Barchester Healthcare Homes Limited

Corrina Lodge

Inspection report

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Ratings

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

Overall summary

Corrina Lodge provides nursing and personal care for up to 58 people. There were 50 people living at the home at the time of the inspection who were living with a range of complex health care needs. This included people who have had a stroke, diabetes and Parkinson's disease. Some people had a degree of memory loss associated with their age and physical health conditions. Most people required a variety of help and support from staff in relation to their health, mobility and personal care needs.

Corrina Lodge is owned by Barchester Healthcare Homes Limited. Accommodation was provided over two floors with a passenger lift that provided level access to all parts of the home. People spoke well of the home and visiting relatives confirmed they felt confident leaving their loved ones in the care of staff.

There is a registered manager at the home. 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.

Summary of findings

This was an unannounced inspection, which meant the provider and staff did not know we were coming, and took place on 22 and 23 June 2015.

At the last inspection 11 June 2014 we asked the provider to make improvements in relation to the number of staff working each shift. The provider sent us an action plan stating they would have addressed all of these concerns by September 2014. At this inspection we found the provider was meeting this regulation.

Care plans were personalised however they did not always demonstrate that people were involved in their development or reviews. They did not always reflect people's individual needs. There was a busy activity programme in place but there was limited information about what people who remained in their rooms done throughout the day. This is an area that needs to be improved.

People were looked after by staff who knew them well and had a good understanding of their physical and psychological needs, their choices and preferences. Staff treated people with kindness and compassion and supported them to maintain their independence. They showed respect and maintained people's dignity.

People were involved in the day to day running of the home through regular meetings and discussions. People's opinions were valued and used to improve and develop the home.

Risk assessments were in place to keep people safe. These were used appropriately and did not prevent people who wished to, take well thought out risks as part of maintaining their independence and lifestyle.

Staff had a good understanding of safeguarding procedures and knew what actions to take if they believed people were at risk of abuse. Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They had a clear understanding of DoLS and what may constitute a deprivation of liberty.

Medicines were managed safely and staff made sure people received the medicines they required in the correct dosage at the right time.

There was enough staff to look after people. They had been safely recruited and were safe to work with people. Staff were well supported by the managers and colleagues. They received appropriate training to enable them to meet people's individual needs.

There was a busy activity programme in place. People were supported to take part and maintain their own friendships and relationships. However, there was limited evidence that people who remained in their rooms participated in any activities.

People had their nutritional needs assessed and monitored and were supported to enjoy a range of food and drink of their choice throughout the day.

There was an open culture at the home and this was promoted by the registered manager who was visible and approachable. People and staff spoke positively about him.

There was an action plan in place where the registered manager had identified areas that required improvement. This included the mealtime experience and aspects of record keeping.Summary here>

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?

Good

Corrina Lodge was safe.

Staff had a clear understanding of the procedures and their responsibilities to safeguard people from abuse.

Risk assessments were in place and these contained guidance for staff to enable people to retain their independence whilst managing risks safely.

There were enough staff on duty to meet the needs of people.

Appropriate checks where undertaken to ensure suitable staff were employed to work at the service.

Medicines were stored, administered and disposed of safely.

Is the service effective?

Good

Corrina Lodge was effective.

Staff were trained and supported to meet people's individual needs.

Staff understood their responsibility in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People received a balanced and nutritious diet.

People were supported to maintain good health and had access to on-going healthcare support.

Is the service caring?

Good

Corrina Lodge was caring.

Staff had a good understanding of people as individuals. This enabled them to provide good, person centred care.

People's privacy and dignity were respected.

People were involved in day to day decisions about their care.

Is the service responsive?

Requires Improvement

Not all aspects of Corrina Lodge were responsive.

Staff knew people well and had a good understanding of their needs and choices.

There were areas of the care documentation that did not reflect the care and support people received.

A complaints policy was in place and complaints were handled appropriately.

Summary of findings

Is the service well-led?

Good

Corrina Lodge was well-led

People were involved in the day to day running of the home, they were listened to and their opinions valued.

