Care Quality Commission

Golfhill Limited

Three Corners

Inspection report

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Ratings

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

Overall summary

This inspection took place on the 8 and 9 December 2014 and was unannounced.

Three Corners provides residential and nursing care to a maximum of 46 people. When we visited there were 43 people living at the home.

A registered manager was in post. 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.

There were enough staff to meet people's needs. However, people told us they felt there were not enough staff available to meet their needs safely. We asked the staff about this and how they knew they had enough staff to meet people's needs. Staff felt there were enough staff to meet people's needs. The registered manager told us they were not monitoring people's needs to ensure they had enough staff on duty at any one time. When we asked them to complete an audit of these they felt there were enough staff. Staff were recruited safely and trained to meet people's needs. This was updated regularly. Staff knew how to keep people safe in the event of a safeguarding concern. People felt they were, and would be, kept safe.

Summary of findings

Staff were not always caring. We observed some good care delivered in a kindly, thoughtful manner. However, we also saw some practice that was concerning. We observed people being spoken with in a manner that was not kind and supportive. For example, a person was told to wait when they wanted to go to the toilet and other staff ignored them as well.

People had their medicines administered consistently by staff trained to do so. Medicines were ordered and stored safely. Some entries on people's medicine administration records lacked essential details. For example, in relation to variable doses. Also, stocks of medicine were not being carried forward each time to ensure these were accurate and available in sufficient number to meet people's ongoing requirement for that medicine. We spoke to the registered manager who agreed to address this with staff to ensure this was corrected.

Risk assessments were completed to ensure people were safe and protected from some risks such as falls, malnutrition and pressure ulcers. However, risk assessments were not in place for people who administered their own medicine. The registered manager advised they would assess those who administered their own medicines. Although people's individual risk of falls was being assessed, the registered manager was not assessing whether there were any environmental or whole service issues that could be learnt from people having falls. The registered manager reviewed the most recent falls following the inspection and put in place a monthly whole service fall audits. This meant risks were more likely to be identified and addressed early.

People were not being assessed in line with the Mental Capacity Act 2005 (MCA). Where people lacked capacity, there was no evidence that decisions about people's care and treatment were being made in their best interest.

People's care planning lacked detail to show they were meeting people's individual needs or people were involved in planning their care. The records also lacked detail to ensure staff were meeting people's needs as they preferred.

People told us they had their health needs met and could see their GP as needed. A range of professionals were involved in planning and delivering people's care. Professionals involved told us they were very happy with the care the staff provided.

Audits of medicine and pressure ulcer management were in place. However, the registered manager was not demonstrating they had good quality assurance processes in place that included listening to people living in the home; learning from past events to make the future better for everyone and auditing other parts of the service to ensure good standards of care were maintained.

We found a number of Breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the end 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?

Requires Improvement

The service was not always safe. There were sufficient staff to meet people's needs however the registered manager was not reviewing this in line with people's needs to ensure this was maintained. This is now in place.

People were having individual risks assessed to keep them safe. However, the registered manager was not reviewing people's falls to see if there was any change that would be made to reduce the likelihood people would fall.

People received their medicine as prescribed however, there were gaps in some recordings.

People told us they felt safe living in the home. Staff were trained and knowledgeable in identifying and keeping people safe from abuse. Staff were also recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective. People were not always asked for consent to their care and were not being assessed in line with the Mental Capacity Act 2005.

People received a balanced diet and their dietary requirements were met.

People said they had their health needs met. A range of professionals were involved with supporting people's care.

Staff were trained to meet people's needs and took part in group sessions to review practice.

Is the service caring?

Requires Improvement

The service was not always caring. Some staff did not always treat people kindly. Some staff were very caring and met people's needs in a special way.

People's privacy and dignity were respected. Policies reminded staff how to care for people and maintain their dignity and how to treat people.

People had end of life care plans but these were not readily reviewed to ensure they were meeting people's current needs.

