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Cornerways Residential Home

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

We undertook an unannounced inspection of this service on 26 and 27 June 2016. Cornerways Residential Home provides accommodation and personal care for up to older 20 people. There were 20 people living at the service at the time of our inspection. The home is arranged over three floors, each person had their own bedroom apart from a married couple who shared a room. Access to the first floor is gained by a shaft lift and by a stair lifts to the remaining floor, making all areas of the service accessible to people.

Our previous inspection of Cornerways Residential Home on 16 and 17 June 2015 found breaches of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We took enforcement action and required the provider to make improvements. We issued two warning notices, the first in relation to the cleanliness and maintenance of the property and some equipment and the second in relation to systems and processes intended to assess and improve the quality and safety of the service provided. We also asked the provider to take action to ensure all risks were, as far as reasonably practicable, mitigated and to ensure that medicines were safely administered and care and treatment provided in a safe way; to ensure there were sufficient numbers of staff on duty and that care and treatment of service users was appropriate, met their needs and reflected their preferences.

At this inspection we found required improvement had been made in some areas. However, we identified other shortfalls where some regulations were not being met. We also made some recommendations for improvement.

Recruitment checks were incomplete because they did not ensure all staff employed were suitable to work at the service.

Systems and processes were not operated effectively to ensure complete records were kept in respect of each person, including a record of care and treatment provided to the person. Records were also not maintained about some fire safety checks.

Medicines were stored appropriately; records and people confirmed they received the right medicines at the right time.

Staff had received training to support the people they cared for and understood about the Mental Capacity Act and how to support people to make decisions.

The service was safe, clean, hygienic and well maintained; appropriate fire safety checks had taken place.

Equipment used at the home was serviced when needed and certified as fit for purpose and safe to use.

People's health needs were well managed and referrals to outside healthcare professionals were made in a

timely way.

People were supported by enthusiastic staff who received regular training and appropriate supervision. There were enough staff to meet people's needs.

Staff were caring, compassionate and responsive to people's needs and interactions between staff and people were warm, friendly and respectful. Staff spent time engaging people in communication and activities suitable for their current needs.

People enjoyed their meals, they were supported to eat when needed and risks of choking, malnutrition and dehydration had been adequately assessed and addressed.

People commented positively about the openness of the management structure and were complimentary of the staff.

We found two of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Recruitment processes did not ensure mandatory checks were completed for all staff.

Medicines were appropriately stored and administered.

Staff knew how to recognise and address any concerns of abuse, accidents and incidents and risks were managed appropriately.

People were supported by enough staff.

Is the service effective?

Good

The service was effective.

People's health care needs were met.

The service was meeting the requirements of the Deprivation of Liberty safeguards and Mental Capacity Act 2005.

Staff received appropriate instruction and training when they first started work; on-going training ensured staff had the skills and knowledge to support the people they cared for.

Staff were provided with opportunities to meet the managers and provider to discuss their work performance, training and development.

People were supported to eat and drink when needed and they enjoyed the variety of food provided.□

Is the service caring?

Good

The service was caring.

Staff were kind to people. They respected people's privacy and dignity, and maintained their independence.

Staff communicated well with people and their family members, giving them information about any changes.

People's families and friends were able to visit at any time and were made welcome.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about the support people needed and care plans reflected people's current needs.

Changes in people's health or social needs were responded to.

People told us they enjoyed the activities provided.

There was a complaints procedure available for people and their representatives should they be unhappy with any aspect of their care or treatment.

Is the service well-led?

Requires Improvement

The service was not always well led.

Complete records were not kept about care and support provided; some recruitment decisions and checks completed on some fire safety equipment.

Staff were aware of the service's values and behaviours and these were followed through into their practice.

People, their relatives and staff thought the service was well run and spoke positively about the staff.

People and staff felt encouraged to speak up with suggestions and concerns.

Cornerways Residential Home

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 was a scheduled inspection, 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.

We undertook an unannounced inspection of this service on 27 and 28 June 2016. The inspection was undertaken by one inspector.