The registered manager was approachable and supportive and took an active role in the day to day running of the home.

There was an effective system to assess the quality of the service provided.

Corrina Lodge

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.'

This was an unannounced inspection on 22 and 23 June 2015. It was undertaken by an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority, looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home.

During the inspection we reviewed the records of the home. These included staff training records policies, audits, and four staff files along with information in regards to the upkeep of the premises. We also looked at five care plans and risk assessments along with other relevant documentation to support our findings. During the inspection, we spoke with 14 people who lived at the home, five visitors, 12 staff members including the registered manager and regional director and three healthcare professionals including a GP and community matron. Following our inspection we spoke with three further healthcare professionals including a falls prevention specialist nurse.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "The staff here make me feel safe." A visitor to the home told us there was, "A feeling of safety and security both in the environment and with the staff as well." People told us there were enough staff to look after them. One person said, "There were always staff available if they were needed." People told us they got their medicines when they needed them,

At the last inspection on 11 June 2014 we asked the provider to make improvements in relation to enough staff to meet people's needs. The provider sent us an action plan stating this would be addressed by September 2014. At this inspection we found there were enough staff to meet people's needs.

The registered manager told us a dependency tool had been introduced by the provider. A dependency tool analyses the assessed needs of people and the number of people who require care and it can take into account other factors for example the environment. Using this information it can calculate how many staff are required to meet people's needs. We saw the provider had taken into account previous concerns identified at the home, which included a reliance on agency staff, to calculate staffing levels.

The registered manager told us there had been active recruitment at the home and all care posts had now been filled. There was however still a reliance on agency nurses, these posts had been recruited to and staff were due to commence a period of induction shortly. As far as possible, regular agency nurses worked when required to ensure people were supported by staff who were familiar to them and aware of their needs. In addition to the nurses and care staff, there was a housekeeper for each floor, laundry staff, maintenance staff, three administrators, one of who worked as a receptionist and three activity co-ordinators. Staffing rotas were on display in the reception area so people and visitors were able to see who was working each day.

We observed the nurses and care staff were busy throughout the day. However, they told us there was enough staff to provide care to people in the way they wanted it delivered. Staff were observed talking to people while they supported them and attending to them in an unhurried manner. One member of staff said, "We're very busy in the morning, but there is enough of us, we work as a team."

Staff recruitment records showed appropriate checks were undertaken before staff began work. This ensured as far as possible only suitable people worked at the home. Staff files showed there was appropriate recruitment and appointment information. This included application forms and interview notes, confirmation of identity, references and police checks. There were systems in place to ensure staff working as registered nurses had a current registration with nursing midwifery council (NMC) which confirms their right to practice as a registered nurse.

Staff received training in relation to safeguarding and had recently training related to the duty of candour. The duty of candour is a legal duty on providers to inform and apologise to people if there have been mistakes in their care that have led to significant harm. It aims to ensure people receive accurate, truthful information from providers.

Staff had a clear understanding of safeguarding and duty of candour. They knew what constituted abuse and what actions they would take if they believed someone was at risk. Although staff told us they would usually report any concerns to the registered manager or senior person on duty, they were aware of their own responsibilities in ensuring concerns were reported appropriately. They told us how they would report concerns outside of the organisation, when they would do this and the importance of openness and honesty when concerns were identified. One staff member said, "It's up to me to report, to make sure it's been reported properly."

Safeguarding information was on display in the corridors, in addition to reminding staff it also informed people about the level of care and support they should expect and what to do if they were concerned. Information also included a confidential whistleblowing telephone number for staff to use if they identified any concerns.

Risk assessments were in place for people, these were regularly reviewed. Risk assessments included mobility, falls and nutrition and provided information for staff on how to manage the identified risks. Assessments identified the risk and the plan contained information about how to minimise the risk whilst maintaining the person's

Good

Is the service safe?

independence. One person had been identified as requiring a specialist diet which they did not wish to follow. Staff told us they were aware of the risks and added, "This person is also aware of the risks, they have capacity, therefore have the right to make their own decisions about the risks they take." Information from the risk assessments were used to update the care plans and provided staff information about how to reduce risks.

