Hillview Care Limited

Cornelia Manor RCH

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 March and 1 April 2016 and was unannounced. The home provides accommodation for up to 34 people including people with dementia care needs. There were 30 people living at the home when we visited. The home comprised an older part that is based on two floors, connected by a passenger lift, and a newer single storey extension. There was a choice of communal rooms where people were able to socialise and some bedrooms had en-suite facilities.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

At our last inspection, in February 2015, we identified the provider was not meeting the fundamental standards of quality and safety relating to consent. We issued a requirement notice and the provider sent us an action plan detailing improvements they would make.

At this inspection we found action had been taken. Staff followed the principles of legislation designed to protect people's rights and liberties. They sought verbal consent from people before providing care and support.

Most risks to people were managed effectively, although special mattresses to prevent people from developing pressure injuries were not adjusted correctly. People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions.

Staffing levels on two nights each week were not sufficient to meet people's needs, but the registered manager told us of plans to address this. There were enough staff to meet people's needs at other times and recruitment procedures were effective.

Medicines were managed safely and administered by staff who were suitably trained. Most people received their medicines when needed, apart from one person who was not always able to access their medicines when they went out for the day.

Staff understood their roles and worked well as a team. However, staff morale had been affected by changes to the duty rota and the management team was not always consistent in its approach to staff.

People felt safe at Cornelia Manor and staff knew how to protect people from the risk of abuse. Enhancements had been made to the environment which supported people living with dementia and helped them navigate their way around the home and be aware of the time.

People praised the quality of the food and were supported to make choices through the use of visual

prompts. They enjoyed meal times and were encouraged to eat and drink enough.

Staff were suitably trained and had a good understanding of people's individual needs. People had access to healthcare services when needed. Care plans provided comprehensive information about the way in which people wished to receive care and support. Staff recognised when people's needs changed and responded promptly.

People were cared for with kindness and compassion. Their privacy was protected and they could choose whether they received personal care from a male or a female care worker.

People were involved in planning their care and relatives were kept up to date with any changes in people's health. The provider sought and acted on feedback from people and there was an appropriate complaints procedure in place.

Most people were satisfied with the provision of activities, although some people in one part of the home expressed feelings of isolation.

People felt the home was run well. There was a clear management structure in place. Staff were organised and were encouraged to make suggestions about how the service could be improved. Audits of key aspects of the service were conducted and the provider had a plan in place to develop and improve the service further.

The service was open and transparent. The previous inspection report was available in the entrance hall, there was a duty of candour policy in place and the provider notified CQC of significant events.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Risks to people were managed appropriately, although special mattresses were not always set correctly and there was no system in place to identify patterns of falls.

There were enough staff to meet people's essential needs during the day, but staffing arrangements at night were not robust.

Suitable arrangements were in place to manage medicines safely.

People felt safe and staff knew how to identify, prevent and report abuse.

Safe recruitment practices were in place.

Is the service effective?

Good

The service was effective.

Staff followed the principles of legislation designed to protect people's rights.

The environment supported people living with dementia.

People received enough to eat and drink; they enjoyed the mealtime experience.

People were supported effectively by staff who were suitably trained.

People had access to healthcare services.

Is the service caring?

Good

The service was caring.

People and staff interacted in a positive way. Staff were skilled at communicating with people effectively.

People's privacy and dignity were protected at all times.

People (or their families where appropriate) were involved in discussing and planning their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care and staff were responsive when people's needs changed.

People were encouraged to make choices about all aspects of their lives.

Care plans were comprehensive and reviewed regularly.

An activity coordinator had been recruited and activity provision had been improved.

The provider sought and acted on feedback from people. An appropriate complaints policy was in place and people knew how to raise a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a lack of consistency in management decisions.

There was a clear management structure in place. Staff understood their roles and worked well as a team.

The provider was open with people; there was a duty of candour policy in place; and visitors were made welcome.

Appropriate systems were in place to assess, monitor and improve the service.

Cornelia Manor RCH

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 March and 1 April 2016 and was unannounced. It was conducted by two inspectors and an expert by experience in dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed previous inspection reports, an action plan the provider sent us after the last inspection and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 12 people living at the home, three relatives and two visiting friends. We also spoke with the provider's representative, the registered manager, nine care staff, four ancillary staff, and two visiting healthcare professionals. Following the inspection we obtained feedback from staff at the local authority commissioning unit.

