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Cornelia Heights

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:
Cornelia Heights is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Cornelia Heights is registered to provide care for up to 23 people, including people living with dementia and physical frailty. At the time of the inspection, there were 20 people living at the service.

People's experience of using this service:
Risks to the health and safety of people were not being managed safely.
People's health was not always monitored effectively and guidance from healthcare professionals was not always followed or requested in a timely way.
Risk assessments in place were not always followed to ensure people's safety was maintained.
Risks posed by the environment were not managed effectively.
Medicines were not always managed in a safe way and this meant people were at risk of not receiving the medicines they needed safely.
There were not always enough suitable staff deployed to meet people's needs and keep them safe.
Records were not always accurately maintained or up to date. This meant that people were at risk of receiving care which was not appropriate.
There was not a robust process in place to monitor, act upon and analyse incidents, accidents and near misses. This placed people at continued risk of harm.
There was a lack of management oversight in relation to the care and service provided. Quality and safety systems were not adequate and did not identify significant risks to people or service wide failings.
Managers had not acted promptly when concerns had been raised with them.
Managers lacked knowledge and understanding of best practice guidance and CQC were not always notified of significant events.
Systems were not in place to allow continuous learning and improving care.
The provider's systems for monitoring and improving the quality of the service had not been effective, because people were not always receiving a good quality of service and risks had not been mitigated.

During and following the inspection our findings were reported to the local safeguarding team and fire service.

Why we inspected:
The inspection was prompted by significant concerns raised from the local authority, safeguarding team, healthcare professionals and the Clinical Commissioning Group (CCG). A focused inspection was completed; which looked at both the 'Safe' and 'Well led' only in line with the concerns that had been raised.
Rating at last inspection:
The service was rated as requires improvement at the last full comprehensive inspection, the report was published on 5 November 2018. After the last inspection the provider sent us an action plan to tell us how

they would address the areas we raised on inspection. At this inspection we found the provider had not made sufficient improvements to address all these concerns. We also found additional significant concerns which has resulted in the rating for key questions in relation to 'Safe' and 'Well led' as being inadequate.

Enforcement:
Five breaches in regulatory requirements were identified at this inspection. You can see what action we asked the provider to take at the end of the report. Full information about CQC's regulatory response to more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Special measures:
The rating for this service is Inadequate and the service is therefore in special measures. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

The service was not safe.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Cornelia Heights

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by significant concerns raised from the local authority, safeguarding team, healthcare professionals and the Clinical Commissioning Group (CCG).

Inspection team:
The inspection was completed by three inspectors.

Service and service type:
Cornelia Heights is a care home registered to accommodate up to 23 older people living with physical frailty or dementia. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We did not give notice of our inspection. Inspection site visit activity started on the 2 April 2019 and ended on 4 April 2019.

What we did:
Before the inspection we reviewed the information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also reviewed information we had received from the local authority, safeguarding team and healthcare professionals.

During the inspection we gathered information from:
- Two people using the service.

- The providers.
- The registered manager.
- The deputy manager.
- Six care staff.
- Two social care professionals.
- 15 people's records in relation to medicine management.
- Six people's care records in detail.
- Records of accidents, incidents and complaints.
- Audits and quality assurance reports.
- Staff training records.
- Staff rotas.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

At our last inspection, completed in September 2018 this key question was rated requires improvement. This was because risks associated with people's care were not always identified or managed safely. There was not always a sufficient number of staff to meet people's needs; medicines were not always managed safely and recruiting practices did not always ensure that all appropriate checks had been completed. At this inspection we found the provider had not made sufficient improvements to address all these concerns. We also found additional significant concerns which has resulted in the rating for this key question as being inadequate.

