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

Overall summary

We undertook an unannounced inspection of this service on 17 and 18 June 2015. This service provides accommodation and personal care for up to older 20 people. There were 19 people living at the home at the time of our inspection. The home is arranged over three floors, most people had their own bedroom although one room was shared by a married couple. Access to the first floor is gained by a lift and by a stair lift, making all areas of the home accessible to people.

This service had a registered manager in post. They were also the registered manager of another home owned by the same provider. They split their time between the two homes, spending mornings at one and afternoons at the other. A registered manager is a person who is 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

We last inspected the home in January 2014. We found the provider was in breach of regulations about the how they assessed and monitored the quality of service they provided. The provider sent us an action plan telling us what improvements they had made. We reviewed this information and completed a desk top review in February 2014 and found the home to be compliant.

The home was not adequately cleaned or suitably maintained; there were areas that were unhygienic and broken tiles that presented a risk of injury. Equipment, intended to support people, had not been checked or certified as fit and safe to use for two years, putting people's safety at risk. Safety features to prevent the risk of people falling from windows were disconnected and a fire exit was bolted shut. The safety test certificate for the electrical instillation at the home had expired and no processes were in place to safely manage water to safeguard people against the risks of legionella.

Some risk assessments did not identify when people's condition deteriorated. This did not support early interventions or provide a suitably robust and preventative system so people remained safe and in good health. Reviews of incidents and accidents did not result in action for staff to take to try to prevent people being at risk again.

People told us they received their medicines safely and when they should. However we found shortfalls in some records in recording and storage of some medicines.

Shortage of staff impacted on the quality of care some people received and the arrangement of some activities reflected staff availability, rather than being planned to meet people's needs. Elements of care planning were not person centred to reflect differences in people's individual needs.

The quality assurance framework was not effective to drive the improvement in services people received; many of the highlighted shortfalls had not been identified by audit and monitoring systems in place. Known concerns about staff shortage had not been acted upon and there was no management plan or action to address other known concerns.

Some records at the home were contradictory about the support people needed and some support plans did not contain the level of detail needed in order to ensure staff supported people consistently. Accurate records about people's support were not always completed and maintained.

Most risks associated with people's care and support were assessed and people were encouraged to be involved in planning their care. People told us staff acted with their consent and felt that they were treated respectfully and that their privacy and dignity were promoted.

People were able to choose their food at each meal time, snacks and drinks were always available. The food was home-cooked, including some homemade cakes, biscuits and desserts. People enjoyed their meals, describing them as "Very good" and "Marvellous".

Staff understood how to protect people from the risk of abuse and the action they needed to take to alert managers or authorities if they suspected abuse to ensure people were safe.

Robust recruitment processes were in place. New staff underwent a current induction programme and there was a continuous staff training programme for all staff. Most care staff had completed formal qualifications in health and social care or were in the process of studying for these.

Staff were clear about the aims of the home and worked towards its vision and values. They recognised their own roles as important in the whole staff team and there was good team work throughout the inspection.

Staff showed respect and valued one another as well as people. Staff dedicated some of their own free time to support people with activities because they felt there were not enough staff employed to enhance people's quality of life. The home benefitted from the support of some voluntary workers.

We found a number 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.

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?

Inadequate

The service was not safe.

The service was not safely maintained or appropriately cleaned. Servicing and safety checks of equipment had lapsed, safety features were disabled and a fire exit was bolted shut.

Some risk assessments lacked guidance and systems of prevention to ensure that identified risks were managed safely. 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.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were given training to meet some specific needs of the people they supported; however, staff knowledge and practice did not provide effective support for people at risk of dehydration.

Staff were provided with opportunities to meet with their supervisor or manager to discuss their work performance, training and development.

New staff received an induction and had access to a rolling programme of essential training.

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

People enjoyed the food they ate and were consulted about their preferences.

Is the service caring?

Good

The service was caring.

People spoke positively of the care they received and people were treated with dignity and respect. Staff adopted an inclusive, kind and caring approach.

People were relaxed in the company of staff and people were listened to by staff who acted on what they said.

