded changes in their weight. Care workers reported all of these people ate well. There were no monitoring systems such as food or fluid records to support these statements. The registered manager reported some of the recordings related to North Corner's weighing scales, which gave different recordings at times. We were also informed by North Corner's administrator after the inspection that some people's weight had been documented unclearly. None of these people's changes in weight had been reported to their GP or a dietician. None of these issues as reported by the registered manager or administrator had been identified and action taken, before our inspection. Therefore the provider was not demonstrating they had effective systems to support people who were at risk of weight loss. We made a safeguarding alert about these people following the inspection.

A person told us they had fallen recently. We looked at the person's records, the record about their fall documented they had felt dizzy at the time. No further reports were made of how the person felt after the fall and there were no records of them being referred to their GP. A care worker

Inadequate

Is the service effective?

and the registered manager both confirmed the person had felt dizzy after their fall. The registered manager reported they had not informed the person's GP, despite the reports of the person feeling dizzy.

The provider was not ensuring care was provided in a safe way to people by assessing risks to their health and safety and ensuring that care plans were put in place with peoples' GPs and other healthcare professionals to ensure their health, safety and welfare. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the provider's staff training policy and the staff training and development programme. We also examined a list of staff training undertaken in the past year. Further up-dated information was sent to us following the inspection. We noted all staff had completed some training in the previous year, for example the safe moving and handling of people . However, in other areas relevant to the care needs of people, such as infection control and record-keeping, several staff had not undertaken any training. We found tablets of soap had been left in two different bathrooms. If tablets of soap are used communally there is a risk to cross infection. The lack of training in infection control meant staff had not taken appropriate action to reduce such risks. A person had a care plan which stated they needed to be turned every two hours to prevent their risk of pressure sores. Care workers told us the person used to have change of position records but they had been discontinued, although the person continued to need support. They were not aware of the importance of the continued maintaining of such records, particularly as the person was not able to inform staff of when they had last had their position changed.

We asked how staff were formally supervised and appraised by the provider. We also looked at the provider's supervision and appraisal policy. The registered manager told us staff received yearly appraisals but did not receive formal supervision. This contradicted the provider's policy and information sent to us following the inspection that supervision was undertaken six weekly. We noted from staff records and files that appraisals had been undertaken but no supervision records were found. Staff told us the provider operated an informal supervision system where staff could approach management and vice versa as issues arose. One care worker told us they received supervision "Quite a lot," another described how they had been supported and supervised when they took up their role. There was no system to record these interactions to enable a review of the effectiveness of the care provided to people by staff.

People were very positive about the meals. One person said the meals were "Very good" and if they did not like the choices the cook would "Always do scrambled egg or an omelette." Another person said "Oh yes we enjoy the food." A person said they did not like rice. They said the cook knew about this and always gave them mashed potatoes on days when other people were given rice.

We observed a lunchtime meal. The dining room was homely, with tables set out attractively, including cloth tablecloths and metal cutlery. People were served drinks in cups, not beakers. The meal smelt appetising. Staff were readily available to support people who needed assistance with their meals.

Requires Improvement

Is the service caring?

Our findings

People told us they were treated with kindness and consideration. One person's relative described the caring "Atmosphere" of North Corner. One person's relative described staff at North Corner as "Very, very kind," another as "Very helpful." Another relative said the person was "Quite happy here." The registered manager said "You're dealing with the whole person," so their aim was to provide a caring atmosphere at North Corner.

However some aspects of service provision did not show a caring approach. We had been informed before the inspection that a person felt people were not respected, this was particularly because on occasion people's beds were not made up with clean linen. We looked at a person's bed on the first day of the inspection. It was tidy and had been made up for the day. However under the top cover there was dry, red-coloured staining on parts of the upper sheet, with some red spotting below on the continence aid and on the sheet under that. Although the bed looked freshly made on the second day of our inspection, the condition of the sheets and continence aid had not changed. We showed this to the registered manager and deputy manager who said the person did not make their own bed, this was done by care workers. They said the person had a wound and the dry staining probably related to this. They stripped the bed and had it made up with fresh linen. Making up a person's bed with linen which is unclean does not foster a respectful approach to people.