We looked at care plans and associated records for nine people and records relating to the management of the service. These included staff duty records, staff training and recruitment files, records of complaints, accidents and incidents, and quality assurance records.

We observed care and support being delivered in communal areas. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we identified that risks were not always managed in a consistent way. At this inspection, we found risk management arrangements had improved. For example, risk assessments had been conducted and measures had been put in place to reduce the likelihood of people developing pressure injuries. Staff were aware of people who needed to use special cushions or mattresses and we saw these being used consistently. However, two mattresses were not set correctly for the person's weight. We drew this to the attention of the registered manager who arranged for the mattresses to be adjusted and the settings monitored more effectively.

When people fell, their risk assessments were reviewed and additional measures were considered to prevent further falls. These included changing the layout of people's rooms and using monitoring equipment to alert staff when people moved to unsafe positions. Where falls resulted in head injuries, staff observed the person regularly for a period of 24 hours to look for signs of neurological damage. One person, who had frequent falls, had been assessed using an assessment tool that looked at every aspect of the person and their environment. A falls prevention strategy had been developed which included changing the floor covering of the person's bedroom to make it more secure. Whilst individual falls were managed appropriately, we found there was no system in place to identify trends or patterns in the frequency of falls across the home. We discussed this with the registered manager, who told us they intended to introduce such a system in the near future.

People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example, people were able to walk around the home freely and without restriction. Some people chose not to use a walking aid when they mobilised; they had the capacity to make this decision and staff respected it. The provider had reduced the risk by improving lighting levels and providing hand rails along corridors so support was readily available.

Risks posed by the environment had been assessed and were being managed safely. A fire safety risk assessment had identified remedial actions, all of which had either been completed or were in progress. Staff knew what action to take in the event of a fire. Personal evacuation plans had been developed. These showed the support each person would need if they had to be evacuated and were kept in an accessible place, together with evacuation routes from each person's bedroom to the nearest fire escape. Staff were trained in administering first aid; first aid equipment was readily available and checked regularly to make sure it was fit for purpose. A hospital transfer checklist was also in place to help make sure medical staff had up to date information about people if they were admitted to hospital in an emergency.

People were supported by care staff, senior care staff, the head of care and the registered manager, as well as by staff working in the kitchen, administration, housekeeping and maintenance. The registered manager told us they based the home's staffing levels on people's needs. These were assessed using a dependency tool which looked at a range of factors relating to each person. This showed that three 'wakeful' staff were needed on nights to support people who needed to be supported to reposition in bed regularly. However, on two nights each week there were only two 'wakeful' staff plus a 'sleeping' staff member who could be

woken if needed. Staff told us this was not sufficient. The registered manager said they were working with the provider to increase the staffing to three 'wakeful' staff every night in the near future.

People told us there were enough staff to meet their essential care needs. A visiting community nurse said there were "always staff available to see people with us, which is good". However, some staff felt they were rushed and were not able to give people the time they needed. Comments from staff included: "It's always so busy; we don't have time to chat to residents. We have to do all the laundry as well; it takes you away from resident time"; "It's impossible to do the work in the time we have. The unrealistic expectations stresses [staff]; you can hear it in their voices"; "I worked a 12 hour shift yesterday and didn't get a break"; "We are short staffed sometimes. We may get behind with the laundry, but we make sure residents' needs are met"; "There are lots of gaps in the rota, so staff have to rush and get tired and don't have time for people."

Staff had raised concerns about their ability to meet the needs of people with high levels of dependency and the registered manager had worked with the local authority to investigate the concerns. As a result, the provider had decided not to admit any more people with high levels of dependency or complex needs. The registered manager had informed the local authority that they could no longer meet the needs of a person who had recently been admitted to hospital as they required nursing care. Therefore, arrangements had been made for the person not to return to the home when they were discharged from hospital.

The provider had an effective recruitment procedure in place which included seeking references and completing checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We found the checks had been undertaken before new staff started work.