Relatives and people's friends told us they were made to feel welcome when they visited the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care planning was not always person centred and meaningfully individual.

Summary of findings

Activities reflected staff availability rather than being planned to meet people's needs.

A complaints procedure was in place, people and visitors told us they had not needed to complain.

Is the service well-led?

Requires Improvement

The service was not well led

Quality assurance process did not allow effective management and oversight of the home.

There was no record of action taken to address known concerns or a plan to bring about and sustain change.

Some records were contradictory and lacked required detail.

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

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 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.

We undertook an unannounced inspection of this service on 17 and 18 June 2015. The inspection was undertaken by two inspectors.

We focused on speaking with people who lived in the home, speaking with staff and observing how people were cared for and interacted with by staff. We looked in detail at care plans and examined records which related to the running of the service. We looked at five 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 home was managed such as audits, policies and risk assessments. We also pathway tracked some people living at the home. This is when we look at care documentation in depth and obtain people's views on their day to day lives at the home. 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 home including bedrooms, bathrooms, the lounge and dining room as well as the kitchen and laundry area. During our inspection we spoke with 10 people who live at the home, five visitors, four care staff, the home's cook and the registered manager. We also spoke with one health care professional who visited the home.

We reviewed the information we held about the service. We considered information which had been shared with us by the local authority, members of the public, relatives and healthcare professionals such as a social worker. 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.

Inadequate

Is the service safe?

Our findings

People said that they felt safe in the home. Some of their comments included, "I feel safe", "It's nice and the staff are nice" and "Everything is fine, I have had no reason other than to think of this as a safe place to be and I am very happy to be here". Visitors were equally positive, telling us, "I have been impressed by the home; I have no concerns about the safety of the home."

Although people told us they felt safe living at Cornerways and relatives said they did not have any concerns about the safety or welfare of their family members, we found the service was not safe.

People were at risk of contracting acquired infections because the service was not clean or hygienic. One bath chair had an accumulation of soap scale; toilet bowls, taps in bathrooms and at people's bedroom sinks were lime scaled, which had built up over time. Areas behind toilets were dirty and faeces was present on one toilet wall. Flooring coverings in bathroom and some ensuite areas was not well sealed and would not allow for adequate cleaning. A wooden toilet plinth, toilet seat and various other bare wooden surfaces around the home, such as doors and radiator covers, were difficult to clean because they had not been sealed. Bins used for dirty waste were not foot operated and did not meet prevention and control of infection guidance. Daily and deep cleaning schedules were in place and had been completed; however, the concerns identified during the inspection demonstrated that cleaning and infection control efforts and management were not adequate to ensure people lived in a clean and hygienic home.

People were at risk of accident and injury as equipment used by staff to assist people to move such as a standing aid, an electrically operated bath chair and a manual bath chair were not subject to maintenance arrangements and therefore could not be guaranteed to be safe. The maintenance contract for six monthly safety and maintenance checks had not been renewed and, although reinstated during the inspection, the equipment had not been serviced or certified as safe and fit for use since May 2013. The frame of the manual bath chair was rusted and some other equipment such as toilet frames, raised toilet seats brackets and toilet hand rails were similarly rusted which makes these difficult to keep clean and is an infection control risk. The deterioration of equipment and consideration of its continued suitability and safety had not been identified in management environmental audits of the home. People were not protected from the risks associated with equipment that was untested and not maintained.

A maintenance book enabled staff to report any items requiring repair. However, inspection of the home found a broken staircase spindle and broken tiles in two bathrooms had not been reported. Some of the broken tiles were at elbow height and if people sat in the manual bath chair, sharp edges presented a risk of injury. The registered manager could not confirm if the provider held a schedule of planned maintenance to address ongoing maintenance requirements, such as the external decoration of the home. Systems intended to ensure the home was safe and routinely maintained were not effective.

People were at risk of significant injuries as safety features, such as restrictors intended to limit the opening of windows were routinely disconnected by staff to air rooms. This defeated the purpose of the restrictors and introduced a risk of people falling from unguarded windows. Fire exits from the building were alarmed to alert staff to their use. However, were found one fire exit was bolted closed, potentially impeding people's safe exit from the home in an emergency.