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not have care plans in place which were personalised or always reflected their current needs. Staff however demonstrated they knew people well so people's needs were met.

Activities were provided to support people maintain their interests. People were supported to follow their religious and cultural choices.

Summary of findings

The service's complaints policy was available to people and their representatives and family. People felt confident to complain and would be listened to.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

The auditing of aspects of the service was not robust. The quality assurance process had not identified the concerns raised during inspection. CQC had not received all notifications as required by law.

People's views about the service were not being regularly sought. Staff meetings were held and staff had been asked to contribute to positive change.

Three Corners

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.

Three Corners was inspected on the 8 and 9 December 2014. The inspection was unannounced. Three inspectors carried out this inspection. The registered manager was present throughout the inspection.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information that we held about the provider and previous inspection reports.

During the inspection we spoke with 15 people, four family members or visitors and seven health and social care professionals. We observed interactions between staff and people. On the second day 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 reviewed 11 care records that were kept by the service in respect of people's care. We also spoke with these people where we were able to. This was to ensure they were receiving the expected care appropriately.

We spoke with 12 staff and read four staff files. We also read staff training records and reviewed the rotas. We read documentation held by the service such as audits, reports on sustaining the quality of the service, policies, procedures and practices.

Following the inspection two GPs responded with positive feedback about the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt there were not enough staff at all times to meet their needs. Staff told us they were busy due to the complexity of people's needs, but it was not impossible to meet people's needs. Most staff thought staffing levels were adequate to meet people's needs. Staff added there were always attempts to replace absent staff but this was not always possible when this was short notice. Visiting professionals thought staffing levels were adequate to meet people's needs.

We discussed people's concerns with the registered manager so we could understand how they knew they had enough staff to meet people's needs. They told us they had requested guidance from the local authority and assessed people's needs before moving to live at the service. They also told us they did not assess people's current needs or monitor staffing levels to ensure they were able to meet people's needs safely. We requested the registered manager complete a brief dependency tool. Having reviewed people's dependency, the registered manager said they had the correct numbers of staff. The registered manager confirmed they would continue to monitor needs and therefore could ensure there were enough staff employed to meet people's needs safely at any one time.

All people had their medicines administered by a nurse who had received updated medicines training. Each person had a medicine administration record (MAR) in their name with associated photograph to ensure staff could identify that person correctly prior to administering their medicines. However, there were inconsistencies in recording people's medicines. For example, where a variable dose of medicine had been prescribed, staff had not always written the dose they had given. Also, where there had been a change to the prescriber's instructions, this was not clearly recorded on the MAR to ensure accuracy.

Most people's medicines were provided in blister packs from one prescribing pharmacist. Routine medicines were ordered monthly. However, stock was not being carried forward accurately to ensure people's MARs were correct and therefore, the correct amount of medicine available for the coming month. For example, one person's MAR showed a prescribed medicine had not been given for over three days. A record of stock received indicated the medicine should have been available. We checked the medicine receipts and stock with the nurse, and the person had received this medicine as expected; it just had not been recorded as given. The registered manager agreed to ensure this and other MARs were checked to ensure accuracy.

Some other prescribed medicine was administered from its original packaging. We saw however, this was not from each person's individual stock. This related to the same medicine, for example laxative medicine, but one box of any person's medicine was being used rather than the person it was prescribed for. The registered manager agreed to review this to ensure each person received their medicine as prescribed and stocks were therefore accurate.

Two people who administered their own medicines had not been risk assessed to ensure they could do this safely. People's consent to having their medicines administered by staff was not recorded. The nurses said this would only be in the case of anyone having their medicines administered covertly that is, without their knowledge.

The controlled drug records were accurate. People's medicines were stored securely and the service employed a specialist contractor to dispose of unwanted medicines.