We focused on speaking with people who lived in the service, speaking with staff and observing how people were cared for and interacted with staff; including the lunchtime meal, administration of some medicines and the activities taking place. To help us capture the experiences of people who may not be able to express this for themselves, 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 looked at four care plans and four staff files as well as staff training records and quality assurance documentation to support our findings. We looked at records that related to how the service was managed such as audits, policies and risk assessments. We also pathway tracked some people; this is when we look at care documentation in depth and obtain people's views on their day to day lives at the service. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We looked around most areas of the service including some bedrooms, bathrooms, lounge and the dining area as well as the kitchen and laundry area. During our inspection we met and spoke with eight people who live at the service, a visiting health care professional, two visitors, three care staff, the chef and the registered and deputy managers.

We reviewed the information we held about the service, including the Provider Information Return (PIR). The PIR is a form that asks the provider to give us some key information about the service, what the service does

well and what improvements they plan to make. We considered information which had been shared with us by the local authority. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they were happy living at the service and felt safe. Their comments included, "I can't fault them, staff and the management are very good", "I'm happy with everything" and "It's a good home, it's clean and I feel well looked after". A visitor told us they were happy with the care and support their relative received and felt they were kept up to date with any changes in their condition. A visiting health care professional was complimentary about the staff and the care and support they provided.

Our last inspection found the service was not safely maintained or appropriately cleaned. Servicing and safety checks of some equipment had lapsed, a window restrictor was disconnected and a fire exit was bolted shut. Some risk assessments lacked guidance and incidents and accidents were not suitably investigated to reduce the risk of them happening again. Identified staffing shortages had not been addressed by the provider, some medicines were not stored appropriately and there were errors in the records of their administration.

At this inspection we found that required improvement had been made, however, we also identified an area of concern which meant that the service was not safe.

People were not protected as far as practicably possible by a safe recruitment system. Disclosure and Barring Service (DBS) checks establish if any cautions or convictions mean that an applicant is not suitable to work at a service. The checks are required for unsupervised volunteers and staff aged 16 and above to help employers make safer recruitment decisions and help prevent unsuitable people from working with people who use care and support services. Staff should not work unsupervised before DBS check results are known. In some circumstances, DBS checks made for previous care sector employment are portable to the next employer. However, checks must be made with the DBS to establish portability and to establish if any new cautions or convictions have been recorded. This should be undertaken by the service as the new employer, but had not always happened. Where existing DBS checks disclosed convictions, although considered by the registered manager, the decision and any associated risk assessment to employ such staff was not recorded. Employers are also required, where possible, to obtain photographic proof of identity of staff. This also had not always happened. Discussion with the registered manager found they had identified the need to review recruitment files and a review of other staff files found this process had started, however, sufficient priority had not been given to this task to ensure it had been fully completed.

Recruitment processes were incomplete; this did not promote the principles of a robust recruitment process to protect the safety of people living at the service. This is a breach Regulation 19 (1)(a)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We walked around the service and looked at most areas of it. Many areas, including the building exterior, were recently decorated; the service and all equipment were clean, hygienic and suitably maintained. Window restrictors were in place; these limited the extent windows could be opened and safeguarded against falls through open windows. Fire exits were clear and unobstructed. Environmental safety audits highlighted any hazards or repairs needed throughout the service and records confirmed these had been

signed off as completed promptly. People, visitors and staff commented positively about the cleanliness and upkeep of the service and the improvements made. One visitor told us "It's a great improvement; the outside has been decorated too, the place just seems more cared for". A maintenance planner scheduled any remaining work for completion.

Records showed other equipment was checked regularly to help keep people safe. Checks included the electrical installation, boiler gas safety, portable electrical appliances, fire alarm and fire fighting equipment. Tests and checks of the alarm and emergency lighting were carried out on a weekly and monthly basis, to ensure equipment was in working order. Service contracts ensured equipment to support people with their mobility such as the service's shaft and stair lifts were safe and fit for purpose. Water safety checks ensured people were not at risk of scalding from excessively hot water; other checks and treatment safeguarded against possible risks of Legionella, a water borne bacterium. We recommend fire safety records are enhanced to record the correct operation of automatic fire door guards; these are devices to enable fire doors to close automatically in the event of the fire alarm sounding.