There was no current Periodic Electrical Installation Test Certificate, to determine if the electrical wiring in the home met with relevant safety regulations. A certificate forwarded by the provider and dated after the inspection confirmed safety testing had lapsed because a current certificate was not in place at the time of the inspection.

Appropriate systems were not in place for the management of water to safeguard people against the risks of legionella, a water borne bacteria. Although a policy had been developed, the registered manager confirmed that no checks or preventative measures took place. Water temperature checks were recorded to safeguard people against the risks of scalding. When temperatures exceeded a safe temperature range, the deputy manager told us temperatures were immediately rectified, however, no evidence of this or revised temperatures were recorded, to ensure people were safe.

The provider had failed to ensure that the home was suitably clean, hygienic and services and equipment at the home were checked when needed to help keep people

Is the service safe?

safe. Maintenance systems were ineffective. Disabled window restrictors and an impeded fire exit compromised people's safety. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of receiving poor care which impacted on their health. Risk assessments, although in place, lacked detail and guidance for staff to follow to ensure that identified risks were managed safely, reflected people's changing needs or always recorded the measures required to keep people safe. For example, the service had identified that some people were currently at risk of dehydration. The registered manager told us about two other people, including one person admitted to hospital and another reassessed as requiring nursing care, where there had also been concerns about dehydration. Risk assessments advised staff to promote hydration; however, there was no guidance or mechanism in place to direct the staff or make sure this took place. Discussion with staff did not show that they had a common understanding about how much fluid people should be encouraged to drink, there was no guidance about target amounts of fluid to be consumed or a method to record how much people had drunk. Hydration risk assessments did not give staff guidance about deterioration indicators to look out for that may signal the onset of dehydration. The risk of dehydration in older people is well known and can lead to complex health problems. During our inspection, a visiting health care professional advised the staff that the person they had attended to was dehydrated. Risk assessments and measures in place did not allow staff to recognise these signs, to monitor people's hydration or to take early action to prevent deterioration. On the second day of our inspection the registered manager showed us fluid monitoring records and told us about the protocols they intended to put in place immediately.

People were at risk of continuing injury and poor health because investigations of accidents and incidents by the registered manager did not reflect learning to minimise the risk to people of incidents happening again. For example, where a person had fallen, their falls risk assessment had not been subsequently reviewed to consider preventative measures such as a referral to a falls clinic or occupational therapist. Similarly, potential causes such as dehydration, a urinary tract infection or physical factors within the person's living environment were not investigated. People were not protected against the reoccurrence of accidents or incidents because the systems in place did not promote this. The registered manager recognised this shortfall when pointed out and undertook to review their procedures.

We assessed the procedures for the ordering, receipt, storage, administration, recording and disposal of medicines. We identified two administration errors, one medicine had not been signed as administered so we were unable to ascertain if the person had received their medicine and witness signatures for the administration of a controlled drug were signed against an unrelated medicine. We found storage temperatures for some medicines were not recorded as required, to ensure the medicine remained fit for use.

Risk assessments and guidance were not sufficient to protect people from foreseeable risk. Systems intended to allow oversight of incidents or accidents were ineffective because they did not enable the staff to do all that was reasonably practicable to ensure care and treatment was provided in a safe way and reduce identified risks. Administration of medicines was not always suitably recorded and medicines were not always suitably stored. This failure was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us staffing levels were determined according to the dependency levels of people, although no specific dependency tool was used. There were 19 people living at the home at the time of our inspection. Day shifts ran from 8am to 8pm and consisted of two care staff. Night cover, from 8pm to 8am, was provided by two wake night staff. When not at the service, the registered manager provided on call support. Cleaning, cooking and maintenance were provided by ancillary staff. Staff told us and the registered manager confirmed that work could feel hectic at certain times of the day, particularly in the mornings between 8am and 10am. One member of staff commented, "We cope, we explain to other residents when we are busy and if things will be late." Another staff member told us, "Mornings can be busy. Between 10.30am and 11.30am we can sit with residents, but we couldn't take them out as only one person would be left at the home." People commented, "I would like to go out more; I don't go out alone in case I fall." Minutes from a residents meeting in August 2014 recorded one person asked "If night staff could have an extra member of staff as

Inadequate

Is the service safe?

it does get quite busy in the morning with residents." Feedback from a resident survey completed in March 2015 contained comments such as, 'I would like more communication on a one to one basis' and 'Staff need more time to listen as they seem to be in a rush.' This indicated that some people experienced delays in receiving support. People were told the provider was looking into this. The registered manager acknowledged that aspects of staffing were of concern and, although these concerns had been raised with the provider, no decision about employing additional staff had been made.