Assessing risk, safety monitoring and management:

- Risks to the health and safety of people were not being managed safely. People's health was not always monitored effectively and guidance from healthcare professionals was not always followed or requested in a timely way.
- Risk assessments had not always been completed as required.
- Risk assessments in place were not always followed to ensure people's safety was maintained.
- People's care plans were not followed. This meant that people were not always provided with the support they needed to meet their personal care needs. Medical advice has not been sought as highlighted in people's care plans. This has lead to constipation for two people living in the service.
- Where people were at risk of malnutrition, dehydration and weight loss this had not been effectively monitored to allow timely action to be taken were required. For example, on one person's weight record it was noted that a healthcare professional had requested this person was weighed every two weeks due to increased weight loss. This had not happened. The person was weighed on the 5 February 2019 where their weight was recorded as being 38.4kg. They were not weighed again for another six weeks when their weight was recorded as 28.4kg, demonstrating a loss of 10kg. No action had been taken. This was discussed with the management team who were unable to provide an explanation for this.
- Food and fluid charts in place for one person were poorly completed. For example, some entries were entirely missing, there were significant gaps in others suggesting the person had not eaten or drank for several hours and the did not demonstrate that food or fluids were being offered or declined.
- Risks associated with people's mobility had not been properly mitigated. During the inspection we found that staff were uncertain about how a person should be mobilised. Within the person's 'Mobilisation risk assessment' it stated that a 'Stand-aid' should be used. However, one staff member, told us that a hoist was required; then added that the person should be stood up to change their position in the chair. Another staff member said that when sat in the chair the person would be repositioned with a frame and two staff. They added, "They have been stood today by two staff I think. Hoisting is new." This person was at risk of suffering harm from unsafe moving and handling techniques.
- People at risk of developing skin damage and pressure sores did not receive the care required to mitigate these risks. For example, a completed body map within the care records for a person highlighted they had a

possible pressure sore. This body map was completed on the 6 March 2019. An entry within the care records on the 8 March 2019 provided guidance to staff for management of this pressure sore. Management information included; 'Pressure Mattress to be set on 140, proshield at each pad change and relieve pressure every 4 hours by standing up or turning in bed.' There was not a repositioning chart in place for this person and this was confirmed by the registered manager. Daily care records did not indicate that staff changed the persons position as noted above. For example, on the 10 and 11 March 2019 there was no record that the persons position was changed for a period of 11 hours 45 minutes. When this was discussed with staff they were unclear as to the repositioning regime for this person when they were sat in the chair. A staff member said, "When in bed we turn every 2 to 3 hours, when in a chair we just change their position during pad changes, there is no set times." On viewing the persons pressure relieving mattress on 2 April 2019 the mattress was set at 120. We asked the registered manager how frequently staff checked people's mattresses and how they were aware of the appropriate setting. The registered manager said the settings were highlighted in people's care plans and that staff checked them. A staff member told us, "I don't know anything about the mattresses."

● Risks posed by the environment were not managed effectively. There was a free-standing radiator in one person's bedroom, placed directly in front of their arm chair. The care plan for this person showed they were frail, their mobility was compromised and that they were at risk of falls. This posed a risk that the person or other people entering their bedroom, might fall against the radiator, be unable to move and sustain burns or serious injury. Additionally, no risk assessment was in place for the use of this radiator.

● There was one standing lift available for people to use. On viewing the lift, we found there to be a deep hole in the flooring inside the lift entrance. This posed a risk of falling to people using the lift, particularly those using a frame or walking stick.

● Fire safety arrangements were not adequate. The night time fire emergency plan detailed the action staff should take if the fire alarm sounds and a fire was identified. This included an evacuation process. However, due to the needs and support requirements of the people living at the home, there was insufficient staffing at night to allow staff to effectively activate the plan as described.

● Personal Emergency Evacuation Plans (PEEPs) were out of date. Four people who no longer lived at Cornelia Heights still had PEEPs in the file and three people currently living at the home were not included in the resident list and PEEPs file. The service user list stated room 14 was empty however, this was not correct and the room was occupied. This meant that in the event of a fire the fire service would be given inaccurate records placing both themselves and people at significant risk of harm.

Learning lessons when things go wrong:

● There was not a robust process in place to monitor, act upon and analyse incidents, accidents and near misses. We found that lessons were not always learnt from incidents, accidents or feedback from external agencies, who had a shared responsibility to ensure people were safe and well cared for.

● There has been a large number of falls recorded in the accident book; 14 falls were recorded in this book for March 2019; however, only 10 of these falls were recorded on the Monthly falls monitoring record which was sent to the local clinical commissioning group (CCG). The falls monitoring chart for February 2019 did not have any entries of falls on it. However, the accident book indicated that falls had occurred on the 18, 23 and 24 February 2019.