The home was clean, well decorated and maintained internally. There were systems in place to deal with any foreseeable emergency. Staff had access to relevant contact numbers in the event of an emergency and knew what to do in the event of a fire. Fire procedures and risk assessments were in place along with individual evacuation plans for each person. The provider had taken steps to ensure the safety of people from unsafe premises and in response to an emergency situation. Records showed regular servicing and health and safety checks had taken place. This included safety checks on gas and electrical services, emergency lighting and fire safety.

People's medicines were managed to ensure people received them safely. Medicines were stored, administered, recorded and disposed of safely. We observed medicines being given at lunchtime; these were given safely and correctly as prescribed. Some people had been were prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain. Prior to giving these medicines the nurse asked people if they required them and recorded when these were given. There were care plans were in place which informed staff about people who required medicines for pain.

We looked at the Medicine Administration Records (MAR) charts for people who lived on the ground floor. These included a photograph of the person, their personal details including any allergies. There was guidance within the MAR files about how to administer specific medicines. For example some people had health needs which required varying doses of medicine related to regular blood test results, there was clear guidance in place for staff to follow. Other people required transdermal patches. Transdermal patches are an adhesive pad that is placed on the skin which slowly releases the medicine through the skin into the bloodstream. Occasionally the patches can cause the skin to become sore or irritated. To avoid this it is best to position the patch in a different place each time it is changed. To ensure this happened body maps were in place to show the patch had been applied to different areas of the skin.

Good

Is the service effective?

Our findings

People told us staff had appropriate training and skills to look after them. One person told us, "Staff are good and have had training to look after us." Another said, "Staff seem to know how and when help is needed and deliver it." People told us the food was good. One person said, "I have no complaints." Visitors told us the food was, "Good" and fresh fruit was always available.

Staff were aware of their roles and responsibilities and had the knowledge and skills to look after people who lived at the home. There was an effective induction programme in place which introduced staff to the running of the home, other staff and people who lived there. This took place prior to new staff delivering care to people. We saw a group of staff were receiving induction during our inspection. In addition to completing the induction, new staff had a mentor who worked with them to observe them working with people and supporting them to gain confidence. Their mentor also guided them in completing their induction booklet to demonstrate their knowledge.

Staff received ongoing training and support which provided them with the knowledge and skills to effectively support people who lived at the home. Essential training updates included fire safety, moving and handling and infection control. The registered manager used a matrix to identify staff who needed refresher training, to ensure they maintained their skills. Reminders were sent to staff with a number of available dates for them to book, further reminders were sent to staff who had not booked. Staff told us they were aware when training updates were due and their responsibilities in attending training.

Staff received training specific to meeting the needs of people who lived at the home. For example a nurse told us about training she was due to receive in relation to changing percutaneous endoscopic gastrostomy (PEG) tubes. This is a flexible feeding tube placed through the abdominal wall into the stomach and allows people who are unable to swallow to receive their nutrition and medicines directly into the stomach.

Staff received regular supervision this identified further training and development needs and individual performance plans were in place. The registered manager had identified some staff required further support to deliver effective care. Therefore a number of senior care staff and nurses had received further training in mentoring and coaching. Staff told us the training was very informative and had provided them with new ways of supporting their colleagues. One staff member said, "The mentoring is fine but coaching is a different way of supporting altogether, it's about enabling staff to solve their own problems." Another staff member said, "Once I understood coaching I realised how good it was, I can tell someone (staff) something lots of times and they don't change how they work but if I use the coaching techniques it makes them think, it makes them realise what they're doing."

The registered manager had identified a number of care staff had not undertaken further training and development such as the diploma in health and social care. This was because English was not their first language and staff did not always have the confidence or skills to undertake courses where written reports were required. The provider had developed a 'caring guru' which was a system to develop writing and language skills and staff were supported to use this. Staff told us this also helped with general communication. One staff member said, "We use caring Gurus, we also pair staff with English speaking carers, this makes communication better."