On the first day, in a bathroom which was accessed by people, there was an unclean comb and two used hairbrushes. None of them were named. They were still there on the second day of the inspection. There was a note in the bathroom which stated people's possessions were always to be returned to their own rooms. If people's own toiletries were left in bathrooms they could be used by other people when using the bathroom. This does not promote an approach to care which ensures people's dignity. We showed the registered manager the items and they disposed of them, they did not know why they were in the bathroom. This is an area which required improvement.

Other aspects of care showed a caring approach. A person in the sitting room had swollen ankles. A care worker saw this and asked the person's permission to put their feet up on a stool so they would be more comfortable. The person smiled at the care worker when they agreed to this. At lunch time there was a high level of engagement between people and staff. Consequently people, where possible, felt empowered to express their needs and receive appropriate care at the mealtime.

Care workers consistently asked permission before intervening or assisting people. A care worker said to a person in a friendly way "Hello, do you want to go outside, it's a nice day." They then waited for the person's response and supported them in the way they wanted. The inspection took place on a hot summer's day. Several people decided to sit out near the porch in the shade. Care workers checked these people continued to be happy where they were at times, chatting casually with them in a kindly way when they did this.

Care workers always knocked on people's doors and awaited an answer before entering. They called people by their preferred name, sometimes their first name or their surname and title, depending on what they preferred. One person preferred to be addressed by a name which was not their first name, staff respected this and always addressed them by this preferred name.

We went into a person's room. We saw they had removed much of their clothing. It was warm in the person's room. We found a care worker and told them about this. The care worker came at once to ensure the person was supported appropriately. The care worker put lighter clothing on the person so they could remain comfortable and continue to preserve their dignity.

In the late afternoon, a person was climbing down from a minibus after an outing. While the person was trying to climb down the steps, they suddenly panicked. The two care workers with the person were very kindly and supportive to them, speaking to them in a gentle tone of voice, listening to what the person was concerned about. They did not rush the person and let them take their time in getting off the minibus. Once the person had managed to get off the bus, the care worker who had been in front of the person made sure they now felt comfortable and safe, before going back to support the other care worker in assisting the next person.

People were supported in personalising their rooms if they wanted to. Some people's rooms were highly personal, reflecting their likes and interests. One person's room had very little in it. The person told us they had chosen to have their room like that because they did not like "Clutter".

Requires Improvement

Is the service caring?

People's relatives told us they felt welcomed into North Corner whenever they came to visit their loved one. They said they had no difficulties in visiting at times which suited them and their relative.

We talked with staff about caring for people. They all stressed how important it was to work with people to preserve their independence and dignity. One care worker said they found it was important to ensure people felt able to make choices in their daily life and that this was respected. In information sent to us after the inspection the provider stated "We value our resident's wishes and put them and their needs first."

Staff were aware of the importance of confidentiality. We were given a quiet area in the garden where we could discuss people's needs with their relatives and staff, without being overheard. People's records were kept in the office, where staff could ensure they remained confidential. North Corner was starting a process to transfer people's records onto a computerised system. Records would be password protected to ensure people's confidentiality.

Inadequate

Is the service responsive?

Our findings

We asked people about involvement in care planning. One person said "I don't know what that is" when we asked them about their care plan. Another person said because things had changed for them "I think it's all wrong now." A person's relative said they had not seen a care plan for their relative but they did have "Lots of conversations" with the registered manager. Another person's relative said they did not know about their loved one's care plan but "They let me know what's going on" for their relative.