Staff, the registered manager and people at the service raised concerns that staff availability impacted on the delivery care and support. Known staffing concerns had not been addressed. The service had not ensured there were, at all times, sufficient numbers of staff to meet the needs of the people. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment practices were robust. Required checks were completed before new staff started work to safeguard people. Proof of identity had been obtained and files contained evidence that disclosure and barring service (DBS) checks had been carried out. These checks help employers make safer recruitment decisions. Application forms had been completed, two references had been received in each case and, where needed, permits to work in the UK were held. This helped to ensure people were protected by safe recruitment procedures because required processes had taken place.

Discussion with staff showed that they understood about keeping people safe from harm and protecting them from abuse. Staff had received training in safeguarding adults. They were able to describe different types of abuse and knew the procedures in place to report any suspicions of abuse or allegations. There was a clear safeguarding and whistle blowing policy which staff knew how to locate. Staff were familiar with the process to follow if any abuse was suspected; they had access to Kent and Medway safeguarding protocols and how to contact Kent County Council safeguarding team to report or discusses any concerns.

Current gas safety and portable electrical appliances test certificates were in place and fire alarm and fire fighting equipment were regularly maintained to help keep people safe. Tests and checks of the alarm and emergency lighting were carried out weekly to ensure equipment was in working order, including a visual alarm for a person who had experienced loss of hearing. Fire drills were held regularly to ensure staff were familiar with actions to keep people safe in the event of an emergency. Staff were provided with information about actions to take in an emergency. Each person had a personal emergency evacuation plan detailing the support they needed to evacuate the building safely. Staff were aware of assembly points and the registered manager was clear where people would be taken to as a place of safety, if the home need to be evacuated. The service had 'grab files' in place for each person to communicate essential information in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

People and visitors told us they thought staff were well trained and cared for people well. Some of their comments included, "They look after us so well" and "The staff are hard working." People and their relatives said that staff communicated with them well. A visitor commented, "Staff are always welcoming, and are good at keeping me updated about how [relative's name] is."

Although people commented positively, we found aspects of the service were not always effective. Staff did not have sufficient knowledge or benefit from best practice procedures to ensure some people's health needs were always recognised and followed up appropriately. This meant that 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. Records showed on three occasions, staff were told by healthcare professionals that people were dehydrated; this was despite their hydration being monitored and promoted by staff at the service. Staff did not demonstrate a practical understanding of how to recognise and respond to these needs to ensure that people always received effective care and support. We have identified this as an area that requires improvement.

Otherwise, people's records showed evidence of regular health appointments and contacts with health professionals for example; community, diabetic and warfarin nurses, dentists, chiropodists and a dietician to ensure people's overall health and wellbeing were maintained. Records showed health professionals were contacted to give treatment as needed. Staff were familiar with medical advice about how to support people and we saw that the advice received was effectively put into practice. Where people had specific communication difficulties, such as loss of hearing, staff showed awareness of people's needs and wrote down messages if they could not otherwise be understood.

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. We saw that a volunteer member of staff who helped with activities had received appropriate training for their role.

Training records and certificates confirmed the training undertaken. 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 awareness and diabetes and insulin training. 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 these are work based awards that are achieved through assessment and training, and show that staff have the ability to carry out their job to the required standard. Most care staff had undertaken this. A visiting health care professional told us they felt communication was good within the home and they did not have any concerns about the training of staff.