Regular staff meetings were used to support and inform staff. Minutes from a meeting in May 2015 reminded staff how to raise safeguarding concerns, and reminded staff how this related to the duty of candour. Staff were also reminded to welcome and support a number of new staff who were staring work at the home. Clinical meetings with nurses were used to highlight any training needs which may have occurred due to the complex needs of people who lived at the home.

Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They had a clear understanding of DoLS and what may constitute a deprivation of liberty. The MCA aims to protect people who lack capacity, and maximise their ability to make decisions

or participate in decision-making. The Deprivation of Liberty Safeguards concern decisions about depriving people of their liberty, so that they get the care and treatment they need, where there is no less restrictive way of achieving this. The Care Quality Commission has a legal duty to monitor

activity under DoLS. This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Providers must make an application to the local authority

when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. The provider was meeting the requirements of DoLS. The registered manager understood the principles of DoLS, how to keep people safe from being restricted unlawfully and how to make an application for consideration to deprive a person of their liberty.

Mental capacity assessments were in place in care plans viewed and where appropriate we saw records of best interest decisions. One member of staff told us about a person who remained in bed all day. They said, "We know it is in their best interests and we have applied for a DoLS authorisation." Another member of staff said, "Where people don't have mental capacity we will make decisions in their best interests." People told us they were able to make their own decisions and staff told us, "It's about what people want to do, not what we want them to do."

People were positive about the food they received. They told us they enjoyed it and were given choices at each meal. They said they could choose whether to eat in the dining room or remain in their own bedrooms. Meals were served in the dining rooms from heated trolleys. Meals were covered and taken on a tray to people who remained in their rooms. There was a hostess on each floor who was responsible for serving the meals and a selection of cold drinks or a glass of wine. The dining tables were attractively presented with cloth tablecloths and napkins and a selection of condiments. Staff told us people were able to sit where they chose however people had developed their own friendship groups and tended to remain in these groups.

People had their nutritional needs assessed and regularly reviewed. The chef, hostess and all care staff had a good understanding of people's nutritional needs, dietary preferences and choices. Meals were well presented, including soft and pureed meals, they appeared appetising and people ate well. People required varying levels of support, some were independent, some required prompting and encouraging and others required a higher degree of support, this was provided appropriately. Staff engaged with people when they were supporting them.

Lunchtime appeared to be a sociable occasion with people and staff chatting to each other. However, it had been identified on the ground floor people were receiving different mealtime experiences. Some people wanted everybody to eat together and other people liked to eat their meal and leave and a number of people required support to eat their meals which meant the mealtime appeared disorganised at times. The registered manager was aware of this and was looking at different ways of addressing it. For example on one day of the inspection the activity co-ordinator was supporting people at mealtimes. The registered manager told us it was important to determine a mealtime experience that met people's individual needs and this would take time.

Where people were at risk of not eating or drinking enough or required their dietary intake to be monitored for health reasons we saw appropriate records were in place. Some people required high calorie diets and the chef was currently working to assess the calorific values of foods to ensure people received adequate amounts to meet their individual needs.

People were offered a range of hot and cold drinks and snacks throughout the day. There was a café available to people in the reception area where they could access drinks and snacks whenever they chose with support of staff if required.

Communication was seen as an effective tool in ensuring staff were kept up to date with changes in people's needs. Daily handover meetings allowed all staff to raise concerns about people's health or well-being, their mood or any information of concern. Where concerns had been identified referrals to healthcare professionals such as mental health, diabetic nurse or Parkinson's nurse were made in a timely manner. The clinical lead nurse told us about actions taken to ensure one person with complex health needs had their treatment reviewed by an appropriate external healthcare professional.