Risk assessments were undertaken for all people. People had personal evacuation plans in the event of a fire in place. Risk assessments for people at risks of falls were not always clearly linked with the care planning or reviewed against any environmental and other needs. The risks associated with falls were not therefore being prevented where possible. Accident returns completed showed a high number of falls and associated injury which were not being reviewed or monitored. We requested the registered manager complete a falls audit of the records from the last three months as a matter of urgency to ensure people at risk of falls were being safely reviewed. This was returned to us and a system put in place by the registered manager to ensure this would now be completed monthly. This meant any risks were likely to be identified early and people's risk assessments and linked care records updated.

Other risk assessments in respect of the likelihood of developing pressure areas (Waterlow), manual handling needs, and people's dietary and weight needs (Malnutrition Universal Screening Tool or MUST) were in place and

Requires Improvement

Is the service safe?

regularly reviewed. For example, manual handling risk assessments were fully completed with information in relation to handling constraints, equipment used or assistance required.

People told us they felt safe living at the home. One person confirmed they thought staff were "good people". Another person replied: "Basically, the staff are good." A third person told us: "The staff are particularly helpful, cheerful and seem to know what their jobs entail and safety; I'm always aware that there are fire doors throughout the building. There is one opposite my room".

People told us their property was respected. The registered manager told us each bedroom had a lockable facility people could use if they wished to keep items securely.

Staff were recruited safely through a structured process. All staff had the necessary checks in place so the registered manager could assess their suitability to carry out their role. Staff were also trained in safeguarding and recognising abuse. This was updated as required. Staff could identify situations that were safeguarding and whistleblowing and would raise an alert if required. Some staff could not identify the external agencies they could refer to however they felt any concerns would be addressed by the registered manager.

Requires Improvement

Is the service effective?

Our findings

People described a mixed picture of whether they felt they were asked for their consent to care. Some people felt staff did not always ask for or wait for them to consent to the care on a time by time basis. Another person stated: "The choice is theirs, not ours" when we asked if they were able to consent to when their care needs were met.

The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made that involves the people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. There were no MCA assessments on the files we reviewed. On one record within the care plan we saw written that one person "has limited ability to consent", but no further details available so staff could support them to consent in the best way possible. Where staff were making decisions on behalf of people who could not consent we did not see recorded that decisions about people's care and treatment were being made in their best interest with details of who had been involved in the decision making process.

Staff were also unsure how to apply the MCA and what actions should be taken if they felt people were being unlawfully deprived of their freedom. Staff told us they had not had training in understanding the MCA and DoLS. Following the inspection the registered manager advised us 34 other staff had undertaken training in the MCA and DoLS but agreed the staff we spoke with had not received the training.

For people able to consent to their care, records rarely showed people had been formally requested to ask whether they consented to their care. One file had a 'General consent form' signed by a person in recent weeks. This showed their consent to sharing of their personal information, photographs, the care described in their care plan and visits by volunteers for example.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2012, which corresponds to Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us she would follow up on the issue of consent to care and treatment, as everyone should have had MCA and general consent form on their records. However, after the inspection the registered manager informed us 10 MCAs had been completed but these were not shown to us during the inspection.

We received a mixed picture from people in respect of the quality of food served at the home. Some felt it was good whereas others felt improvements could be made. The menu was available to view and people were asked what they would like to have for their meals the following day. Five people told us they felt the portion sizes were the right size for them. Everyone confirmed staff would offer them something different if they did not like the choice available. People with special diets were catered for.

Nutritional needs were being met however the format of food was not always consistent with what was defined in the care plan. For example pureeing rather than mashing. Two people's care records stated their food should be provided as forked or mashed to assist with swallowing. However, the kitchen staff only prepared the food in a liquidised form for those who had swallowing risk assessments in place. The detail of how their food should be prepared had not been passed to the chef. This meant their food was not being provided as assessed. The registered manager agreed to review everyone's care plans and staff practice to ensure people were receiving their food in the way they needed.

