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# Cornelia Heights

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Cornelia Heights is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation for up to 23 people. There were 19 people living at the home at the time of the inspection.

The home was based over two floors, connected by a passenger lift and stair lifts. Not all bedrooms had en-suite facilities but there were toilets available on each floor. There was a lounge and conservatory dining room. There was also an accessible garden.

The inspection was conducted on 19 and 25 September 2018 and was unannounced.

Systems and processes used to monitor the quality and safety of the service had not been fully effective in preventing the shortfalls found at this inspection.

There was not always a sufficient number of staff to meet people's needs. At times staff were not present in the communal areas of the home to ensure people's safety and staff did not always have the time to spend with people in a relaxed and social way.

Oral medicines were managed safely and administered in line with the prescribing instructions. However, systems in place to ensure topical creams were used safety were not effective.

Recruitment procedures were not followed consistently, so the provider was unable to confirm that all staff employed were suitable.

People were provided with enough to eat and drink but staff were not always available to provide them with consistent support were required. People had access to health professionals and other specialists if they needed them. Staff worked in partnership with healthcare professionals to support people at the end of their lives to have a comfortable, dignified and pain-free death.

Staff demonstrated an understanding of people's needs and people's care plans were personalised and reflected the care and support that was required. However, people were mindful of staff workload so were reluctant to ask for additional support. Monitoring records, such as food and fluid charts and daily records of care provided were not always completed robustly to demonstrate that care had been delivered appropriately.

Individual risks to people were managed effectively. Where accidents, incidents, and near misses had occurred processes were in place to help mitigate reoccurrence and future risks.

People were protected from the risk of abuse and staff knew how to identify, prevent and report abuse. Staff

understood how to keep people safe in an emergency.

The home was clean and there were systems in place to protect people from the risk of infection. With the exception of the stairlifts all other environmental risks were managed effectively.

Staff were not consistently supported in their roles. Systems in place to monitor staff training were ineffective in identifying training that had been received or when it was required to be updated.

Staff understood and followed the principles of the Mental Capacity Act 2005 (MCA) and were aware of people's rights to refuse care.

People and their families were positive about the care received. Staff had developed caring and positive relationships with people and treated them with dignity and respect. People were encouraged to be independent.

People received mental and physical stimulation and had access to a range of activities. Staff supported people to meet their cultural and religious needs. The registered manager and provider sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

The providers were fully engaged in running the service and their vision and values were clear and understood by staff.

We identified one breach of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

There was not always a sufficient number of staff to meet people's needs.

Individual risks to people were managed effectively. Where accidents, incidents, and near misses had occurred processes were in place to help mitigate reoccurrence and future risks.

Oral medicines were managed safely and administered in line with the prescribing instructions. However, systems in place to ensure topical creams were used safety were not effective.

Recruiting practices did not always ensure that all appropriate checks had been completed.

The home was clean and there were systems in place to protect people from the risk of infection.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff were not consistently supported in their roles. Systems in place to monitor staff training were ineffective in identifying training that had been received or when it was required to be updated.

Staff understood and followed the principles of the Mental Capacity Act 2005 (MCA) and were aware of people's rights to refuse care.

People were provided with enough to eat and drink but staff were not always available to provide them with consistent support when required.

People had access to health professionals and other specialists if they needed them.

Procedures were in place to help ensure that people received consistent support if they were admitted to hospital.

## Is the service caring?

Good

The service was caring.

People and their families were positive about the care received.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's privacy.

Staff respected people's independence and encouraged people to do things for themselves.

## Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us that staff were kind and caring; however, people were mindful of staff workload so were reluctant to ask for additional support.

Monitoring records, such as food and fluid charts and daily records of care provided were not always completed robustly to demonstrate that care had been delivered appropriately.

Staff demonstrated an understanding of people's needs and people's care plans were personalised and reflected the care and support that was required.