There were safe medication administration systems in place so that most people received their medicines when required. However, we found that one person did not always receive one of their medicines as staff did not allow them to take a pain relief medicine with them when they went out for the day. The person also needed to have cream applied to their legs; if they were out at the time it was due, staff wrote "declined" on the records and did not apply it when the person returned. We raised these issues with the registered manager and by the end of the inspection suitable arrangements had been put in place for this person.

Staff were suitably trained to administer medicines and their competence was assessed regularly. All medicines were stored securely and safely. Appropriate action had been taken to ensure medicines remained safe when the temperature of the fridge they were stored in had exceeded recommended limits. Some people were prescribed medicines "when required" and guidance was available to help staff recognise when these needed to be given, for example for agitation.

People told us they felt safe at Cornelia Manor. One person said, "I'm not scared or worried about anything here they're all kind. I'd tell [the registered manager or the head of care] if I was." Another person said of the staff, "You are completely dependent on them so it's important that you can trust them." We saw people smiled at staff and looked relaxed and happy in their company.

Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse, and how to contact external organisations for support if needed. A staff member told us "If I had [concerns] I would go to the senior on shift or the head of care." Another staff member had alerted the registered manager when they were concerned about the way a person was treated by one of their colleagues. This had prompted an investigation, which the provider had conducted in liaison with the local safeguarding

authority, and had led to disciplinary procedures being followed. Records of the investigation showed it was thorough and had been completed promptly.

Good

Is the service effective?

Our findings

At our last inspection we identified that staff did not understand, and were not following, the Mental Capacity Act (MCA). At this inspection we found staff were more knowledgeable and were following the principles of the MCA in most cases.

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. One person was receiving their medicines covertly. This is when tablets are hidden in small amounts of food and the person does not know that they are receiving them. An assessment of their ability to consent to this decision had been completed and the person's family and their GP had been consulted. This protected their rights and had helped make sure they received essential medicines to keep them well.

Assessments had been conducted of people's ability to consent to the care and support they received. When these indicated people lacked capacity, family members had been consulted and staff had made best interests decisions on behalf of people. However, the decisions made related to all of the care and support the person received rather than specific aspects of their care. The way they were recorded did not acknowledge that people were able to make some decisions themselves, such as when to get up, what to eat and what to wear, either on their own or with some support. We discussed this with the registered manager and the provider's representative and they agreed to review the way best interests decisions were recorded.

Staff were clear about the need to seek verbal consent from people before providing care or support and we heard them doing this throughout our inspection. A staff member told us, "If [a person] declined personal care we'd go away and try later or with [another staff member]. For example, one person wouldn't take their medicines from [another staff member], but they would from me, so I gave them."

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 provider was following the necessary requirements. One DoLS authorisation was in place and applications had been made for other people. Staff understood the process and knew how to keep people safe and secure in the least restrictive way. For example, a staff member said, "[The person on a DoLS] undid the door recently and was half way out. Rather than stopping them, a staff member went out and had a walk with them and then they were happy to come back." Another staff member confirmed that they used the same approach when the person wanted to leave the building.

Enhancements had been made to the environment since our last inspection which supported people, particularly those living with dementia, to navigate their way around the building and orientate themselves

in time and space. Bedroom doors had signs, pictures or objects relevant to the person and bedrooms had been personalised with memorabilia and items that were important to the person. Toilets and bathrooms were easily identifiable due to large signs; brightly coloured boards were used to show the day, the date and the weather; clocks with large displays showed the correct time; and age-appropriate pictures were hung at a height which made them easy for people to enjoy. A small 'sensory garden' had been developed to provide safe outdoor space for people to spend time in when the weather was suitable.

People told us they liked the food and were able to make choices about what they had to eat. Comments made to staff at lunchtime included: "The food is lovely"; "That was very tasty"; and "That was very nice thank you". Staff were aware of people's dietary needs and preferences. For example, one staff member told us, "Some people have a small dinner because they have a sweet tooth and like to have pudding." They were aware of people who needed special diets and we saw these were provided. Some people stayed in their bedrooms and needed support with their meals; this was provided on a one-to-one basis. Other people needed to be encouraged to eat and this was done in a supportive way. Snacks were offered to people throughout the day and people could help themselves to fruit which was available in the lounges. People had drinks within reach at all times and were encouraged to drink often.