People's nutritional intake was recorded where there were concerns about people's weight. However, it was not always clear what action had taken place. For example, for one person who was recorded as taking in low fluid and food amounts, it was not clear what action had been taken to ensure their food and fluid intake was reviewed or advice sought from their GP. Where people were prescribed supplements it was not possible to track these were given as required as they were not always recorded. The registered manager advised these were being given as required but agreed the recording was not always completed accurately. They agreed to address this as a matter of urgency.

People told us staff noticed if they were unwell and sought advice from health professionals promptly. They confirmed they received routine health checks such as for their sight and chiropody. Prompt action was taken by staff to contact GPs when people developed health problems such as sore

Is the service effective?

skin areas. Staff reported there were good relationships with GPs, and GPs visited individuals rather than trying to prescribe over the phone on the basis of what staff told them.

Social workers, occupational therapists, physiotherapists, and an optician were contacted by staff during the inspection. Other services such as dieticians and speech and language therapists were contacted and requested to assess people's diet and swallowing needs as required. Some people we met had conditions such as diabetes and Parkinson's Disease. They had been seen by specialist nurses within the last year. People's pain and mental health were being monitored. An appropriate pain scale was being used for people who couldn't communicate well, such as those living with dementia. People with or at risk of pressure ulcers were being carefully monitored.

The service did not have a first aid kit. The registered manager agreed to address this as a matter of urgency and, within 72 hours of the inspection, confirmed first aid kits were present in the home and staff had been informed of this.

The majority of staff had worked at the service for a number of years, which meant people were supported by staff who knew them well. The majority of staff had completed a range of training and this was up to date, however there were some gaps. The registered manager was aware these staff needed to have their training updated. All staff told us they could take higher or further qualifications in care and had achieved or were working towards completing this. They were also supported to attend extra training such as catheter care and to meet people's specific needs. One staff member commented new staff always received training for their role. Another told us they shadowed more senior staff until they were confident to work on their own.

Records were not clear as to who had received supervision and whether all staff members were having their competency checked. Most staff told us they did not have formal one to one supervision sessions. Two staff said they had supervision, recently. One said they asked how they could better support someone living with dementia in their supervision. They were given advice as well as training on dementia care, and felt they had a better relationship with the person now as they understood how to approach them better. Some staff received supervision as a group. The registered manager said supervisions had been group supervision sessions for a while. Group supervisions looked at whether there were lessons to be learnt. For example, in reviewing the management of end of life care.

Annual appraisals were completed. Five staff had appraisals planned in December 2014 with 11 noted to have not had an appraisal for over a year. Staff said their appraisals were a useful two-way discussion, about their work and any training needs. One also commented that they could always speak with a senior member of staff at any other time if they had any questions or concerns.

Requires Improvement

Is the service caring?

Our findings

People had a very mixed experience of staff and whether they felt they were caring. Staff on the whole treated people with kindness. We heard appropriate banter and humour being shared between staff and other people. When we asked one person if staff seemed interested in them as a person or individual, they told us "most are". When we asked another person if staff were kind, they replied "You have your ups and downs as everywhere. Some you get on with, others it's a struggle. But generally we get on alright." This person had various medical conditions and felt staff were "sympathetic to a degree" about these. Another person who stayed in their room said: "The staff don't come and talk to you". Another person said: "Sometimes nobody turns up when I ring for them, or they say 'in a minute, in a minute'." They felt this meant their continence needs were not met quickly and affected their dignity.