Healthcare professionals told us there had been an improvement in the clinical skills and knowledge at the home since the appointment of more nurses. This had led to a reduction in the amount of unnecessary hospital admissions and GP visits. A local GP visited the home weekly to discuss any healthcare concerns with staff and people. A community matron visited the home fortnightly to identify any specific clinical needs staff may require support with. For example it had been identified a number

Good

Is the service effective?

of people had developed urine infections therefore the community matron had worked with the registered manager and nurses to reduce this. This had been achieved through supporting staff to identify signs and symptoms and measures to prevent further infection.

Good

Is the service caring?

Our findings

People told us the staff were caring, they treated them with dignity and respect. They told us they were looked after in the way they wished to be. One person said "Just everything is done," another said, "I have only got to call my carer if I need anything." We were also told, "Staff have enough time to talk to me and they show me respect." Visitors were made welcome when they visited the home. One visitor said, "I think they (staff) are great, patient and caring." Another told us their loved one was always treated with kindness and respect. A member of staff said, "We are not perfect but we are like a family, that's what makes our care team excellent."

People were seen in their own bedrooms, lounges, dining rooms, garden and corridors. We observed positive interactions and conversations between staff and people. Staff stopped to talk with people when going about their day to day work, asking them if they were ok or where they were going, for example to the garden or activities. When people were looking unsure staff stopped to ask if they needed any assistance. They spoke with people discreetly and sensitively making eye to eye contact, using their preferred name and taking time to listen to them ensuring they gave people enough time to respond. One person had been away on holiday, we observed staff stopping and asking if they had enjoyed themselves and updating them about things that had happened at the home in their absence.

Staff were able to tell us about people's choices, personal histories and interests. They told us how they communicated with and understood the needs of people who were less able to express themselves. When people required support this was provided with care and compassion and staff ensured people received the care they wanted in a way they wanted. One staff member said, "We give person-centred care, it's about what people want not what we think they should have."

People were involved in decisions about their day to day care and support. People were able to spend their day as they chose. People spent their day in the lounge or in their bedrooms we saw staff checked on them regularly ensuring they did not require support or company. We saw staff asking people if they would like to take part in activities or sit outside in the garden. One person told us about their daily routine and how they decided what to do. Another person told us, "Sometimes I like to stay in my room, other times I like to join in with things, I decide, staff offer but I decide."

When staff provided personal care to people we saw bedroom doors were closed and a notice was hung on the door to inform others the person was receiving care and not to enter. Staff told us they helped people maintain their dignity by making sure doors and curtains were closed and people were kept covered when personal care was being delivered. One staff member said, "I reassure people as well, I tell them what I'm doing." Another staff member told us they maintained people's dignity by, "Making sure they have the care they need."

People were dressed in clothes of their own choice which were well presented. Staff supported the choice of clothes people made. One person told us how staff had helped her put together the outfit she was wearing. People were encourage to make their bedrooms their own, their rooms were personalised with their belongings and memorabilia such as photographs and other items that were important to them.

The registered manager had developed a card which staff carried with them and a larger copy was on display in the communal areas. It reminded staff of their caring responsibilities in relation to safeguarding people, supporting them to make decisions and being open and honest with people. It also asked them to think, before they left at the end of each shift, "Would you leave your mother at Corrina Lodge." From our observations and discussions with staff we saw these principles were embedded into their everyday practice.

Requires Improvement

Is the service responsive?

Our findings

People told us they were able to do what they liked during the day. One person said, "We can get up and go to bed when we like." Another person said, "I can go wherever I want to, I don't go out but I enjoy the activities." People were treated as individuals and care and support was personalised to their needs and wishes. One person told us they did not like taking part in activities but knew they were on and could join in if they chose.

Staff knew people well and had a good understanding of their needs and choices. The registered manager showed a real commitment to providing individualised care and talked about how care was personalised to each person. For example when staff asked if a person could undertake a certain activity, stay in bed, eat at a different time etc. his response would be, "Does the person have capacity to make that choice, if they do it's their home, they can do what they like."