● We requested details of investigations and the audits of falls. Records showed that falls that had occurred had not been robustly investigated to identify further risks or triggers or prevent recurrence to help ensure peoples safety.

● One person's daily record from the 5 March 2019 to the 2 April 2019 showed that on seven occasions the person was found to be 'slipping down their chair' or had slipped from the chair. There was no evidence within the daily records that regular observations were put in place or that actions to mitigate the risk of falling from the chair had been fully investigated.

Using medicines safely:
● Medicines were not always managed safely.
● We found variation within the medicines administration records (MAR) we reviewed. For example, allergy information was either absent or contradictory for nine people. This posed a risk that people might inadvertently receive medicines to which they were allergic.
● Medicine administration care plans were not always in place for all people. These are required to provided information for staff on how people liked to take their medicines and important information about the risks or side effects associated with them.
● People were not always provided with their medicines as prescribed. For example, one person was prescribed a medication to help with mood, yet this had not been administered for a period of six days. The entry on the persons MAR chart stated; 'Awaiting stock.' The registered manager was unable to provide evidence that the GP had been made aware that this medication had not been given for six days and medical advice had not been requested about possible implications of not receiving this medication. This was brought to the attention of the registered manager on the second day of the inspection who investigated this concern.
● There were not appropriate arrangements in place for obtaining, administering and recording of medicines safely and in accordance with best practice guidance. There was not a process in place for ordering medicines mid-cycle.
● Where people required 'as required' (PRN) medicines not all people had information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. PRN medicine was not always provided as needed. For example, people were not always provided with pain relief or medicines to support with constipation when needed.
● Not all prescribed topical creams and liquid medicines were labelled correctly with opening and expiry dates. Topical creams, eye drops and liquid medicine have a limited shelf life once opened; although there was guidance available to care staff about waste medicines shelf lives this had not been followed. For example, a person was prescribed eye drops, which were dated as opening 25 March 2019; with an expiry date of 15 September 2019. This type of medicine should only be in used for 1 month following the date of opening. This meant these medicines might not have been fully effective or safe to use.
● Some records for people, who were being administered topical medicines, lacked information to support the safe and consistent administration of these medicines. Patch application records and the use body maps to show where creams were to be applied were not always available or completed.
● Medicines that have legal controls, 'Controlled drugs' were not appropriately managed. Balance checks or internal audits of these medicines were not robustly completed.
● Staff told us they had been trained to administer medicines and this was also indicated on the staff training matrix.
● The concerns noted by the inspectors in relation to the management of medicines were discussed over the course of the inspection with the registered manager. However, we were not assured that appropriate actions would be taken to address the concerns.

Preventing and controlling infection:
● The risk of infection was not managed effectively in some areas of the service. For example, the evacuation chair was badly stained with a brown substance and a stair lift and an arm chair had a torn seat with foam exposed, which could pose a risk of cross infection.
● Dirty laundry was not appropriately stored. For example, on the morning of day one of the inspection we observed a yellow bag of dirty washing placed on the floor of the laundry room. The registered manager stated when the machines were full dirty washing was left in bags piled on the floor, including red bags containing soiled washing. During the afternoon two white bags were placed on top of a yellow bag, one contained dirty tea towels and the other dirty flannels; this was confirmed by a member of staff. These bags

remained open and on the floor for a number of hours.
● There were not appropriate systems in place to protect people by the prevention and control of infection. We reviewed an infection control statement, which was dated 1 November 2018 and completed by the deputy manager. We found it was not personalised to the home and did not reflect the operational infection risks or any action to mitigate risks in relation to infection control.
● The registered manager stated they carried out regular visual cleanliness audits of the home but these were not recorded.
● A staff member told us that they were the infection control lead but they had not received any training to enable them to take on that role. All other staff told us that they had received infection control training.
● Personal protective equipment (PPE) was available to staff. Staff were seen to be wearing gloves and aprons when appropriate.