The dining area was carefully laid out, with tablecloths, cutlery, placemats, condiments and a variety of drinking vessels to suit people's needs. People could choose where they sat. Some people were offered clothing protectors; this was done by staff checking whether people wanted them. People could choose from a choice of two main meals. These were presented on plates at the time of service, so people could make their choice at the time, as they may forget a choice they had made earlier in the day. This showed staff had a good understanding of the communication needs of people living with dementia. Picture based menus were also displayed on a notice board to help people understand the choices. People chatted freely with each other and clearly enjoyed the dining experience, which was calm and unhurried.

People had confidence in the knowledge and the ability of staff to provide effective care. One person said, "These staff are very good, they know what they're doing here. I've been in other homes and this is the best on the island; my family thinks so too." Another told us, "I was in a bit of a state when I came here, but I've put on weight and feel much better now." A relative told us, "Everything was really good here. [Staff] knew how to relate to him and he was happy."

Staff demonstrated a good understanding of the needs of the people they cared for. One staff member told us, "It's about being supportive to understand their needs and adjusting to meet their needs. If [a person] wanders and starts shouting, you know it's because they need [personal care]." Another said, "You have to approach [people living with dementia] really calmly and patiently. I approach with a smile and simplify things to help them to understand."

Staff supported a person, who was registered blind, to mobilise around the home by guiding their arm and verbally explaining whether to go left, right or straight on, for example. When the person sat down, the staff member described the people who were sitting nearby, to enable to person to communicate with them.

Staff completed a series of computer based competency assessments to test their knowledge in key areas. The results were then used to identify individual training needs. Each online course was given a score and if the score was not at the required level, the registered manager said they went through the incorrectly answered questions with staff to improve their knowledge. If this was not successful, staff were then scheduled to attend an appropriate course.

Not all staff had positive views about the online assessments. One staff member said, "[The online

assessments] are a real bug-bear; they not really used properly. If you get a low score, you have to re-do it until you get the answers right. You might [eventually] get the answers right, but still don't have an understanding. I didn't do [one assessment] as I wanted to do the course; that's how I learn." Another staff member told us, "The online assessments are not good as they don't show our true knowledge. Some people will deliberately get a low score as they feel they need the training." Practical, face-to-face training was provided by external providers and staff felt this equipped them well for their roles.

New staff completed an induction. This included an explanation of the fire procedures, daily routines, safety checks and the policies and procedures. They undertook "shadow" shifts, during the day and at night, where they could observe other staff and learn how to support people living in the home. A record was kept to monitor their progress. The provider also supported new staff to gain the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people.

Staff felt supported in their role by management and received regular supervisions. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. Staff who had worked at the home for more than a year also received an annual appraisal which assessed their performance. A staff member said, "I would not hesitate to go to [the head of care] for support. I feel I have a lot of support and also from [colleagues]." Another told us, "The bosses are always about and you can approach them."

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. Some people had chosen to receive private dental care and visits from the dentist had been arranged. A visiting community nurse told us "There are no concerns from me or the team. [Staff] normally let us know if there are any pressure injuries and blood sugar monitoring was always done well [in the past]."

Good

Is the service caring?

Our findings

People told us they were cared for with kindness and compassion. One person said, "They treat me like no one's business here; it's marvellous." Another person told us staff were "good as gold".

We observed positive interactions between people and staff. When people became upset or anxious, staff used touch appropriately to reassure people and offer support. This helped people to visibly relax and become calm. When people were supported to move to a chair, staff checked they were comfortable and offered additional cushions when needed. One person was reluctant to receive personal care and we heard a staff member quietly and warmly encourage them to go to the bathroom "so I can make you comfortable".

Staff understood how to communicate effectively with older people and people living with dementia. They spoke fondly about people, took time to listen and interacted positively, for example by offering compliments such as "That's a beautiful choice" and "That's a lovely song [you're singing]". We heard a staff member ask a person if they wanted a bath. When the person agreed, they said, "Ok, I'll just go and run the bath for you and get you some warm towels ready, I'll be back in a minute or two; alright?" The person replied, "Oh yes; lovely." Staff supported people to keep in contact with friends and family members and to maintain positive relationships. The importance of this to each person, together with details of those close to them, was known to staff and recorded in the person's care plan.