Observations in the lounge raised concerns about how some staff related to people. There was only one call bell in the lounge which was not in anyone's reach. We asked people how they sought staff attention. One person told us: "I have to wait for a member of staff to come if I want them" and another "it is normal there is no one in the lounge". One person asked to go to the toilet and asked us to find a member of staff. On arriving the staff member said: "You will have to wait as we are doing lunches" and left without giving the person any idea of how long that would be. A nurse came into the lounge soon after and gave someone their medicines. They left, ignoring the person loudly requesting staff assistance. During a further incident the staff member who answered the call for assistance shouted across the room "sit down" and "use your frame" before telling the person off for putting themselves at risk of falling. They did not ask what the person wanted or treat them in a manner which was kindly. The registered manager told us this person fell frequently because they forgot they were unable to walk unsupervised. We felt it was necessary to ask the registered manager to intervene and ensure that people's needs were being met.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting professionals went to the nurses' office but this was too small to accommodate them all. Conversations about people were therefore taking place in the corridor outside, where they could have been overheard, especially as occupied bedrooms nearby had open doors. Staff and the registered manager told us the nursing office was being moved in the new year, and the new area would be much bigger so that all conversations could take place in private. In the meantime, they reminded staff in staff handover of the need to ensure such conversations were not overheard.

One person told us they appreciated the staff stating: "They enjoy a joke, or tell you a joke." One person's care records showed staff had made them a drink when they were awake in the night. Another person stated: "I think it is very good here; well good".

When we were talking to one person a staff member brought breakfast to them. They greeted the person with: "Good morning, I've brought your breakfast. Does that sound nice? Would you like to sit in bed or your chair". The person responded "Oh lovely" and requested the chair and the staff member supported them to do this while still talking kindly and encouragingly to them. The care was delivered in their time and carefully. As we left the room we heard both the staff member and person were enjoying the interaction and time with each other.

Everyone was able to personalise their rooms and people told us their visitors were welcomed. We observed a visitor brought their dog to see one person who spent all their time in bed. The dog was special to the person and they were supported to stroke and have the dog with them on their bed for a little while. This was observed to be a special time for all involved. The visitor confirmed the staff have been very supportive of this taking place once a week. We asked staff how they supported people to make choices or decisions for themselves. They spoke about presenting people with options such as for where they spent their time or alternatives to the day's menu; "not putting words in their mouths" but showing them the choices if possible; using different communication methods, such as picture cards; responding appropriately to people with variable mood or ability, such as returning to them later when they were more able to choose or addressing problems that might be affecting their ability to choose.

Staff promoted people's privacy and dignity keeping people covered with a towel for example during personal care. In rooms which were shared staff promoted privacy

Requires Improvement

Is the service caring?

for each person or closing curtains between beds in the shared bedrooms before providing personal care. They also were mindful of the impact this could have on the other person and attempted to manage this for the benefit of both. One staff member said "You treat them like your own mother." When staff started to work at the service they were provided with a range of information of their expected behaviour. This included responding to people correctly and a staff code of conduct.

People confirmed they were encouraged to remain as independent as possible for as long as they could. Staff also spoke about promoting people's independence. They asked if individuals wished to wash themselves or help themselves at mealtimes, providing equipment such as plate guards to support them with this.

We did not review people's end of life care in detail. People's care records held space for people's wishes and feelings to be recorded. Three care plans we reviewed stated they were for 'end of life care', but none of these plans include individual's wishes relating to this. Staff told us they were awaiting guidance being developed by the local hospice. They showed us a 'Palliative care plan' template, which they completed if someone was so poorly they were cared for in bed and not able to eat or drink for example. We discussed the term 'end of life care' with staff and the registered manager as the definition in use was quite broad and encompassed a wide number of people. For example, one person stated to be 'end of life' and to be nursed in bed was in the lounge but did not have a care plan which mentioned this or advised staff what role they could take.

We observed the friends of one person, who sadly passed away while we were at the home, were called to the service and were able to spend time with the person. Staff supported them and the situation was handled carefully. The visitors wanted us to know they had appreciated how the staff had handled the situation.

Requires Improvement

Is the service responsive?