Many of the people living at North Corner were frail, some were living with dementia and needed support. The provider's systems for care planning did not ensure they responded to people's needs. North Corner used a range of different care planning systems, some were not up to date, others did not include information about people's needs that care workers had told us about. Care plans included task-based plans which listed people's personal care needs and were kept in their rooms. Each person also had care plans in a ring-binder folder in the office, which care workers reported they used to inform them of how to meet people's needs. People had more detailed information including assessments of needs kept in folders in a separate filing cabinet. The provider had just started introducing a new care planning system. Information about people was being transferred to the new system. This meant different information stated different matters about people's needs. For example one person had a sensor mat in their room and there were instructions about its use, together with the care plan in their room. One of their care plans dated October 2014 stated they needed the sensor mat as they could get out of bed independently at night. There was no information in the person's newly revised care plan about if they continued to need the sensor mat, although it was available in their room. Care workers we spoke with said they did not know if the person needed the sensor mat or not. One care worker told us the person could experience hallucinations at times. This was not documented in any of their range of records.

A visitor told us about their relative who was living with dementia. They said there were some days when the person got up and walked about, and ate and drank well, however they had other days when they sat in their chair, was very sleepy and ate and drank very little. On both of the inspection days, the person was mainly asleep in their room, sitting in their recliner chair. We asked care workers about the person's pattern of being asleep and awake. Care workers told us a wide range of differing information about the duration and frequency of person's periods of being awake and asleep. The person did not have monitoring records about this to enable assessment of risk to them from periods of time when they were asleep. Most of the person's care plans related to when they were awake and mobile and did not state how care workers should support them when they were not mobile and did not eat or drink much. One care plan which did document sleepy periods gave very limited information about how care workers were to support them to ensure their comfort and safety during these times.

Several of the people at North Corner were assessed as being at risk of developing pressure sores. This included a person who had a pressure sore risk assessment which had not been completed correctly. This was because they were documented as being an average build for their height and weight when their other records showed they were under-weight for their build and height. The assessment also did not document an additional risk factor relating to a medical condition, which was clearly documented elsewhere in the person's records. Therefore the person had been assessed as being at a much lower risk of pressure sores than they were. The person did not have a care plan to state how their risk of pressure sores was to be reduced. The person had not been provided with any pressure relieving equipment to reduce their risk. Care workers were unaware the person was at risk. None of the care workers we spoke with had been trained in prevention of pressure sores. Pressure sores, once developed, take an extended period to heal, are painful and can present a risk of infection, therefore the emphasis needs to be always on their prevention before they occur.

We had been told before the inspection that there was a lack of focussed activities to meet people's individual needs. A person responded in a questionnaire from North Corner in January 2015 stating "I think you could do more activities for the residents." There was no evidence of follow-up after this comment being raised. We asked people about activities. One person told us "Nothing happens," another said they "Just sit around here," and another "Now and again someone offers to take us out but it's very seldom." Many of the people sat in the sitting room during the morning, with music playing in the background, but no other activities took place. Staff came in and out at

Inadequate

Is the service responsive?

times but there was minimal interaction otherwise. During the afternoon some people went out on a trip in a minibus, other people sat in the sitting room or outside the front door in the shade. Again, no activities were provided for people who remained at North Corner and interaction was minimal. There was a blackboard displayed in the entrance area which outlined a programme of activities but people we spoke with were not aware of them. Following the inspection, the provider sent us information in which they stated "We ask them if they would like to participate in activities and they can do so if they wish, if they do not want to they are free to do something else." We did identify some appropriate actions to support people with activities. The provider described an individual activity which they had set up for a person in the information they sent to us. This was taking place when we inspected.

We looked at people's care plans. Care plans did not assess people's needs and wishes for activities which were based on people's past and present preferences. Where activities were documented there was limited information. For example one person who told us limited activities were provided had a care plan which only stated 'enjoys activities except ART', with no further information. This person's last record of activities participated in was dated 29 November 2014. There was no evidence that staff regarded activities as an important part of people's wellbeing, or that taking part in an activity may reduce feelings of loneliness and may give purpose to people's days. This did follow current published guidelines with regard to providing care for people living with dementia.