Suitable procedures were in place for ordering, receipt, storage, administration, recording and disposal of medicines. Medicines held by the service were securely stored, at appropriate temperatures and people were supported to take the medicines they had been prescribed. We looked at people's Medicine Administration Records (MAR), all records had been signed to indicate they had been given, or correct codes entered to indicate, if for example, a person had declined to take their medicine. Staff had received specific training in the management of diabetes; new equipment was in place to monitor people's blood sugar levels and some staff were trained to administer insulin. All staff administering medicines had attended appropriate training and were assessed as competent to manage and administer medicines.

Assessments had been made about risks associated with people's medicines; including whether people were able to self-administer their tablets and creams. Information was held for each person about how they took their medicine and their ability to express their need for medicines. These documents gave staff important guidance about individual people's needs and preferences and also about how different people communicated pain. People we spoke with told us they received the right medicine when they were supposed to.

Individual risk assessments were completed and reviewed when needed. Staff were knowledgeable about the people they supported and familiar with risk assessments. These included medication, eating, drinking and risks of choking as well as use of equipment such as pressure reducing mattresses, lifting aids and wheelchairs. Incidents and accidents were recorded and analysed. They were used to look for any patterns or trends and to inform learning and care plan reviews. This helped to minimise the risk of incidents happening again. Where needed, input had been sought from other professionals, such as the GP, occupational and speech and language therapists as well as psychiatric services and pharmacists to help resolve any problems identified.

There were sufficient staff with a suitable mix of experience and skills to meet people's needs. Daytime staffing comprised of two care staff including a senior carer in addition to the deputy manager. The registered manager shared her time between this service and another local service owned by the same provider. An additional carer provided support seven days a week during busy times, typically in the mornings; however, this arrangement was flexible and could be extended if needed. Two waking staff provided support at night. Cleaning was undertaken by external contractors five days a week, with care staff providing cover for the remaining two days. Staffing allocations ensured a senior carer was always on duty on each shift. A chef provided meals and the service made use of visiting and voluntary service as well as care staff and a resident to organise and facilitate activities. Any staff shortfalls were usually met through use

of existing staff to help to ensure consistency of care, although, on occasion agency staff were used. Risk and needs assessments formed the basis to determine how many staff were needed. Discussion with the registered manager and a review of staffing records demonstrated staff deployment was flexible allowing for additional staff when needed.

People, their relatives and staff told us they were satisfied with staffing levels. We spoke with people about how long it took staff to come to their bedroom if they pressed the call bell or if they needed help around the service. People were confident staff would come when called, no one told us they felt they had to wait for too long. People told us they could go out if they needed to be accompanied by staff and gave us examples of when this had happened. Observation throughout the inspection found staff were aware of people's support needs and people received appropriate support.

Any concerns about people's safety or wellbeing were taken seriously. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. Policies ensured staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed all care staff had received safeguarding training and any safeguarding referrals were made when needed.

People were protected from fire and other risks. Personal emergency evacuation plans were in place for each person and included information about individual support needs. Numbers of staff needed to assist people and any equipment required, such as a wheelchair or walking frame were also documented. There was an emergency plan in place for major incidents which had been recently reviewed.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about the quality of care provided. People told us they had confidence in the staff who supported them, they felt staff understood their needs and knew how to meet them. Comments included, "You couldn't ask for better staff", "All the staff are thoughtful and work hard" and "I think the staff are very good". People and their relatives said that staff communicated well with them. A visitor commented, "Staff are always friendly and welcoming, they take an interest in how my relative is". We spoke with a visiting health care professional. They felt communication was good at the service; staff took on board their comments and instructions and were proactive in ensuring people received the care and support they needed.

Our last inspection found the service was not always effective and required improvement because some areas of people's care and support did not promote the best outcomes possible. For example, knowledge and procedures around hydration and the effects of dehydration did not allow staff to recognise and react to deterioration indicators.

During this inspection, where warranted, we found improved monitoring systems to safeguard against the risks of dehydration. Additionally other processes measured risk of skin breakdown or deterioration as well as weight loss and malnutrition. This helped to ensure changes in people's condition were noticed and appropriate action taken.

CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS), which form part of the Mental Capacity Act (MCA) 2005. It aims to make sure people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep people safe. Where restrictions are needed to help keep people safe, the principles of DoLS should ensure that the least restrictive methods are used.