A staff member told us, "[One person] gets very anxious in the bath, so we use little tactics to make them feel more in control; like asking if they want breakfast first or a bath first. It seems to work." Another said, "We've got a good bond, me and [another person], but they can still get [agitated] with me sometimes. I just go away and try again later or let someone else try [to support them]." People who were able to express a preference for a male or female staff member to support them with personal care had done so, and their preferences were respected.

The provider told us they promoted dignity by encouraging staff to follow a set of "dignity standards". These were advertised on the home's notice board and the provider was in the process of identifying a suitable member of staff to act as a 'dignity champion' to promote best practice to their colleagues. Minutes of the most recent staff meetings showed the registered manager used the meetings as an opportunity to encourage staff to treat people in a dignified way; they provided examples and discussed ways this could be improved.

Staff did not appear to rush people when providing care. When people wished to move around the home, they encouraged them to travel slowly and at their own pace. When using equipment, such as hoists, to support people to move, staff checked people were ready to move and explained what they were doing throughout the process; this helped reassure the person and made the experience less frightening for them.

People's privacy was protected by staff knocking and waiting for a response before entering people's rooms. When personal care was provided staff ensured doors were closed and curtains closed. Some people, who were being cared for in bed, preferred to have their doors open and privacy screens were used appropriately

to prevent them being seen by people passing their doors. Screens were also used when people were supported to use the hoist, to protect their dignity in the event that clothing became dislodged. Confidential information, such as care records, was kept securely and only accessed by those authorised to view it. Promotional photographs of people on the provider's web site had been taken with people's permission and only people's hands were shown, so they could not be identified. Bedroom doors had locks which people could choose to use; one person told us they locked their door whenever they went out.

When people moved to the home, they (and their families where appropriate) were involved in assessing and planning the care and support they received. A family member told us, "We get a copy of the paperwork so we can go through it together and check it, then let [staff] know if there's anything to change." Another had been involved in discussing arrangements for end of life care for their relative, to help make sure their wishes were met when the time arrived. Family members said they were always kept up to date with any changes to the health of their relatives.

Good

Is the service responsive?

Our findings

At our last inspection we identified that people were not always supported in a consistent way. At this inspection people told us they received personalised care from staff who understood and met their needs well. One person said, "I'm well looked after; [staff] know what help I need." Another person told us, "I like to have my hair done here every two weeks. You always feel great when you've had your hair done."

Staff demonstrated a good awareness of people's individual support needs and how they preferred to receive care and support. For example, they knew what support people needed to dress; what medicines people were taking, why they were taking them and how they liked to receive them; they understood people's individual dietary needs and where people liked to eat their meals; they recognised when people's behaviour changed, for example if they became confused or anxious. A staff member told us, "[A person] can become physically aggressive sometimes; we know [they] are not doing it to be nasty, but because [they may] have an infection. The early signs to watch for are if they start to decline personal care; then we know we have to contact the GP and try and get a sample [from the person]."

Care plans provided comprehensive information to support staff to provide personalised care in a consistent way. Records of care provided confirmed that people received appropriate care and support. For example, charts showed people were supported to reposition in bed regularly and received diets appropriate to their needs. An appropriate tool was used to help staff identify when people were in pain and we saw people received pain relief when required. A staff member described how they would recognise whether people were in pain. They said, "You get to know residents; people can get quieter or chattier when in pain. One person walks with a purpose a lot, if in pain they will sit down." Care plans were reviewed by senior care staff on a monthly basis or earlier if a person's needs changed. This had helped ensure the care plans remained up to date and reflective of people's current needs.

People were supported and encouraged to make choices about every aspect of their lives, including when they got up and went to bed; and how and where they spent their day. One person said they liked to be in the lounge "as it's livelier". Another told us they preferred spending time in their room "listening to my radio" and we saw their radio was tuned in to their favourite station. A further person said, "You can have your meals up [in your room] or down [stairs]." A staff member confirmed this and said, "We give people full choice about when to go to bed and when to get up. You have to remember this is their home; many like to get ready for bed early and then sit up in the lounge watching television." Another staff member told us, "If a person doesn't want to go to bed, that's ok; we can offer Horlicks and talk to them."