All staff received regular individual supervisions and an annual appraisal; these were scheduled in advance and recorded when complete. Staff supervision was a one to one meeting with their manager. Staff told us supervisions were usually 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 manager to maintain oversight and understanding of the performance of all staff to ensure competence was maintained. We saw,

Is the service effective?

where needed, supervision processes linked to disciplinary procedures to address areas of poor practice, performance or attendance. This helped to ensure clear communication and expectations between managers and staff.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

DoLS form part of the Mental Capacity Act (MCA) 2005. It aims to make sure that 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. The registered manager confirmed that people were not restricted from leaving the home and were able to consent to their care and treatment; therefore DoLS authorisations had not been required. 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.

People received a wide variety of homemade meals, fresh fruit and vegetables were available every day. Home baked cakes, biscuits and desserts were also particular favourites. People were provided with menu choices and said the food was very good. Some comments included, "The food is very good and there is plenty of it", and "The food is first class, it's excellent." One person told us if they did not like the menu choices for the day "I can ask for something else, it's never a problem." A menu planner showed lunch and supper time meals and choices of desserts. There was a wide selection of breakfast choices, including a cooked breakfast and snacks were available at any time. Mid-morning and mid-afternoon drinks were served with a choice of home-made biscuits or cakes. The food served was well presented, looked appetising and was plentiful. 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.

People's weights were recorded when they moved to the home and then monthly. Any significant weight gains or losses were reported to the registered manager and GP referrals made. Each person had a nutritional assessment, showing any concerns about weight and any specific dietary needs. This was used to inform any specific dietary requirements, such as fortified meals or meals with lower sugar content. The chefs were familiar with people's different diets, and regularly discussed the meals and the food with people, so that they were aware of people's preferences.

Good

Is the service caring?

Our findings

People told us "I am comfortable and happy living here," and "It's all very good, they are very good to me". One visitor told us, "The home is always welcoming and staff are friendly." Another visitor comment included, "You always feel the staff care," and "It is a caring atmosphere and welcoming home."

People were cared for in a kind and compassionate way. They felt valued and respected as individuals and said they were happy and content in the home. They were able to move around the home and sit where they wanted to. Several people told us they had made friends since moving to the home and spent time chatting together. Staff ensured people's privacy and dignity was maintained, by carrying out personal care discreetly in people's own rooms or bathrooms. They knocked on doors and waited for a response before going in, showing their respect for people's private space. People were addressed by their chosen name and told us they got up and went to bed at the times they wished.

During the inspection staff talked about and treated people in a respectful manner. Staff knew people well; they treated them equally but as individuals. People felt staff understood their specific needs. Staff spoke affectionately about the people they cared for and were able to tell us about specific individual needs and provide us with a good background about people's lives prior to living at the home; including what was important to people. Staff also gave examples of what might make a person distressed and what support they would give to relieve this. People's rooms were personalised with their own possessions according to their choice, so that they could have their own things around them. We saw a lot of interaction between staff and the people they supported was light hearted, warm and friendly.

Staff were patient and sensitive when giving information to people and explaining their support. We observed staff making sure people understood what care and treatment was going to be delivered before commencing a task. For example, when giving medicine staff explained what the medicine was and checked if people wanted to have it.

They asked people whether they were experiencing pain and offered pain relief where people wanted this. There was a calm and supportive atmosphere throughout mealtimes to ensure that people didn't feel rushed and were able to eat and drink what they wanted to. Staff checked if people had enjoyed their meal and asked regularly whether there was anything else they wanted.

Throughout our inspection we saw that staff communicated well with people. Staff were mindful that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made. For example, one person wanted to remain in their bedroom for most of the day. Staff ensured they were in a safe environment and we saw they made visits to them during the day.

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 us positive comments about how well staff communicated with them, telling us staff always contacted them if they had any concerns about their family members. 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 happened.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care were supported by staff and the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Staff told us that they enjoyed their work and felt this was demonstrated in the support they provided. A number of staff told us and people confirmed that they often came to the home in their own time to support people to go into the town and be there for company. Staff interacted in a sensitive way which people responded to. One person confirmed this, commenting, "'They look after me very well, everyone is so kind and they are always cheerful".

Requires Improvement

Is the service responsive?