When people lack capacity to make some decisions, the MCA requires providers to submit DoLS applications to a 'Supervisory Body' for authority to impose restrictions. No DoLS applications had been made because people had capacity to make their own decisions and had agreed to any restrictions in place, for example, being accompanied by staff if outside of the service.

Staff understood the basis of the MCA and how to support people to make their own decisions. Staff encouraged people to take their time to make decisions and supported people patiently whilst they did so. Staff gained people's consent to give them care and support and carried this out in line with their wishes. People were involved in their day to day choices about the food they ate, the clothes they wore and the activities they preferred. Policies reflected that where more complex or major decisions needed to be made, involvement of relevant professionals such as GP's and an Independent Mental Capacity Advocate was required. Advocates are people who are independent of the service and who support people to make and communicate their wishes. Information about these processes was available to people and visitors within the service.

Induction training for new staff had previously been based on common induction standards for staff working with older people. Common induction standards were competency based and in line with the recognised government training standards (Skills for Care). The registered manager had enrolled all staff, new and existing, to undertake the new training for the Care Certificate. This is an identified set of standards that social care workers adhere to in their daily working life. Other training for new staff included some class room based sessions, shadowing experienced staff, written assessment workbooks and observational assessments of competency. This helped to ensure staff had understood what they had been taught and could apply their training in practice. Staff said that induction could be extended or they could be asked to repeat units if necessary. This helped to ensure staff had the right basic level of knowledge and skills to support people effectively and safely. Discussion with staff confirmed they understood their roles and responsibilities.

Staff were positive about the training received. Certificates confirmed training undertaken and the training plan identified when essential training, such as fire safety, health and safety, manual handling and safeguarding required updating. Training was obtained from external sources as well as in-house so as to gain the maximum benefit from training available. Staff training included other courses relevant to the needs of people supported by the service such as dementia and diabetes awareness. Care staff were encouraged to carry out formal training in health and social care, such as vocational qualification training or diplomas to levels 2 or 3. Most care staff had undertaken this. The deputy manager was undertaking their level 5 diploma. These are all work based awards that are achieved through assessment and training, and show staff have the ability to carry out their job to the required standard. A visiting health care professional told us they did not have any concerns about the training of staff or their competence.

Supervision records showed and staff confirmed supervision took place when planned. Staff supervision was a one to one meeting with the registered manager. Staff told us supervisions now took place every six to eight weeks, but said they also had informal discussions to keep up to date with any changes. Supervisions included discussions about best practice and setting of personal objectives and development plans. Staff said they welcomed the opportunity to think about their development and received support to achieve their goals. The supervision and appraisal process enabled the registered managers to maintain oversight and understanding of the performance of all staff to ensure competence was maintained. This helped to ensure clear communication and expectations between managers and staff. Supervision processes linked to disciplinary procedures where needed to address any areas of poor practice, performance or attendance.

Staff told us they felt proud of where they worked. They described the service as clean, friendly and a homely place for people to live. All staff said they would recommend the service to others. Staff told us people's choices were respected, people felt the service was not institutionalised; they did not have to do anything they didn't want to. We observed a staff handover during the change of shift. This was structured and informative, giving a summary of people in terms of their wellbeing and any needs as yet unmet.

People's care records showed evidence of regular health appointments and contacts with health professionals, for example, the mental health team, community, diabetic and warfarin nurses, dentist, chiropodist, dietician and speech and language therapist. Health and social care professionals were contacted to give treatment as needed. Staff were familiar with advice about how to support people and advice received was effectively put into practice. People's weight was recorded when they moved to the service and then again monthly or more frequently if needed. Any significant weight gains or losses were reported to the registered manager and GP referrals made. This helped to ensure people's overall health and wellbeing was maintained. However, one person could not always be weighed when needed because of their difficulty in using scales they needed to stand on. We recommend the service provide a method of weighing people to satisfy the needs of each person, for example, seated weighing scales.

People received a wide variety of homemade meals, fresh fruit and vegetables were available every day. Home baked cakes, biscuits and desserts were frequently made, they were popular and people told us they appreciated this. People were provided with menu choices and said the food was usually very good. Some comments included, "There is always something good to eat, but it can vary if a different chef is working", and "The food is excellent." Visitors and staff commented the food was very good. A menu planner showed lunch and supper time meals and choices of desserts. There was a selection of breakfast choices, including a cooked breakfast and snacks were available at other times. Mid-morning and mid-afternoon drinks were served often with a choice of home-made biscuits or cakes. The food served was well presented and looked appetising.