All the above demonstrates a failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment:
● There were not sufficient numbers of skilled and experienced staff deployed to keep people safe.
● The registered manager told us that five staff were required in the morning, three in the afternoon and two overnight. The provider wrote to us on the 13 December 2018 and stated within their letter, 'We have reviewed staffing levels for our care staff. We have recruited additional staff to ensure that we have at least five care staff in the morning (excluding the manager and deputy manager, although for unexpected staff absences and sickness at short notice, the manager deputy manager will cover as required), Three care staff in the afternoon and two at night.'
● The staff rota for the period of 4 to 10 March 2019 demonstrated that, for the whole week the registered manager and deputy manager were not in the home resulting in no management oversight. In addition to a lack of oversight this also meant that staffing levels provided were not as described by either the provider or registered manager. We consistently found over a period of eight weeks that the provider had not ensured the staffing levels provided were in line with their assessments of what was needed.
● Rotas also demonstrated that staff cover arrangements were unorganised and staff often worked extensive hours. For example, on the 12 and 14 January 2019 two staff members had worked a 14-hour shift. On the 16 February 2019 the rota showed that the registered manager worked 08:00 to 14:00, returned to work at 22:00 to complete a night shift and completed a shift following this night shift working until 14.00 on the 17 February 2019.
● There were inadequate staffing levels at night to ensure that people could be kept safe and their needs met. We were advised that two staff were available to people throughout the night to care for 20 people, some of whom required two staff and equipment to support them, a number of people were at high risk of falls and one person with dementia and at risk of falls would spend periods of the night walking around the home unsupported and unsupervised.
● Care staff told us they often got called in to cover shifts during days off or annual leave to cover short term absences. Senior care staff also told us that it was their responsibility to arrange cover for short term absences and that if they were unable to arrange this cover they were expected to do the shifts themselves.
● During the inspection a person told us, "They [staff] come as quickly as they can."
● Following the inspection additional information was received from the local authority in relation to a person. This person told a social care professional, they don't ask staff for help as they perceive them as being too busy.
● Staff members commented, "We don't have enough staff to cover sickness. There was only three members of staff on yesterday morning", "I have known times when staff have had to stay until 2am because the night

staff haven't come it. It's so hard to give people proper care and attention" and "I have had phone calls at four in the morning asking me to come in. There is not enough staff at night too many people need help from two staff."

- During the inspection we observed periods of time when people at risk of falls were left unsupervised.
- We did not check recruitment processes at this inspection.

The failure to ensure sufficient staff were deployed to meet people's needs at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

At our inspection completed in September 2018 this key question was rated requires improvement. This was because systems in place to monitor the service were not effective. At this inspection we found the provider had not made sufficient improvements to address these concerns. We also found additional significant concerns which has resulted in the rating for this key question as being inadequate.

Managers and staff being clear about their roles, and understanding quality performance risks and regulatory requirements; how the provider understands and acts on duty of candour responsibility:

- The management team demonstrated a lack of knowledge and understanding of best practice guidance in key areas and this had contributed to five breaches of regulations.
- At our last inspection, which was conducted in September 2018 we highlighted the lack of audits and monitoring completed in relation to people's food and fluid intake and ensuring daily records were kept up to date. The provider sent us an action plan of how this would be addressed. At this inspection we found that actions the provider had told us they would take had not been taken or sustained. Furthermore, at this inspection we found significant concerns in relation to effective monitoring of people's health needs. For example, audits of care plans, daily records, food and fluid charts and repositioning charts were not completed. Therefore, risks to people were not identified including risk of skin breakdown, malnutrition and dehydration, constipation and falls. The lack of robust falls audits meant staff would not be able to identify trends or patterns and design strategies to protect people from falling.
- There were not effective systems and processes in place for assessing, monitoring and improving the quality of the service provided at the home. Audit records viewed demonstrated that audits were not completed regularly and did not provide a clear oversight in respect of the quality of the service provided. Poor quality assurance systems in place put people at risk of harm. For example, an audit had been completed in relation to the Personal Emergency Evacuation Plans (PEEPs) however the information was inaccurate.
- The management team were unable to provided us with an up to date medicine audit; records indicated that the last medicines audit was completed in July 2018. This meant that the management team and staff had not been able to identify that people did not always receive their medicines as prescribed.
- The systems in place to ensure that vital information about people's health needs or changes in their needs were shared with care staff were ineffective. Staff spoken to were unclear about changes in people's health or mobility needs.
- There was a lack of management oversight in relation to the care and service provided. Quality and safety systems were not adequate and did not identify significant risks to people or service wide failings. Failings that were found by inspectors had not been identified by the management team, this meant that people would have continued to be exposed to the risk of harm.