Our findings

People told us they felt staff supported them and responded to their needs, they said they were asked about their interests and preferences and were offered choice in all parts of their care. One person told us, "I get offered choices and can decide my own routine." Another person commented, "I like to stay in my room, I'm happy in my own company, the staff do respect that." Throughout our inspection people were cared for and supported in line with their individual wishes. However, we found some elements of care plans were not person centred. In addition, some people told us although they enjoyed the activities provided, "The afternoons drag on when nothing's happening" and "I'd prefer more to do, it's not the same sitting about indoors. The girls (staff) do try really hard, but sometimes it can get me down."

Pre-admission assessments ensured that the home would be able to meet people's individual needs. These included all aspects of their care, and formed the basis for care planning after they moved to the home. Each person had a care plan. Their physical health, mental health and social care needs were assessed and care plans developed to meet those needs. Care plans included information about people's next of kin, medication, dietary needs and health care needs. However, we found that some aspects of care planning were not sufficiently developed or adequately detailed to be individually meaningful. For example, continence support plans advised staff to promote continence. They were not personalised specifically for the people they were intended to support, they did not indicate people's daily routines, their preferences for support or the extent to which people may wish to manage their continence themselves. The support plans did not indicate the degree of incontinence or provide guidance about how people may wish their continence to be supported, such as, taking them to the toilet upon waking, prompting them to use the bathroom throughout the day or a plan to consider any other support required. Individual needs and preferences had not been established.

In house activities were delivered by a part time voluntary support worker, people were complimentary and appreciative of the activities they provided. In addition, the home arranged for visits from a hair dresser, entertainers such as a singer, music and visits from Ruby, a pat dog, brought along by an NHS volunteer. Some people enjoyed gardening and had planted pots, which they tended to. However, some people told us that time could drag when nothing was arranged and felt that more staff were needed to broaden opportunities to go into town or on organised days out. Staff told us "We can't always take residents out of the house as only one member of care staff would be left at the home," and "I arrange outings and take people out on my days off or holidays." Other staff also told us that they came to the home on their days off to help support people with activities. This demonstrated staff recognised people required more support with activities than was available. We spoke with the registered manager about the concerns raised by staff and some of the people they supported. They were aware of people's views and shared similar concerns about the limited activities. The registered manager told us they had raised these concerns with the provider and awaited their decision. Activities reflected staff availability rather than being planned to meet people's needs.

The provider had not ensured that the care and treatment was person centred to meet with people's needs and reflect their preferences. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives had completed questionnaires to give their feedback about the service provided and resident meetings also took place. Responses held on file contained mixed findings, with some people commenting about a shortage of staff and its impact on activities. No action plan was in place to address any concerns raised. Evaluation and feedback processes were undermined because action had not been taken to address the concerns raised. This is an area we have identified as requiring improvement.

A complaints procedure was available to people and visitors to the service. The process was displayed in the main entrance area and also available in each person's bedroom, so people knew how to report a complaint and what the process was. The procedure was clearly written and was in large print to make it more easily accessible. The complaints policy set out how the staff should log a complaint together with various acknowledgement and response timeframes. People and visitors that we spoke with told us they did not have any complaints and did not wish to make any. They told us they knew the staff and registered manager by name and recognised the provider when they visited and confident that if given cause to

Requires Improvement

Is the service responsive?

complain, it would be resolved quickly. The service was not dealing with any complaints at the time of our inspection. However we have reported that people had made comments about their dissatisfaction with the activities and staff available. They had done this through meetings and surveys but these had not been dealt with as complaints. Adequate action had not been taken as a result of people's concerns.

One visitor told us, "I am very happy with the care my relative receives, but wouldn't hesitate in raising a concern if I needed to. I feel the staff all pull in the same direction and all want the best for the people that live here. If I needed to complain, I have no reason to doubt it would be taken seriously and sorted out quickly."

Requires Improvement

Is the service well-led?