People received mental and physical stimulation and had access to a range of activities. Staff supported people to meet their cultural and religious needs.

The registered manager and provider sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

People would be supported to receive good end of life care and effective support to help ensure a comfortable, dignified and pain-free death.

## Is the service well-led?

Requires Improvement

The service was not always well led.

The systems and processes in place to monitor the quality and safety of the service, were not always robust.

The providers were fully engaged in running the service and their vision and values were clear and understood by staff.

People, their families and staff had the opportunity to become involved in developing the service.

# Cornelia Heights

**Detailed findings**

## Background to this inspection

We carried out this comprehensive 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 inspection took place on 18 and 25 September 2018 by two inspectors 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 the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. Notifications are information about specific important events the service is legally required to tell us about.

During the inspection we spoke with 12 people who use the service and three family members. We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with one of the providers of the service, the registered manager, four care staff and the cook. We also received feedback from one social care professional who had contact with the service.

We looked at care plans and associated records for 13 people and records relating to the management of the service. These included staff duty records, five staff recruitment files, records of complaints, accidents and incidents and quality assurance records.

The home was last inspected in September 2017 when it was rated as 'Requires improvement'.

Requires Improvement

# Is the service safe?

## Our findings

People told us and indicated they felt safe. One person said, "I feel safe". Another person told us "I always feel safe; I wouldn't stay if I felt unsafe."

People and their families told us that they felt that there was not always a sufficient number of staff to meet people's needs. People voiced concerns about the pressure on the staff and described staff as being overly busy and rushed. Comments included, "The staff always seem to be rushing about"; "Sometimes they [staff] are busy, they are under a lot of pressure"; "The response to the bell is not always instantaneous, the girls may be assisting someone else – after all this is not a hotel"; "There is never enough staff" and "The staff give me help as best they can – they have limited time." All the staff we spoke with also felt that they required more staff on duty. One staff member said, "We definitely need more staff." Another staff member told us, "There isn't enough staff, people get what they need but we are so busy."

During both days of the inspection we found the staff to be very busy meeting people's essential care needs and responding to frequent call bells. One person said, "The thing that annoys me is the buzzers going off all the time." We observed periods of time when staff were not present in the communal areas and staff did not always have the time to spend with people in a relaxed and social way. During lunch on the first day of the inspection we observed that one person took it upon themselves to assist the person sitting adjacent to them, with eating their lunch. On day two of the inspection we noted that a person in the communal area who appeared to be unsafe attempting to mobilise without support. Staff on shift were not present to support this person as they were all busy in other areas of the home. The inspector supported the person to sit down before going to find a staff member to support them safely. The staff member found told us this person would not be safe to mobile independently. A social care professional who was visiting the home told us that during their visit staff had not been available to them to discuss the person's needs.

The registered manager told us that they used a dependency tool to determine staffing levels. The dependency tool took into account the level of support people using the service required. The registered manager told us that as well as the use of the dependency tool they listened to feedback from people and staff, regular walk rounds of the home, observing care and monitoring call bell response times to determine appropriate staffing levels. However, from discussions with people and staff and observations during the inspection it was evident that there were not enough staff available to keep people safe.

There was a duty roster system in place, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime or cover from staff employed at another home nearby also owned by the provider. The registered manager was also available to provide extra support when required.

The lack of staffing was discussed with the registered manager and the provider. The registered manager said that usually the staff would have requested additional support from them during busy times but this had not happened on the days of the inspection as staff were mindful that the registered manager was busy with the inspector. Following the inspection, the provider sent us information in relation to increasing the

staff numbers within the home.

The registered manager had assessed the risks associated with providing care to each individual person. Each person's care file contained risks assessments which identified the risks along with the actions taken to reduce these risks. Risk assessments in place included; skin integrity; bathing; the use of bed rails; medicines; eating and drinking and social isolation. People also had specific risk assessments in place in relation to the use of staircases to access their rooms; smoking and leaving the home alone. These helped to ensure people's safety. Staff explained the risks related to individual people and what action they needed to take to mitigate risks.