● Staff members described the running of the home as "chaos". Four staff members spoken to reported, a lack of communication from the management team. A staff member said, "There's no communication, staff don't know what is going on with the residents and no-one knows how to work the CMS system (computerized recording system)." Another staff member told us, "There is a lack of communication- or too much information which is conflicting." Another staff member said, "We are going around in circles and we are under appreciated and undervalued."
● Staff described a lack of support and poor management. A staff member said, "The managers and owners pass the buck all the time. It's not organised and the place in falling apart." Another staff member told us, "I'm here for the residents not the staff. I don't feel that there is a lot of leadership from anywhere, there is a blame culture. Leaders should be leading and guiding not blaming."
● When concerns were identified, these were often addressed in a limited way that only considered the immediate issue raised and not the broader issues around specific aspects of the service. For example, when we highlighted the concern in relation to constipation for one person on day one of the inspection the registered manager asked a staff member to contact the GP. Yet, no actions were taken or considered for other people at risk of constipation until the afternoon of day three of the inspection following insistence from the inspector.

The failure to operate effective systems to assess, monitor and improve the service was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The providers and registered manager had not complied with a requirement of their registration, to notify CQC about significant events without delay. Although the provider and registered manager had notified CQC of some events as required, in one case there was a delay of 20 days.
● We also identified that the registered manager or provider had failed to notify us of six counts of possible neglect that had been discussed with them as highlighted by the local safeguarding team. This limited our ability to perform our regulatory duty of monitoring events that occurred at the service.

The failure to notify CQC of significant events without delay was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents occurred. However, during the inspection we found the registered manager was unable to demonstrate that this was followed when required. The requirements of duty of candour highlights that following a notifiable safety incident that has occurred the registered person must act in an open and transparent way, which includes providing a written apology.
● On the first day of the inspection both the registered manager and deputy manager were unable to confirm if there was a duty of candour policy in place. Both the registered manager and the deputy manager were unaware of their responsibilities regarding the duty of candour. They were not aware of the requirement to provide a written notification, including an apology when an incident resulting in injury had occurred.
● We found that one person was involved in a notifiable safety incident when they fell resulting in a fractured wrist. There were no records to confirm that written information or an apology had been given to them or other relevant persons.

The failure to act in an open and transparent way in line with Duty of Candour requirements was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care:

● Systems were not in place to allow continuous learning and improving care. For example, falls were not robustly investigated to identify further risks or triggers or prevent recurrence and to help ensure people's safety. Audits were not completed in a timely way in ensure improvements of care and promote safety. More details can be found within the safe domain.

● The management team told us they conducted regular spot checks of staff and the service, however, were unable to provide us with written evidence of this and could not demonstrate that actions had been taken as a result of these spot checks.

● Appropriate and effective infection control audits had not been completed. On viewing the most up to date infection control audit completed by the management team in November 2018 we found that this was not an infection control risk assessment but a compliance document in respect of the Department of Health (DoH) criterion requirements. It was not personalised to Cornelia Heights and did not reflect the operational infection risks or any action to mitigate risks in relation to infection control.

● The lack of completed medicine audits, meant that medicine errors or issues could not be identified and therefore improvements in medicines management practices would not be made.

● Quality assurance processes that were in place failed to identify that staff did not follow the provider's guidance placing people at risk. For example, there was a water outlet temperature chart in place which stated, 'When recording temperatures above 43 degrees centigrade maintenance must be informed at once and the outcome recorded.' On reviewing these forms, we found that on the 9 March 2019 eight out of 11 outlets recorded above this temperature; on 3 March 2019 five of the 11 outlets checked recorded above the required temperature and on the 23 February eight of the 12 outlets checked recorded above the required temperature. No action had been taken in relation to the high readings of water temperature.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC of significant events without delay.

The enforcement action we took:

We removed the location from the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager failed to ensure risks relating to the safety and welfare of people using the service were assessed, monitored and managed effectively.

The enforcement action we took:

We removed the location from the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to assess, monitor and improve the service . This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We removed the location from the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider failed to act in an open and transparent way in line with Duty of Candour requirements.

The enforcement action we took:

We removed the location from the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient staff were deployed to meet people's needs at all times.

The enforcement action we took:

We removed the location from the providers registration.