People did not have care provided which was appropriate, met their needs and reflected their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before the inspection, we had been given information from a person who felt they had raised issues of concern verbally during meetings about a person's care with the registered manager. We discussed this with the registered manager who told us no issues of concern had been raised with them during the past year. They showed us their complaints records, these showed they had no records relating to formal complaints made about North Corner.

We asked people about raising concerns about their care. We received mixed responses. One person said "I suppose you can tell the manager but she does not take much notice of you." Other people were much more positive. One person told us if they were not happy they would tell the manager and "She does something about it." A relative told us if they were unhappy about their loved one's care they would "Go straight to her" (meaning the registered manager) and another one said "Oh yes I'd talk to the manager," if they had concerns.

We discussed with the registered manager that sometimes people felt they had raised concerns, without making a formal complaint. They said they did not maintain records about such occasions. They said they would consider doing this in future, so they could ensure they had responded to all comments raised.

Requires Improvement

Is the service well-led?

Our findings

We received mixed information from people about the management of North Corner. One person told us "I never know who's in charge here." Another person said "The manager lives in the office," so they didn't see them. A person's relative said the registered manager "Can be a bit officious with some people." However other people made positive comments about the registered manager. One person's relative described the registered manager as "Very approachable," and another person's relative said "We get on well with the manager." A person's relative said there was "Such a happy welcoming atmosphere" about North Corner.

Although the provider had systems for reviewing the quality of service, these systems were not always effective. After the inspection the provider sent us information which stated 'Every day the managers will go through the building and so will care staff to make sure that there are no risks of broken furniture or potential hazards for all persons using the building.' On both days of the inspection, a person had the fire door to their room held open by an object which meant it would not close in the event of a fire. Care workers reported this was the person's choice. Appropriate action had not been taken to ensure the person's safety in the event of fire and up-hold their continued right to choose. There was also no assessment of the risk of fire to the person from a free-standing radiator which was placed in their room, close to their chair. Care workers reported the person liked to have this radiator turned on. The person had fallen recently. Their risk assessment had not been reviewed, so therefore their choice to have a free-standing radiator had not been taken into account to ensure risk to them of contact burns was assessed and reduced. As well as individual risks to people, general environmental risks had not been identified by the provider's systems. On both days the hot pipes in the laundry showed considerable deposits of dust on them. Dust can harbour micro-organisms and present a significant risk of cross infection in utility areas like the laundry. This had not been identified and action taken during the provider's audits.

After the inspection, the provider sent us information to describe their risk assessment and care planning processes. The provider's audit systems had not identified people's risk assessments and care plans were not always accurate. A person's recently revised nutritional assessment stated they were not at nutritional risk and it also stated they were not eating poorly and did not lack appetite. This was despite the person having a very low body weight, the persons' own reports that their appetite was not good and a care worker confirming that the person ate only small amounts. Additional risk factors due to the person living with a specific medical condition had not been included in their risk assessment. A different person's recently revised care plan stated they were 'immobilised.' Both the electronic care plan and the care plan in the person's room made reference to the person sitting out of bed at times during the day. There was no information on how the person was to be supported to get out of bed in either care plan. Care workers told us about different ways in which they supported the person to get out of bed. The provider's audits had not identified the person's care plans had not set out how the person and care workers' safety was ensured when supporting the person to get out of bed.

The provider's audits had not identified other matters. The medicines policy stated all medicines must be stored securely. Medicines requiring cold storage were kept in a fridge in an area of corridor off which six people had their rooms. The fridge was not lockable. The provider's audits had not identified they were not following their own policy to ensure all medicines were safely and securely stored and people protected from risk. The provider also did not audit when people fell, to reduce their risk and ensure their safety and wellbeing was maintained. A person had records relating to a fall in their daily records, this had not been documented in the accident book. The provider's audits had not identified they were not following their own policies on accident reporting. There was no documentation to show there had been an investigation into the circumstances relating to the person's fall, and actions taken after they fell. The registered manager told us about a person who had fallen several times, and the actions they had taken. The information the registered manager told us about had not been documented in the person's records.