There were processes in place to enable the registered manager to monitor accidents, adverse incidents or near misses. These helped to identify any themes or trends, allowing timely investigations, potential learning and continual improvements in safety. On reviewing documentation in relation to accidents, incidents and near misses, the registered manager and staff had taken appropriate action to mitigate risks to the people living at the home.

People told us that they received their prescribed topical creams as required. These creams were kept securely in people's rooms. We found that most of the prescribed topical creams viewed were not labelled with opening and expiry dates. This meant staff were not aware of the expiration date of the item when the cream would no longer be safe to use. Two creams were found to be labelled appropriately; however both were past the 'safe to use by' date on the label.

All other medicines were managed safety. We checked the Medicine Administration Records (MAR) for seven people and no gaps were identified. This demonstrated that people had received their medicines as prescribed. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Each person who needed 'as required' (PRN) medicines such as, pain relief or medicine to support with anxiety had clear information in place to support staff to understand when and why these should be given. There were suitable systems in place to ensure that medicines were securely stored, ordered and disposed of correctly. Stock checks of medicines were completed monthly to help ensure they were always available to people.

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. We viewed five staff recruitment records and found that for four of these staff all appropriate checks, such as references, employment history and Disclosure and Barring Service (DBS) were completed. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. However, for one staff member who had worked at the home for many years there was no information available which indicated that a DBS check had been completed or that information about their employment history had been obtained. This was discussed with both the registered manager and the provider who agreed to look into this.

Staff protected people from the risk of abuse and were clear about their safeguarding responsibilities. Staff knew how to identify, prevent and report abuse and all the staff had received appropriate training in safeguarding. One staff member told us, "If I had concerns I would talk to the manager or go to safeguarding or CQC." The registered manager explained the action they would take when a safeguarding concern was raised with them and records confirmed appropriate action had been taken.

The home was clean and free from offensive odours. People and their families described the home as being clean and tidy. One person said, "They are always cleaning and come in and out [bedroom] with a duster." Systems were in place to ensure that all areas and equipment were cleaned on a regular basis. There was a

clear and detailed cleaning schedule in place which both domestic staff and care staff worked to; staff understood their responsibilities in relation to the cleaning schedule. The registered manager told us that as well as completing regular audits on the cleanliness of the home they completed a 'daily walk around' to ensure the home was clean and tidy. Staff had access to personal protective equipment (PPE) and wore these when appropriate. The staff described how they processed soiled linen, using special bags that could be put straight into the washing machine to avoid the risk of cross contamination.

Risks posed by the environment including uneven flooring; short staircases and individual stairs had been considered. This were clearly signposted to highlight the risk to people, through the use of warning signs; both written and in picture form and fixed floor strips of a contrasting colour to the flooring. Environmental checks had been undertaken regularly to help ensure the premises were safe. These included water, building maintenance and equipment checks. However, on day one of the inspection we viewed the documentation following the recent checks for the four stairlifts in the home and noted that one of these stairlifts had been decommissioned. When this was discussed with both the registered manager and the provider they were unable to confirm which stairlift should not be used. Staff members also demonstrated some confusion about the effectiveness of the stairlifts. One staff member said that they didn't think they were ever used and another said that one stops mid use. The provider agreed to investigate this; ensure that stairlifts were in working order or removed if required, labelled to ensure that lifts could be separately identified and to inform staff of appropriate stairlift use.

There were plans in place to deal with foreseeable emergencies. Staff were aware of the action to take in the event of a fire. Fire safety equipment was maintained and tested regularly. An emergency bag and file had been prepared, containing contact details for staff and management out of hours, together with personal evacuation plans for people. These included details of the support people would need if they had to be evacuated in an emergency.