The provider had recently introduced a key worker system. A key worker is a member of staff who is responsible for working with a particular person, taking responsibility for monitoring that person's care and liaising with their family members. People had been supported to choose their own key workers by viewing photographs of staff on a handheld computer and selecting the staff member they felt most comfortable with.

Staff told us people could choose whether to have a bath or a shower, but were not asked how often they

wished to have one. Each person was allocated a day a week when they were supported to bathe and staff used a 'bath rota' to organise this. If a person declined a bath on their allocated day, staff told us they would "try to fit them in" on another day, although staff said it was "rare" that they had the capacity to do this; this meant people had to wait a further week until they were offered another bath. We discussed this with the registered manager, who told us they would explore more flexible bathing arrangements for people.

A part-time activity coordinator had been appointed since the last inspection and had spent time with people to ascertain their interests and understand their social needs. One person told us, "There's always something to do you're never bored." Another person confirmed this and said, "They do lots of things; memory activities, singing and music which I love, and a fellow comes in with his guitar." The activity coordinator told us they had also introduced flower arranging. They said, "It opened up conversations with people and memories about flowers and the gardens they used to have." Other group activities were advertised on the home's notice board. These included 'themed days' such as St Patrick's Day and Easter when special meals and events were organised. For example, a staff member told us they had created an intimate environment for a person to have a meal on Valentine's Day when their wife had visited. They said, "We set a table up in a cosy corner, with candles and flowers on the table. They loved it."

We observed a game of bingo run by the activity coordinator and another staff member during the afternoon, which 11 people took part in. People had talked excitedly about this at lunchtime and clearly enjoyed the activity. Staff positioned them in an appropriate place so they could be heard by those taking part. One person had been given board with large numbers and a magnifying glass to support them to participate.

Some people in upper rooms, in the older part of the home, chose not to take part in group activities and expressed feelings of isolation. The activity coordinator spent time on a one-to-one basis with these people when they could, but their availability to do this was limited. One person told us, "I suppose I could go down but I don't know if [staff could] bring me back after a short time; I just don't know. I can be up here all day and evening and not see a soul." Another person said, "The staff are always busy so they don't have time to chat with you much." A staff member told us "People are getting more one-to-one time now, but there's not always enough time for key workers to spend with people."

Staff responded promptly and appropriately to people's wishes and changing needs. For example, one person had requested a change of rooms. Their relative told us, "He was isolated in an upper room, so we discussed it and negotiated a room on the ground floor where he was more part of the home. He loved the room and was happy there." Staff had noticed that another person was becoming frail, so had contacted the GP and the community nurse for advice. They had advised providing the person with a special bed and the person was offered a larger room to accommodate this. Staff had also started monitoring the amount the person ate and drank to check they were receiving appropriate nutrition and hydration.

When people became agitated or distressed, a 'behaviour management plan' was used to support people. This included the use of 'behaviour records' to record incidents and the effectiveness of staff responses; however, the behaviour records did not include details of the possible triggers or causes of the incident which might help staff take preventative action in future. We discussed this with the registered manager who said they would review the way such incidents were recorded.

The provider sought and acted on feedback from people. Some people had commented that the food was not always hot when served. This had prompted staff to start using a heated trolley in the dining room to help make sure food remained hot until served. When we spoke with people, they told us this had been effective and they were satisfied with the new arrangements. One person said, "We talked about the food

not being hot enough and it's much better now, full marks for dealing with it."

People knew how to complain and there was a suitable complaints procedure in place, which was included in the 'residents' handbook' which was given to people and their families when they moved to the home. Records showed complaints had been responded to promptly and in line with the provider's policy. For example, one person complained about a missing item of clothing; a search had been conducted, the item had been found and the person was satisfied with the outcome.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we identified that necessary improvements had not been made to meet the requirements of one regulation. Following this, the provider sent us an action plan stating what they would do to achieve compliance. At this inspection we found improvements had been made and the provider was meeting all regulations.

However, most care staff told us morale was not good. They felt they had not been involved in the process of changing their working hours and shift rosters that were being implemented by management. Care staff told us they had not agreed to the changes and did not understand the need for them. Comments from staff included: "The rota changes were intended to cut out the 12 hour shifts as they're hard to cover if someone goes sick; but then the whole rota changed. Everyone is up in arms" and "People are not happy with the process [of changing the rosters] as they weren't communicated properly."