Our findings

Staff were positive about the registered manager and the deputy manager, describing them as "Approachable and supportive." People were involved in developing the home and asked their views about the quality of service provided. Examples included assisting in staff recruitment selection, taking part in meetings where things like the day to day running of the home was discussed and completion of satisfaction surveys. One person told us "I think the manager does a good job, they all work very hard." However, we found some areas in how the home was led that required improvement.

The quality assurance framework was not effective to ensure the safety of people. Systems had not ensured continuous oversight of key safety checks and required maintenance. For example, checks to ensure equipment used at the home was serviced, safe and fit for use had not taken place for two years. A current test certificate to certify that the electrical wiring in the home was safe had lapsed. Maintenance needs had not been adequately reported, resulting in risks to people's safety. Environmental and infection control audits had not identified deficiencies in cleaning, the lack of legionella checks in the water systems or the failure of some staff to monitor and record temperatures of cooked food, or the temperatures of the fridges and freezers food was stored in. Although medicine errors were infrequent, records of identified errors did not address their cause or manage processes to make sure the risks of repeated errors decreased. Analysis of incidents and accidents did not result in reviews of relevant risk assessments. This meant risks to people's health, safety and welfare were not mitigated to keep them safe.

Although the registered manager undertook surveys and meetings for people and staff to monitor the quality of the service provided, the information gathered was not effectively used to drive forward improvement. Staff had raised concerns at meetings including the deterioration in standards of cleanliness at the home and that staff handovers were not always as thorough as they needed to be. However, there was no record of action taken or a substantive plan to bring about and sustain change, in order to improve the quality of services people received.

Some records at the service lacked information. For example, records intended to monitor hydration did not provide staff with enough guidance about the target amount people should drink. In addition, the amount of fluid people had drunk was not always quantified. This meant the records in place did not provide sufficient detail for staff to know if people were at risk of dehydration.

This inspection highlighted shortfalls in the service that had not been identified by monitoring systems in place. The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services and keep complete and accurate records of was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection, the registered manager was responsive to our concerns about the breaches of regulations identified and, once pointed out, put in place immediate measures to reduce some of the risks. Although staff and people told us that the provider regularly visited the home, there was little evidence of formal assessments or their review of the quality of the service provided. The registered manager told us input from the provider was on an informal basis and, at the time of the inspection, they awaited a decision by the provider about addressing recognised staffing shortages. The registered manager could not give any indication when a decision would be made.

Although the Registered manager divided her time managing Cornerways Residential Home and a sister home owned by the same provider, people and staff told us they were a visible presence in the home, who instilled confidence. While deputy managers were in place at both of the homes to act in the registered manager's absence, the level of breaches identified illustrated that there had been a failure in the day to day oversight of the home.

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 home was supportive and

Requires Improvement

Is the service well-led?

enabled them to feel able to raise issues and comment about the home or work practices. However their views had not consistently been acted on. They said they felt confident about raising any issues of concern around other staff members practice and using the whistleblowing process to do so; they felt their confidentiality would be maintained and protected by the registered manager.

The home's care philosophy set out the principles of providing quality care. The deputy manager told us that the values and commitment of the home were embedded in the expected behaviours of staff. Staff recognised and understood the values of the home 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 dedication to 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 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 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered provider had not taken steps to ensure that care and treatment was provided in a safe way for service users including assessing risks to their health and safety, doing all that is reasonably practicable to mitigate any such risks and ensuring the proper and safe management of medicines. Regulation 12 (1)(2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not always have sufficient numbers of persons deployed. Regulation 18 (1) Staffing

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users must be appropriate, meet their needs and reflect their preferences. Regulation 9 (1)(a)(b)(c)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered person had not ensured that the premises and equipment was clean, secure and properly maintained. The registered person did not in relation to premises and equipment maintain standards of hygiene appropriate for the purposes for which they were being used. Regulation 15 (1)(a)(b)(e) (2)

The enforcement action we took:
A warning notice was issued which must be met by 17 August 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to assess and improve the quality and safety of the services provided, assess, monitor and mitigate risks and evaluate and improve practices, act on feedback and maintain complete records Regulation 17 (1)(2)(a)(b)(c)(e)(f)

The enforcement action we took:
A warning notice was issued which must be met by 24 August 2015.