Requires Improvement

# Is the service effective?

## Our findings

People and their families told us they received effective care from experienced and competent staff. One person said, "I am confident in their [staff] skills and abilities." Another person told us, "They know what they are doing." A family member said, "The staff are very good."

The provider had an electronic system in place to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. On viewing this training matrix gaps, were identified which demonstrated that not all staff received training or that it was updated in a timely way. This was discussed with staff who told us that they received training in a timely manner and that they were offered additional training focused on the specific needs of people using the service, such as, dementia awareness, first aid and end of life care. The registered manager acknowledged that the training matrix did not give a true reflection of the training that had been received and provided us with some copies of staff training certificates which indicated that some staff had received training as required. However, these were not provided for all staff. The registered manager told us that they would review the training matrix to reflect the training that has been completed and when training is required.

Staff had not received regular one-to-one sessions of supervision consistently with a member of the management team. Supervisions provide an opportunity for the management team to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. The providers staff supervision policy states that, 'Cornelia is committed to providing its care staff with formal supervision at least four times a year.' The registered manager was unable to provide us will a copy of their supervision matrix at the time of the inspection. This was received following the inspection and did not provide clear evidence that staff had received supervision four times a year as per the providers policy. The staff supervision policy also stated that 'All formal supervision meetings for care and non-care staff are to be recorded in an agreed format' however, the registered manager was unable to provide us with supervision records for all staff when requested. For one staff member information provided indicated that they had not received any sessions of supervision since 2015; another staff member had only received one session of face to face supervision in the last three years and another staff member had not received supervision for the last seven months. Within the staff survey completed in July 2018 three staff members had rated the supervision they received as 'poor' and six staff members had rated it as 'satisfactory'.

People were supported by staff who had received an induction into their role, which enabled them to meet the needs of the people they were supporting. This included a period of shadowing a more experienced member of staff and the completion of essential training. Staff confirmed that they had received induction when they started work at the service. Staff that were new to care were supported to complete training that followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life and aims to ensure workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.

Staff followed the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. We found assessments of people's capacity had been completed, where needed. Records showed that where people lacked capacity, decisions made on their behalf were done so in their best interest and with the support of people who had the legal authority to make those decisions.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of the inspection two people living at the home were subject to a DoLS and although the registered manager was able to confirm this and whether these DoLS authorisations had any conditions attached two members of care staff were unaware of this. This meant people's legal rights may not be assured.

Throughout the inspection we heard staff seeking verbal consent from people. Staff often used simple questions and always gave people time to respond. A person told us, "They [staff] wouldn't just do something, they always ask me first." Staff were aware of people's rights to refuse care and were able to explain the action they would take if care was declined. One staff member told us, "If a person didn't want me to help them I would encourage them but can't make them."

People were supported to access appropriate healthcare services when required. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. Additional healthcare support had been requested by the staff when required. For example, we saw that a community nursing visit had been requested when staff were concerned about a person's skin. All appointments, visits and communication with health professionals and the outcomes were recorded. Staff knew people's health needs well and information in as to how these should be managed was clearly documented within people's care files.

We saw a range of well-known tools were used to monitor people's health and wellbeing in line with best practice guidance. For example, staff used the Malnutrition Universal Screening Tool (MUST) to help calculate the person's body mass index and identify the need for nutritional support. Other nationally recognised tools were used to assess a person's risk of developing pressure injuries and to monitor their bowel movements.

The registered manager used the 'Red Bag Pathway' to help to ensure that people received consistent support when they moved between services. The Red Bag Pathway helps ensure that all standardised paperwork, medication and personal belongings are kept together throughout the people's hospital stay and is returned home with them. The standardised paperwork ensured that everyone involved in the care for the person had the necessary information about their general health, current concerns, social information, abilities and level of assistance required. This allowed person centred care to be provided consistently should the person be transferred to another care setting.