People were encouraged to eat independently and supported to eat when needed. Drinks were provided during meals together with choices of refreshments and snacks at other times of the day. Where people required soften or low sugar meals, these were provided. Staff encouraged people to drink where needed. The chef was familiar with people's different diets, and discussed meals, choices and favourites with people. This helped to ensure they were aware of people's preferences and received direct feedback about the food they provided.

Good

Is the service caring?

Our findings

People were cared for in a kind and compassionate way. Staff respected and treated them as individuals and people said they were happy and appeared content in the home. One person said, "I find staff kind and caring." Another person told us "Staff are considerate, gentle and kind". A relative commented about their mother, saying, "Staff treated her with understanding and good grace". Another visitor commented that their relative "Always seemed content and happy". People told us staff listened to them and acted on what they said; this was evident from our observations during the inspection.

Staff were clear about how to treat people with dignity, kindness and respect. Staff used effective communication skills which demonstrated knowledge of people and showed them they were thought of and treated as individuals. For example, staff spoke with people at the same level so it was easier to communicate with them or to understand what was being said. They made eye contact and listened to what people were saying, and responded according to people's wishes and choices. Staff told people what they were doing when they supported them. They gave some people a narrative, such as your lunch has arrived, tell me what you would like to drink and would you like me to assist you. This respectfully helped people to make decisions and introduced orientation to any support they might need. Staff were courteous and polite when speaking to people in private. They gave people time to respond and spoke in a way that was friendly and encouraged conversation.

Visitors told us they found staff knowledgeable about the support their relatives needed. They commented that whenever they visited, people seemed well cared for and happy. People were supported to maintain important relationships outside of the service. Relatives told us there were no restrictions on the times they could visit the service, they were always made welcome and invited to social events. Staff recognised people's visiting relatives and greeted them in a friendly manner and offered them drinks. Visitors told us they could speak to people in private if they wished and gave positive comments about how well staff usually communicated with them, for example, about changes in people's health.

Staff knew people well and demonstrated a high regard for each person. Staff spoke with us about the people they cared for with genuine affection and were able to tell us about specific individual needs and provide us with a good background about people's lives before living at the service; including what was important to people. People were addressed by their preferred name and staff took the time to recognise how people were feeling when they spoke with them. For example, when one person needed reassurance, staff touched their hand and spoke calmly and slowly with the person. Staff knew how to reassure them, they chatted and smiled and this helped to calm the person and reduce their anxiety.

People's care plans showed that discussions took place at the time of admission to ask if their family members wished to be contacted in the event of any serious illness or accident. We saw where needed, this had usually happened.

Care plans recorded end of life wishes. However, in one instance, a person had told staff that they did not wish to be resuscitated should the need arise. Discussion with the registered manager found almost two

months on from making this decision, arrangements had not been made with the GP to have a (Do Not Attempt Resuscitation) DNAR put in place. The purpose of a DNAR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest. This meant that the person could be resuscitated against their wishes. We recommend the service action all DNAR requests in line with the Resuscitation Council (UK) Guidelines.

People's privacy and dignity was protected. Staff knocked on people's doors and tended to people who required support with personal care in a dignified manner. Care records were held securely and information was treated confidentially. Staff had a good understanding of privacy and confidentiality and there were policies and procedures to support this.

Good

Is the service responsive?

Our findings

People told us they felt staff were responsive and supportive to their needs and were offered choice in all parts of their care. One person told us, "I get offered choices and decide my own daily routine, I think we all do, you hear staff asking." Some people told us they liked to stay in their room and keep their own company, while other people told us they enjoyed the activities and preferred to join in. Throughout our inspection people were being cared for and supported in accordance with their individual wishes.

Our last inspection found the service was not always responsive and required improvement. This was because care and treatment was not always person centred to meet with people's needs and reflect their preferences.