There was a lack of consistency in management decisions. The registered manager told us the roster changes would result in care staff working every other weekend. However, care staff said this was not the case and when we looked at the new roster we saw they had been scheduled to work three weekends in four. We raised this with the registered manager, who told us they would review the roster and discuss it with the senior staff member who had designed it. Following representations by staff members, the provider subsequently told us they had made changes to the working patterns of individual staff members.

Senior staff told us decisions made by one manager were often overturned by another manager. For example, they said the registered manager, the head of care and the provider had each made suggestions about changes to the format of people's care plans, which had left them confused. A care staff member told us they had requested a period of leave; the leave had been approved by one manager but then refused by another manager. We discussed this with the registered manager who took action to resolve the issue.

People were happy at the service and felt it was well-run. They were on first-name terms with the management team and described them as "approachable". One person said, "I'd probably speak to [the head of care]; she's very good to me, well all of us; and [the registered manager is nice too." Another person told us, "The manager is excellent and kept us informed. You could visit at any time and [staff] always knew what was happening [with my relative]."

The provider's representative visited the home every week. The registered manager described them as "supportive" and said the provider had agreed to fund her to obtain additional management qualifications. They added: "Anything that needs addressing [during the weekly visits] is sorted. For example, we found the emergency lighting wasn't good enough during the [recent] storm, so he agreed improvements. We needed a new hoover, so he ordered a new one." A system was in place to share best practice between managers of other homes operated by the provider. For example, following a medicines error at Cornelia Manor, a manager from another home had visited and looked at their medicines management arrangements. As a result, changes were made to the times medicines were administered, to avoid similar errors in the future.

There was a clear management structure in place, consisting of the provider's representative, the registered manager, the head of care and senior care staff. People benefitted from staff who understood their roles and worked well as a team. Each senior staff member had specific responsibilities and took the lead on an aspect of people's care. A staff member told us, "It's a good team." Another said, "There's a fantastic senior team; they look after people really well."

We observed a 'handover' meeting. These were held at the beginning of each shift to pass information about people from one shift to the next. They were also used to deploy staff to support particular people or complete certain tasks. At the end of the meeting, staff were clear about what was expected of them and got on with their work without delay. A staff member told us, "[Tasks] are always designated very clearly; who we have to bath, where we are working; we all know what we're doing."

Staff were encouraged to make suggestions about ways the service could be improved. For example, a senior staff member had suggested introducing the key worker system and had taken responsibility for implementing it. The provider sought to use the skill set of each staff member to the benefit of people living at the home. For example, they had recognised that a senior staff member was skilled at organising activities, so had appointed them as the activity coordinator. Another senior staff member had asked to work more hours and were skilled at writing care plans, so were given an additional role with extra time to focus on this.

The service was open and transparent. The previous inspection report was available in the entrance hall and the provider had discussed it with residents and relatives. There was a duty of candour policy in place and the registered manager gave examples of how they had followed this by informing family members when their relative had been injured. However, following one incident, they had not put this information in writing, as required by the regulation and the provider's policy. We raised this with the registered manager who undertook to ensure this was done in future. Relatives were able to visit at any time and were made welcome. One said of the staff, "I come in most days and they are very friendly. It's a welcoming place from the minute you walk in. I'm very glad [my relative] is here." Links had been developed with the community through families, friends and volunteers who visited often.

Audits of key aspects of the service, including care planning, medicines, infection control and the environment were conducted regularly to assess, monitor and improve the quality of service. The frequency of the audits was appropriate and relevant to each aspect of the service. For example, medicines were audited weekly, care plans monthly and infection control arrangements twice yearly. In addition, the registered manager conducted spot checks of cleaning and infection control procedures. When concerns were identified, changes were made to improve practice. For example, the infection control audit identified the need for pedal-operated bins in the bathrooms and we saw these had been put in place.

The provider had a development plan in place. This included appointing a 'dignity champion'; developing more robust contingency plans for emergencies; further enhancements to the environment; and a 10-point plan to improve the CQC rating of the home. They had drawn up a set of goals to help ensure continuous improvement. These included the introduction of staff awards and reinforcing core values of dignity and respect. They described how these would be communicated and shared with staff during future staff meetings.