People were supported to have enough to eat and drink. Drinks and snacks were offered throughout the day and evening. People and their families were complimentary about the food and of the 14 people and family members that had completed the recent quality assurance service in July 2018 all rated the quality of the

food provided as 'good' or 'excellent'. When we asked people if they enjoyed their food their comments included, "Oh yes the food is lovely, they will always bring me a drink or a treat if I want it" and "The food is excellent." People were provided with a choice of food and alternatives were offered if they did not want what was on the menu. We observed lunch and saw that people had different meals according to their choice and dietary needs. Staff were aware of which people needed soft or pureed food or special diets such as diabetic diets. There was also an individual preferences folder available to kitchen staff which detailed the foods people like and didn't like.

People were supported to eat independently and where necessary specialist cups, crockery and cutlery were provided. However, we found that at lunch time of day one of the inspection staff were not always available to support people if required. On day two of the inspection we saw a staff member was attempting to encourage and support a person to eat but was unable to give them consistent support as they were also supporting other people in the communal area.

People's nutritional needs were assessed to help identify if they were at risk of malnutrition and if a referral was needed for specialist assessment by a GP, dietician or speech and language therapist (SALT). Care records showed referrals were made where people had nutritional or swallowing needs and the advice of the SALT was recorded.

The staff made appropriate use of technology to support people. The service used a computerised system to document each person's care plan and this was accessible to staff. People would be provided with equipment to help keep them safe if required, including pressure mats to alert staff when people moved to unsafe positions and pressure relieving mattresses. There was an electronic call bell system in place which allowed people to call for assistance when needed.

Cornelia Heights is an older style building set over two floors with bedrooms on both floors. Floors could be accessed by people, staff and visitors via a passenger lift, staircases and stairlifts. The home is an adapted building and not purpose built so some parts were less suitable for people, due to slopes and steps. This was considered by the registered manager prior to people being admitted to the home. Bedrooms varied in size but overall were suitable for their occupants. People's bedrooms had been decorated to their tastes, together with some of their furniture and important possessions. Some adaptations had been made to the home to meet the needs of people living there. For example, corridors within the home had handrails fitted to provide extra support to people. At the time of the inspection the home was undergoing decoration and people had been involved in picking colours for the walls and wallpaper. People had access to two adjacent communal areas which were bright and airy and an enclosed garden.

Good

# Is the service caring?

## Our findings

People and their families told us that the staff were kind and caring. Comments included; "The staff are very kind"; "I am treated with respect and they are all very kind"; "The staff are always cheerful and the owners come round and often talk to us" and "The staff are undoubtedly kind to all of us." A written compliment from a family member described the staff as 'thoughtful and kind' and another described the staff as 'helpful and attentive' towards the people living at Cornelia Heights.

People described times when the staff and the providers had made them feel that they mattered. One person said, "The staff take notice of me when I want anything; the owner took me out for a haircut yesterday, at his suggestion." Another person told us, "The boss [one of the providers] noticed that I had ornaments of elephants in my room, and when he went on holiday to Africa he brought me a picture of a tree, painted by a three-year-old elephant. Just an act of kindness."

People were treated with dignity and respect and appeared relaxed and comfortable in the company of the staff. During the inspection one person asked a staff member for support to visit the bathroom; this person required assistance from two members of staff and equipment. The staff member reassured the person before finding another staff member to support and during the transfer in the hoist gave continual reassurance and clear guidance to help the person feel safe. On another occasion we heard a staff member comment on a person's recent hair cut; they said to the person, "I say, smashing haircut [name of person]." This comment invoked a friendly and relaxed conversation between them.

Staff understood the importance of protecting people's privacy and people confirmed that staff considered their privacy when providing personal care by closing doors and curtains. A staff member told us, "I shut the door and keep the person covered as much as possible when helping them to wash." During the inspection we observed staff supporting a person in a communal area of the home using a mobility hoist. While doing this, staff maintained the person's dignity by ensuring they were covered and supporting the person with ongoing reassurance. Information regarding confidentiality, dignity and respect formed a key part of the induction training for staff. Confidential information, such as care records, were kept in the registered managers office and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected.