Staff knew people well but care plans did not always reflect the individualised care and support staff provided to people. Although the care plans provided detailed guidance for staff to support people, there was so much information it was not easy to find the pertinent information to identify the actions required to meet people's needs. Some guidance was not clear. For example some people were unable to use their call bell and the care plan advised staff to check people 'regularly' but did not inform staff how often. There was guidance in the care plans about what medication people required for pain however this information was not in the MAR charts. There was a current reliance on agency nurses at the home and this did not provide clear guidance for staff to ensure consistency or demonstrate evidence that people's needs were met.

There were daily charts in people's bedrooms which staff completed when they delivered care or undertook regular checks. There was no information on the charts to inform staff how often these checks should take place. Some people had pressure relieving air mattresses in place, these were specifically set to ensure optimum benefit in the prevention of pressure sores. Staff were required to check these were set correctly each time they delivered care. However, not all settings were recorded in the daily charts.

Although staff knew people well not all guidance in place to demonstrate people's care needs had been met or ensured consistency. We discussed our findings with the registered manager as an area for improvement.

The registered manager had reviewed some areas already and was aware of other issues to address. Care plans were regularly reviewed. They were personalised for each person however, they did not demonstrate that people had been involved in their development and review. Daily records recorded what care people had received during the day for example personal hygiene but it did not include how their needs had been met. For example did they have a bath or shower or was it a wash in bed. There was no information about people's moods, whether they had enjoyed their day or for example enjoyed their meals. Work was in progress to address these shortfalls.

There was a vibrant activity programme in place and people who were able were observed taking part and enjoying themselves. One visitor told us activities were changed to suit people and people were encouraged to follow their hobbies. However, we did not observe this in relation to people who were less able to participate or did not leave their rooms. There was limited information about what activities they were offered and took part in or what they did each day. The registered manager was aware of this and there was an action plan in place which was working towards ensuring everybody received at least ten minutes of one-to-one time each day.

Staff told us about specific interests of one person, they told us how they used this information to talk with them. There was no information about this person's hobbies or interests and no evidence staff had used their knowledge to develop specific activities this person may enjoy. We saw another person was read to as a one-to-one activity. There was no information to suggest this was something the person wanted to do or enjoyed. Records showed when people had taken part in an activity but they did not reflect if people had enjoyed themselves or actively participated. When people moved into the home there was information about their social needs including their hobbies and interests. There was no evidence these had been reviewed or updated when staff got to know people better. We discussed this with the registered manager as an area for improvement.

Before people moved into the home the registered manager carried out an assessment to make sure they

Requires Improvement

Is the service responsive?

could provide them with the care and support they needed. The registered manager told us people would only be admitted to the home if he was sure their needs could be fully met. We were told about a recent assessment for a person with complex care needs. Following the assessment the registered manager had discussed the person's needs with nurses and care staff to identify whether they could provide the appropriate care. As a result of the discussion the person was not admitted because staff recognised they would not be able to provide the care this person needed.

People were supported to maintain relationships with people who were important to them. We observed people visiting throughout the day. Visitors told us they were always welcome at the home. They told us they were able to visit whenever they wished.

There was a complaints procedure in place and there was a copy of this in each person's room within a folder. People told us they did not have any complaints at the time but if they did they would be happy to raise them with the manager and know they would be addressed. We saw evidence that complaints which had occurred had been responded to appropriately.

Good

Is the service well-led?

Our findings

People told us they liked the registered manager and he was available and approachable. One person told us, “He seems to be in control here and if I have had problems someone comes to see me and see if there is anything I need.” Other people said, “The manager is a sincere person, I think he is doing a good job,” and, “The manager, he is lovely.” Visitors told us they thought the home was well run. One said, “The manager is approachable, things certainly seem to run well.”

Staff told us the registered manager was supportive and they were able to discuss any concerns with him. One staff member said, “If we have any concerns the manager has an open door policy and he actually listens to us.”