Our findings

People's care records were concise and easy to follow however some of them lacked the detail necessary to ensure the staff were meeting people's individual needs. For example, none of the care plans reviewed included any goals or aims individual people wished to achieve. Staff were able to tell us what care people needed and liked but the same detail was missing from people's care plans. Staff told us they relied on shift handovers to keep up to date. Other care plans raised concerns about their accuracy and whether they were being amended as people's health needs improved or deteriorated. For example, one person who was feeling very low in mood said they had told staff about this. However, their care plan did not mention their low mood and how they could be supported. No aspect of their care plan reflected what their social needs and what their life was before they required care. This meant people were at risk of inappropriate or inconsistent care

People said they felt their care had to fit into staff routine. One person stated: "They don't ask whether I'm happy, they just get on with it. They're all efficient. It's not a social gathering; I am never included in my care planning or in reviewing my care needs". A family member also said they had not been consulted in relation to the planning of their relative's care. During the SOFI, we observed staff were rarely in the lounge. Staff who came to the lounge came to complete a task such as supporting people to go to the toilet.

Also during the SOFI, we saw one person living with dementia was taken to the toilet. There was little communication or time taken by staff to ensure the person was able to understand what was happening and they shouted out at staff. When the person's pad was changed there was also a very strong smell that came from the toilet. Records in their bedroom showed this person had last had their pad changed four hours previously. They would not have had the ability to ask for help from staff or ask to be taken to the toilet. Staff took a continence pad from a set of drawers near one of the toilets. In that drawer were three varied sized and types of continence pads. None stated who they were for. We asked the registered manager what this meant. The registered manager advised pads had been used from other people's stock or the general stock held by the service for people who stayed with them for short periods having been transferred from the local hospital. The only care plan available to staff for this person was created during a previous stay when they had been at the service for respite. Their current continence needs had not been assessed despite being in the service for two weeks and they had no pads available for their personal use. The registered manager advised they would have expected the assessment to have been completed within 72 hours. Recordings by staff in the daily records did not mention the lack of continence pads. This meant this person's needs were not being correctly assessed and met.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The recording of people's care in respect of preventing pressure ulcers was inconsistent. Recordings for one person highlighted staff noticed they had an area of redness and action was taken so the person received the care and treatment they needed. Another person had pressure ulcers. Their care records showed they were repositioned two hourly in the first part of the day, then there was a gap of five hours in the afternoon, and three to four hourly overnight. Their care plan did not specify how often they should be repositioned. There were however, examples in other daily care records of staff reporting observations about changes in people's skin to nursing staff, and the subsequent action taken by nursing staff to address the problem identified. The registered manager agreed to speak to staff and ensure all records were accurate.

Some people told us they felt staff supported them in line with the staff routine. Other people and recordings of care in the daily records demonstrated people's decisions were also supported. For example, one person declined a bath or shower so they were assisted to have a full wash instead. They had a variable bedtime and we asked them if this was their choice. They replied: "It's whatever is convenient to me at that time."

A married couple confirmed they were happy with the care provided at the home; one stated: "They do everything for me, I am quite happy, I have my bell if I need someone".

A relative said they were very happy with the home, there was good communication and all their questions had always been answered by staff.

Requires Improvement

Is the service responsive?

Care plans did not always detail how people would like to spend their free time, what they wanted to do, or how staff could support them spend their time in positive ways. A member of staff was employed to carry out activities with people. On the second day we observed them interacting with people in the lounge on a one to one basis. Different activities were carried out depending on each person's individual choice. A musician also attended and sang songs with people. There were computers for people to use to communicate with family. There were also a range of games and equipment available to use to enable people to stay active. One person told us they had enough to do with their time. They attend musical entertainments organised at the home, and used the garden. They didn't want to go on outings, as we saw reflected in their care plan. Another person told us they got bored but added they did not like mixing with people. They did however make cards on their own with the activities organiser and said they enjoyed this. People told us they had their religious and cultural needs respected.