Staff understood the importance of respecting people's choice. People confirmed they were offered choices about meals, where they spent time and what they did. Choices were offered in line with people's care plans and preferred communication style. Throughout the inspection we saw that people's choices were respect. One person had chosen to remain in their bed clothes and another person had chosen to spend the morning in bed. People's care plans contained comments about providing choices to people in relation to their care. One care plan stated, 'Respect [name of persons] wishes to remain in bed clothes when they are having a day in bed'.

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. One person told us, "I do what I can for myself." Comments in care plans highlighted to staff

what people could do for themselves and when support may be needed. Comments included, '[Person] can brush her teeth with verbal guidance' and '[Person] is independent with walker'. Throughout the inspection we saw staff encouraged people to be independent. For example, specific cutlery and walking aids, such as frames and sticks were provided when required and staff gave encouragement, support and reassure to people.

Where people had specific communication needs, these were recorded in their care plans and known by staff. People's communication needs were discussed at the time of admission and reviewed regularly to help ensure that their communication needs continued to be met effectively. At the time of the inspection, no one living at the home required the support of specific communication devices to aid communication such as computerised support or picture cards but the registered manager advised that support would be provided to access these if required.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identified people who were important to the person. Family members confirmed that the registered manager and staff supported their relatives to maintain their relationships. One family member said "We [family] can visit at any time." People's bedrooms were individualised and reflected people's interests and preferences. The bedrooms were personalised with photographs, pictures and other possessions of the person's choosing.

Requires Improvement

# Is the service responsive?

## Our findings

People told us they received personalised care and support that met their needs. However; although we saw some positive interactions between staff and people and people told us the kind and caring nature of the staff we found that staff had few opportunities to engage with people on a one to one level and spend time with them. People living at the home were protective of the staff and were clearly concerned about giving staff additional work. People's comments included; "I try not to abuse them – I try not to give them any more to do than I can help"; "I have to make allowances that staff are busy"; "My bath day is tomorrow, it's on my care plan- it would be inconvenient for me to ask for it another day" and "You must remember that it is not a hotel, you cannot expect pristine service, and the staff have a lot to do." These comments demonstrated that although people felt comfortable with the staff there was a reluctance to request changes to their 'planned' care or required support with things they felt that was beyond the 'personal care' role of the staff.

People's care plans clearly reflected the care and support they required. Care and support plans were centred on the individual needs of each person. Assessments of people's needs were completed by a member of the management team before they moved to the home. This information was then used to develop an appropriate care plan in consultation with the person and their relatives where appropriate. Care plans contained detailed information to enable staff to provide care and support in a personalised way according to people's individual needs. They included people's normal daily routines, their backgrounds, hobbies, interests and personal preferences; such as when they would usually like to get up or go to bed and when they would prefer to have a bath. Within care records people's health conditions and management of these were clearly recorded. This information provided staff with guidance on signs and symptoms to look for and actions to take to prevent health deterioration. Care plans were reviewed and updated by a member of the management team every month or as people's needs changed.

Although staff demonstrated an understanding of people's needs, monitoring records, such as food and fluid charts and daily records of care provided were not completed to an appropriate standard to demonstrate that care had been delivered appropriately. For example, one person's daily record only commented on what the person had eaten and drunk in the day; there was no information about personal care they had received, or their emotional and physical wellbeing. One person had a fluid monitoring chart in place which showed that on one day they had only received two drinks and had a fluid intake for the day of 350 mls, on another day 400mls of fluids and on a third day 650mls fluids. The recommended fluid intake for adults is 1.5 litres per day. Without effective monitoring of people's fluid intake where required timely interventions and support may not be provided to prevent dehydration. This was discussed with the registered manager who told us that people did received personal care and fluids as required and felt this was a recording issue. The registered manager confirmed that they did not have a clear process in place for checking this documentation and agreed that this would be addressed.