We observed an open an inclusive atmosphere at the home. People, relatives and staff were involved in the development of the home through regular meetings and discussions and were regularly asked for their feedback. Resident meetings were held throughout the year. These provided people with the opportunity to discuss any concerns, queries or make any suggestion. People had been involved in interviewing new staff. To ensure people who did not wish to participate in the interview process when prospective staff attended for an interview they spent time in the reception area so people who wished to could talk with them in an informal way. The registered manager had also involved relatives and visitors in observational audits of the home in which they spent periods of time observing care and interactions in communal areas of the home to identify areas of good practice and those that may require improvement.

Minutes from the last meeting in May 2015 were seen confirmed food, activities and care was discussed. Satisfaction surveys were also distributed to people and their relatives to obtain their feedback on the running of the home. There was an action plan in place to address issues from the survey, for example people were not satisfied with the laundry service and changes had been made in relation to labelling. Laundry staff proudly told us, “The laundry had not been brought up at the three latest residents meeting, so things must be better.”

The registered manager had a good knowledge of the day to day running of the home. He knew people and staff well manager was seen as approachable and supportive, taking an active role in the running of the home. By working with staff and engaging with people and staff regularly he had a good understanding to the day to day culture within the home and was clearly passionate about providing a home where people wanted to live their lives as they chose with the support they needed. People and staff appeared very comfortable and relaxed with him.

There was a clear management structure in place. Staff members were aware of the line of accountability and who to contact in the event of any emergency or concerns. Staff said they felt well supported within their roles and described an ‘open door’ management approach. They told us the registered manager was, “Always looking at ways of improving things.”

There were regular staff meetings where staff were updated about changes at the home, reminded of their roles and responsibilities, and training updates. The registered manager had daily meetings with the heads of each department to identify and discuss any concerns. For example any new person moving into the home, change in clinical needs or maintenance issues. The nurse responsible for each floor completed a daily report which updated the registered manager about people’s needs and demonstrated the nurses had a good knowledge of people they were looking after.

There were regular provider and local audits in place. These included medicines, care plans, nutritional risks and training. Where concerns or shortfalls were identified an action management plan was in place to address them. This included for example shortfalls in documentation and where people had not been involved in their care plan reviews. There were also targets for the home to address this included unplanned hospital admissions and reducing the number of people at high risk of malnutrition. From the feedback we received we saw improvements had been made. If other concerns arose for example in relation to the mealtime experience this was included on the action management plan with timescales to address the problems.

The registered manager involved all staff in understanding the needs for improvements. Where people were at high risk of malnutrition the chef was working to determine how many calories people at risk ate. This would enable staff to provide people with appropriate foods to improve their

Good

Is the service well-led?

well-being. All nurses and care staff were involved in supporting people to drink more fluids and monitoring general health to prevent hospital admissions from urinary tract infections.

When actions had not been met the registered manager identified why this may be and looked at other ways of addressing the concern. People had charts in their rooms which staff completed these included what people had to drink or when their position had been changed. At the end of each shift the nurse in charge of each floor was responsible for checking the chart had been completed and they would sign to demonstrate this had been done. Staff had been reminded about their responsibilities but forms were not always checked or signed. The registered manager identified this happened when agency nurses were working. Whilst agency staff were reminded of their responsibilities the registered manager took responsibility for checking and completing the charts each shift to ensure people did not receive inadequate care which could impact on their health and well-being.

There was a current reliance on agency nurses and a previous reliance on agency for care staff. The registered manager identified that once staff had been recruited they left within six months. To address this a mentorship programme had been introduced where new staff were allocated a mentor to work with them and support them. Staff who were working as mentors had undertaken coaching and mentorship training to ensure they had appropriate skills in place. Staff were reminded to welcome new staff when they started work and to offer them ongoing support.

A new induction programme had been introduced for nurses starting work at the home to ensure they had sufficient skills, knowledge and confidence. This included a mentor and regular written reports to the registered manager to demonstrate their learning and understanding of working and looking after people at Corrina Lodge. The registered manager told us this would highlight areas where nurses required more support in clinical and written skills.

The home maintained and was developing new links with the local community. Volunteers regularly attended the home, providing interaction for people and supporting with tasks around the home.