The service had a complaints policy and procedures in place to handle complaints and concerns. This was made available to people and family on enquiring about the home. Information given to people also stated the service operated a key worker policy; the aim being people had one staff member they could speak to. People felt confident they knew how to make a complaint and who to talk to. Most people said they would speak to the registered manager or one of the deputy managers. All thought they would be listened to by staff. All but one person said they would speak with staff; they said they would tell their family if they had an issue. One person told us: "I think it's very good here; no real complaints. I would ask to see [the registered manager] if I did." They also identified the complaints policy was in a folder in their room.

Requires Improvement

Is the service well-led?

Our findings

Three Corners in owned and run by Golfhill Ltd. They own another service in the local area. The registered manager was registered for both homes at the time of this inspection. The same person was also the nominated individual registered with CQC to take accountability at the company level. Three Corners had a staff management structure in place to maintain the running of the home. This included deputy managers and a nurse in charge on each shift. There was an administrator employed to handle the financial side, contracts and initial communications with people, family and professionals. The provider was observed, in minutes of meetings, as having regular involvement with the home. There was a monthly 'Quality' meeting attended by the provider and senior members of staff from both homes.

Policies supporting the running of the service were last updated in 2012. We were advised by the registered manager and administrator many of the home's policies were under review.

The issues we found in respect of care planning had not been identified through any auditing process. Auditing of paperwork such as daily records, food and fluid charts and other forms of communications was not evident. The registered manager told us they would review this as a matter of urgency.

An audit of medicines was last completed in August 2014. Actions were identified; some of which had been completed. Other actions were in progress. There was a detailed audit of people who were at risk of developing pressure ulcers. The oversight for this was delegated to one member of staff with knowledge and training in this area. This was regularly updated, reviewed weekly, and all staff were clearly briefed to ensure the care was consistent. Staff told us they received positive and negative feedback during handovers to support their learning from events and incidents.

Staff were not following current data protection practices as staff used a communication book and a method of recording tests which detailed several people's names and personal care details on one page. This meant anyone, such as GPs, needing to access these records would have access to everyone's personal details not just the one person they were interested in.

Registered persons are required to notify us of significant events. Prior to the inspection we had received three serious injury notifications from the previous 12 months. The accident records kept by the service from April-October 2014 showed there were 28 serious injury notifications we should have received. This was for times when a person had received an injury which had required medical attention, transfer to hospital or likely to have meant the person was in prolonged pain. When we discussed this with the registered manager, they informed us they thought they only had to notify us when a person received a fracture.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People told us there was no formal way in which they were asked their views about the home. For example, there were no resident meetings. One person told us they had seen the registered manager around and they had brief chats with her about the service. The registered manager informed us that satisfaction surveys were sent out annually and short term residents were asked to fill surveys on leaving the home. These were then reviewed and next steps were documented leading to actions.

Two staff members told us staff meetings were held, with records kept that non-attenders could read. Some meetings were for representatives from each staff group, such as a domestic or staff who delivered care. Neither staff member was confident changes came about as a result of these meetings. For example, one said tidiness had been discussed but would be difficult to improve whilst the staff were so busy.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9(1)(a)(b)(i)(ii) **which corresponds to Regulation 9(1)(a)(b)(c)(3)a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**. The registered person had not taken proper steps to ensure each person was protected against the risks of receiving care which was inappropriate and unsafe, by means of carrying out an assessment of all people and planning and delivering care which met people's individual needs and ensured the welfare of the service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17(1)(a)(2)(a) **which corresponds to Regulation 10(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** The registered person did not have suitable arrangements in place to ensure the dignity, privacy and independence of people; and treat people with consideration and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18(1)(a)(b)(2) Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2012

This section is primarily information for the provider

Action we have told the provider to take

which corresponds to Regulation 11(1)(2)(3)(4)(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users, or the consent of another person who is able lawfully to consent to care and treatment on that service user's behalf; or establishing, and acting in accordance with, the best interests of the service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Regulation 18(1)(2)(a)(i)(ii)(iii)(b)(ii) The registered person had not notified CQC without delay of all serious injury incidents as required.