Staff were kept up to date about people's needs through handover meetings which were held at the start of every shift. Information was provided to staff during these meeting which included information about changes in people's emotional and physical health needs and where people had declined assistance with personal care. During this handover meeting staff shared ideas and knowledge of how best to provide

support to individual people.

People received mental and physical stimulation and had access to a range of activities. The home had an activities programme and a part-time activities coordinator providing activities on an individual basis and in groups. Activities included games, armchair exercises, reminiscence, painting and manicures. The registered manager explained that they also purchased activities staff from external providers which included, arts and craft and music. People reported enjoying the activities and also spoke positively about the activities coordinator. On day one of the inspection the activities coordinator was playing a hoop game and a word game which invoked happy conversations. One person who spent most of their time in their room told us, "I like it when [name of activities coordinator] comes; I always go down [to the communal area] when they are here." All people that responded to the family and friends survey completed in July 2018 rated the range of activities as good or excellent. Staff were knowledgeable about people's right to choose the types of activities they liked to do, and respected their choice. Activities were discussed during the resident's meetings to give people the opportunity to comment on past activities and share ideas about things that they could do in the future.

Cornelia Heights had developed some links with the local community. For example, local school children visited the home and spend time talking to people, completing activities with them and sharing stories. Representatives from the local church visited monthly to provide a church service to those who wished to attend.

The management team sought feedback from people's families on an informal basis when they met with them at the home, during telephone contact and via email correspondence. People and their families felt able to approach the management team and staff at any time. One person said, "The owners are here often and talk to all of us – they are very approachable." Another person told us, "The boss is always here and comes around to speak to all of us." Residents meetings were held approximately every two months to discuss all aspects of care, update people on any changes in the home and to get people's view on the service provided. During these meetings people and their families were given the opportunity to talk about any concerns or issues they had and to share ideas about the development of the service. The registered manager and provider also sought formal feedback through the use of quality assurance survey questionnaires sent yearly to people, their families, staff and professionals. We looked at the outcome records from the latest survey completed in July 2018 and most responses to these surveys with the exception of the staff survey were positive; (outcome of the staff survey will be commented on in the well led section of the report). Where concerns or issues were raised, we saw that action had been taken.

The registered manager told us they explored people's cultural and diversity needs by talking to them and their families and by getting to know them and their backgrounds. This information was then documented within the person's care plans. Care plans contained a section for information to be recorded about a person's religious or cultural preferences. This was completed for each person, even where a religious preference had not been identified. Policies in place for sexuality and religious beliefs which gave clear information on how people should be supported to maintain relationships and follow beliefs. The registered manager also told us that people living at the home were offered the opportunity to attend the recent Lesbian, Gay, Bisexual and Transgender (LBGT) parade that had taken place in the local area.

People knew how to complain and there was a suitable complaints procedure in place. There was information about how to complain available for people and visitors in the home's hallway and within the service user guide provided to people and their families. People were also reminded how to complain during resident and relative meetings. One person told us, "I have never felt the need to complain, although I do know how to do it." The family and friends survey completed in July 2018 demonstrated that all 14

people that responded felt that the management would be good or excellent at dealing with a complaint. One comment from a family member on this survey stated, 'I haven't had to complain yet but everyone seems very approachable. So, I am sure you would be good at listening to complaints.' Two formal complaints had been received since the last inspection and we saw that these has been fully investigated and a face to face meeting with the complainant offered.

At the time of the inspection no one living at Cornelia Heights was receiving end of life care. However, the registered manager was able to provide us with assurances that people would be supported to receive good end of life care and effective support to help ensure a comfortable, dignified and pain-free death. Some staff members had received training in end of life care and we found that the end of life wishes and preferences for people had been recorded within people's care records. This should help to ensure that people's wishes were respected and acted upon. The registered manager also told us that they would work closely with relevant healthcare professionals and provide support to people's families to help ensure that they were fully involved.