During this inspection, the care plans reviewed were improved, well developed and focussed upon people's choices and preferences. People had been involved in their care planning and many had signed their care plans in agreement of their content. Where people had particular health care concerns, in most cases, health care plans provided clear guidance about how people should be supported and what to look out for that may indicate a change or deterioration in a person's condition. Risks of dehydration, skin breakdown and malnutrition were recorded and set against established care sector tools intended to identify pathways to address changes in people's condition.

All staff spoken with were knowledgeable about people's conditions, including diabetes, epilepsy and catheter care. In cases of diabetes, completed health care plans provided guidance about most high and low blood sugar level (BSL) readings and what to do in these circumstances. During our inspection one person's BSL was high; staff knew what to do and responded appropriately to help to reduce it. People who experience diabetes can be susceptible to circulation problems in their feet and lower limbs, diabetes can also place people at greater risk of serious eye problems, such as cataracts, glaucoma, and retinopathy (a disease of the retina). Although arrangements were in place for foot and eye care to take place, it was not clearly recorded and linked to diabetic care. Recording of this day to day care would help to ensure any changes in condition were noted and acted upon.

Where people experienced epilepsy, staff knew, or health care plans explained how people may present when experiencing seizures, including possible triggers and how people preferred to be supported. Monitoring of seizures helped to inform reviews to determine how well the epilepsy was managed. Staff understood epilepsy can be different for each person, so the need for care can vary greatly and, even if people don't have seizures very often, the need for care during or after a seizure may be urgent. Although staff were knowledgeable, clearer presentation of health care plans would ensure a more consistent way of conveying information, particularly for new staff.

Staff had been provided with information about catheter care; they knew catheters presented a potential source of infection. Leaflets explained about catheter bag positioning to ensure correct drainage, frequency of emptying, attachment of larger night bags and what it could mean if blood was present in the catheter bag. Staff were aware of the correlation between urine output and colour in relation to the risks of

dehydration. However, although available, relevant information had not always been pulled together to represent an individual and encompassing health care plan.

Staff were knowledgeable. Even although health care plans were not clearly linked all of the time in relation to the above conditions, relevant information was held and staff could explain potential causes for concern and what to do should they encounter them. We recommend the service adopt a best practice ethos to ensure health care plans are individually fully completed for each person in relation to their particular condition to meet published guidelines as set out by organisations such as Diabetes UK, the Epilepsy Society and the National Institute for Health and Care Excellence (NICE).

Pre-admission assessments completed from the outset intended to ensure the service could meet people's individual needs. These formed the basis for care planning after they moved to the service and included physical health, mental health and social care needs. They were comprehensive and had been reviewed monthly or as required and were up to date. People had the opportunity to be involved in the assessment of their needs and preferences as much or as little as they wanted to be. This helped to ensure care and support was tailored to meet their needs.

Changes in health or social needs were responded to. Where weight loss was noted, action plans ensured relevant external bodies had been consulted such as GP's, a dietician and if needed, a speech and language therapist. Where advice and instruction was received from health care professionals, including District Nurses, these directions were put into practice. A visiting health care professional told us staff took on board what they said and acted accordingly. They did not raise any concerns and felt that communication within the service was good. This showed evidence of staff being responsive to the changing needs of people who lived at the home.

An activities timetable was displayed in a communal area. Some of the activities listed included quizzes, puzzles, armchair exercise, bingo and visiting musicians. We observed people engaging in seated exercise sessions and playing and playing bingo. One person living at the service organised arts and craft sessions, making cards among many other things. There was much laughter and engagement during activities and people told us they enjoyed spending time with one another and staff. However, some people commented the service could do with a quiet lounge if people preferred to sit and talk or listed to music rather than joining in with activities. Some people did not leave their rooms to join in with organised activities and staff visited these people to have one-to-one chats if they wished to try to prevent people from becoming socially isolated.

People were supported to stay in touch with family and friends. The service organised outdoor summer events held in the service and garden. People were encouraged to have visitors to stay for meals.

The service had a complaints procedure, which was available to people and visitors to see. It was also included in the information given to people and their relatives when they moved to the service. The procedure was clearly written; it contained details of different contacts and also advised people that the service would find an independent advocate if anyone needed help to complain. There was an 'open door' policy and the registered manager made themselves available to people and their relatives, this was evident during our inspection and commented upon positively by visitors we spoke with. There was a system for people to write down any concerns and staff told us how they would support people doing this if needed. Documentation showed concerns and complaints were taken seriously, investigated, and responded to in a timely way.