The provider did not have effective systems to assess, monitor and mitigate risks to people and ensure accurate records in relation to people. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider used questionnaires to seek people's views on the quality of services provided. A range of people's views

Requires Improvement

Is the service well-led?

were sought, this included contractors like the window cleaner, as well as staff and people's relatives. All of the questionnaires we saw responded positively about the service. The manager also held meetings with staff. This included meetings with the night staff. For example we saw from a recent visit at night that the provider had discussed annual leave with staff so the needs of the service and staff preferences could be taken into account. Staff told us the registered manager operated an 'open door' policy. They said they felt able to share any concerns they may have, in confidence with them.

Throughout the inspection, the registered manager and staff were open to different ideas when we raised matters. Their responses showed they were keen to develop the service, so they could meet people's needs. The registered manager also wished to ensure they were in a position to comply with our regulations. For example, we asked them about their awareness of the duty of candour which had come into effect in April 2015, and they were keen to find out more. By the end of the inspection, they had downloaded a copy of this part of the regulation and were working on developing a policy. We discussed with the manager and their deputy that they might find attending further training on their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards beneficial. They had started trying to access relevant training by the end of the inspection.

The provider's philosophy of care stated the service strived to 'preserve and maintain the dignity, individuality and privacy of residents within a warm and caring atmosphere.' In their statement of purpose they said their aim was to 'provide all residents with a secure, relaxed and homely environment in which their care, well-being and comfort are of prime importance.' The registered manager summed up their philosophy by stating "At the end of the day it's all about the elderly person." They said they aimed to create an environment which was like a persons' home. In order to achieve this they had set up the home in a domestic, homely way. This included domestic-style furnishings and fittings. There were occasional chairs in the hall-way and items such as ornaments, cushions and what the registered manager described as "nick-nacks" across the home, which gave it a domestic, homely feel. People's relatives said this was one of reasons they had supported their relative in choosing to live North Corner. One person's relative said "It's a small home which is what we wanted."

Care workers understood the importance of maintaining the domestic feel of the home. One care worker said "It's a comfortable place this" for people. Another care worker said the aim of North Corner was to ensure people were "Kept safe, clean, looked after just like their own home." Staff felt the morale was good at North Corner and said due to this, all staff supported each other and worked well as a team.

This section is primarily information for the provider

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The care and treatment was not provided in a safe way for people because risks to the health and safety of people were not assessed and all that was reasonably practicable to mitigate any such risks had not taken place. Proper and safe management of medicines was not ensured. Timely care planning with other healthcare professionals to ensure the health, safety and welfare of people did not take place. Regulation 12 (1)(1)(a)(b)(g)(i)

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Where people were unable to give consent because they lacked capacity to do so, the care of people was not being provided with the consent of relevant people. This was because the provider was not acting in accordance with the Mental Capacity Act 2005. Regulation 11(1)(2)(3)

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of people was not appropriate, did not meet their needs, and reflect their preferences. An assessment of people's needs and preferences was not carried out and care was not designed with a view to achieving people's preferences and to ensure their needs are met. Regulation 9(1)(a)(b)(c)(3)(a)(b)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes were not established and operated effectively to ensure the quality and safety of services people received was assessed, monitored and improved and risks relating to the health, safety and welfare of people and others were mitigated. Each person did not have an accurate, complete or contemporaneous record, including a record of the care of each person and decisions taken in relation to the care. The processing of the information was not used to evaluate and improve practice. Regulation 17 (1)(2)(a)(b)(c)(f)

The enforcement action we took:
Warning Notice