Requires Improvement

# Is the service well-led?

## Our findings

The provider had a programme of audits and quality checks in place which were currently being completed by the provider and registered manager. Regular audits had been completed of the environment, medicines, health and safety and infection control. Where concerns were identified action, plans were produced and actions were taken within a timely manner. However, there was no clear auditing process in place to review people's food and fluid charts or daily records of care. Recruitment, supervision and training record audits had failed to identify the concerns raised at the inspection and no action had been taken in relation to the recent stairlift safety checks which noted that a stairlift was unsafe to use. Audits had also failed to recognise that staff did not always have time to engage with people and had not picked up on people's views of not wanting to ask for additional support due to staff being busy. These issues were discussed with registered manager and provider who acknowledged the shortfalls in these areas and agreed to review and update the current documentation and processes. Following the inspection information was received from the provider which highlighted that actions for the above issues were underway.

The failure to effectively assess, monitor and improve the quality and safety of services was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in place. 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 and associated Regulations about how the service is run. At the time of the inspection the management structure of the home consisted of the providers and the registered manager. Recruitment processes were underway to replace the deputy manager and head of care who had left the service one week prior to the inspection.

The staff team at Cornelia Heights was a small team and the provider was currently recruiting additional staff. At the time of the inspection staff told us that a number of staff had recently left the service and current staff were working a number of additional hours, using staff from a neighbouring home also managed by the provider and the registered manager providing additional care cover. The registered managers on going need to cover care shifts and lack of current managerial support was likely to be having an impact on their abilities to complete all their required management duties.

All the staff we spoke to were positively about the provider and the registered manager but some made comment about the ongoing pressure on them to work additional shifts, the lack of staffing and the pressure on them to meet people's needs. One staff member said, "There isn't enough staff at the moment, but I know they [provider] is recruiting." Another staff member told us, "There isn't enough staff; it can be ok but some [staff] have recently left and I have had to do extra." The staff survey completed in July 2018 showed that four of the 17 staff members that responded to the service rated staff morale as 'Poor'; three as 'Satisfactory' and 10 as 'Good'.

The provider and registered manager encouraged staff and people to raise issues of concern with them.

However, from discussion with staff and evidence gained from the staff survey staff had mixed views on the effectiveness of the management team's response. A staff member said, "I have raised a concern before with [name of provider] who took action straight away; they will listen and do their best to sort things out." Another staff member told us, "I can go to the manager with anything; or the provider, they will listen." A third staff member described the registered manager and providers as approachable. However, four staff who completed the staff survey had rated 'Poor' and four had rated 'Satisfactory' to the question; 'How do you rate action if you provide feedback or ideas are acted on?' Staff morale was discussed with the registered manager and the provider who acknowledge that this had been a recent problem and they were working to address this through the registered manager working closely with the staff and providing additional support at key times of the day and staff recruitment.

The providers were fully engaged in running the service and their vision and values were built around providing people with care that was specifically tailored to people's wishes and needs, promoting independence and treating people with respect. The registered manager told us they, "wanted to raise the standards of the home and for people to live in a happy, safe and comfortable home". Staff were aware of the provider's and registered managers vision and values and how they related to their work. Regular staff meetings provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision.

The registered manager and provider worked in partnership with the local authority, healthcare professionals, GPs and social services to help ensure that people received effective and safe care. The registered manager was also aiming to further develop more robust links with the community.

There was a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary. There was a duty of candour policy in place, this required staff to be open with people and relatives when accidents or incidents occurred. The registered manager was able to describe the actions they would take to adhere to the duty of candour policy.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed within the reception area of the home to allow easy access to people, families and visitors.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to effectively assess, monitor and improve the quality and safety of service. |