People were confident they could raise any concerns with the staff or the registered manager and said they

would not hesitate to complain if they needed to. At the time of the inspection, the service was not dealing with any complaints. Where lessons could be learnt from previous complaints, effective systems ensured key messages were passed on to all staff. This helped to prevent complaints from reoccurring.

Requires Improvement

Is the service well-led?

Our findings

Staff and people were positive about the management of the service, describing them as "Knowledgeable and supportive". The provider visited the service regularly, people told us they often spoke with them and they seemed interested in how they were by asking if they were happy living at the service and if any changes needed to be made.

Our previous inspection highlighted shortfalls in the service that had not been identified by monitoring systems in place. During this inspection quality checks and audit processes were more effective and further developed, however, although known, all tasks identified in quality audits as requiring improvement had not always been completed.

Examination of monitoring records, such as some diabetic blood sugar levels and records of some care and treatment provided, such as diabetic foot care, were found to be incomplete. Additionally, although individual articles of guidance was available to staff about diabetes, epilepsy and catheter care, it had not always been composed as specific health care plans as a record to support individual people requiring this care; staff were however knowledgeable about the support people required.

Records of decisions about the employment of some staff were not maintained where DBS checks had identified cautions or convictions and, although tested by the provider, fire safety checks did not record the correct operation of fire door safety guards.

The provider had not ensured systems and processes were established and operated effectively to ensure complete and contemporaneous records were kept in respect of each service user; including a record of care and treatment provided to the person and of decisions taken in relation to the care and treatment provided. The provider had not maintained other records as necessary to be kept relation to persons employed and management of the regulated activity. This is a breach of Regulation 17(1)(2)(c)(d)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and provider undertook regular checks of the service to make sure it was safe and people received the support they needed. These included areas such as infection control, medicine management, nutrition, mobility and care plan quality. In addition, audits completed by the provider helped to support governance processes and reviewed the quality of life for people, the environment they lived in, care, leadership, operational processes and systems. Where checks identified concerns, action plans, timescales and accountable staff ensured they were addressed. For example, checks had identified the need for improvement of infection control measures and some improvements to the building, contract cleaners were employed and refurbishment work undertaken to facilitate this.

Established systems sought the views of people, relatives, staff and health and social care professionals. Regular meetings and a suggestions system ensured people and their families felt involved in the service and listened to. Where people had made suggestions, these were well received and acted upon; people felt their opinions were listened to and taken into account. For example, one person, a former teacher, was

interested in providing art and craft activity sessions for people, they told us they had been given free rein to do this.

Regular meetings and surveys helped to gain people's views about what they thought of the service and their levels of satisfaction with it. People felt involved in the service and staff encouraged people's suggestions and ideas.

There was a clear staffing structure. Staff understood lines of accountability and their individual roles and responsibilities. People knew the different roles and responsibilities of staff and who was responsible for decision making. Observations of staff interactions with each other showed that staff felt comfortable with other staff of all levels and there was a good supportive relationship between them, working together to achieve good outcomes for people. For example, discussing activities, or the health of a person who was unwell and suggested actions.

Staff told us that they attended regular staff meetings and felt the culture within the service was supportive. They said they felt confident about raising any issues of concern around other staff members practice and using the whistleblowing process to do so if the need arose; they felt their confidentiality would be maintained and protected by the registered manager.

The care philosophy for the service set out the principles of providing quality care. The registered manager and provider told us that the values and commitment of the service were embedded in the expected behaviours of staff. Staff recognised and understood the values of the service and could see how their behaviour and engagement with people affected their experiences. We saw examples of staff displaying these values during our inspection, particularly in their enthusiasm toward the people they supported.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured systems were established and operated effectively to ensure complete, contemporaneous records were kept for each service user; including a record of care and treatment provided and of decisions taken in relation to care and treatment provided and other records as necessary to be kept in relation to persons employed and management of the regulated activity. Regulation 17(1)(2)(c)(d)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured recruitment processes were complete; this did not promote the principles of a robust recruitment process to protect the safety of people living at the service. Regulation 19 (1)(a)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.