Care Quality Commission

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Cornelia Heights

Inspection report

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Ratings

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

Overall summary

Cornelia Heights is a privately run residential care home providing care for a maximum of 23 older people. The last inspection of the home took place in October 2014, which identified a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to tell us what action they were taking and they sent us an action plan stating they would be meeting the requirements of the regulations by 10 February 2015.

This inspection was unannounced and carried out on 27 and 29 April 2015. During the inspection we found the provider had completed all the actions they told us they would take in respect of meeting the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the time of the inspection the manager was not registered because they had only been in post for four months. The new manager had started the process to become the registered manager for the home. A

Summary of findings

registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered provider's, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the home is run.

People told us they felt safe. However, we found that there was not an effective system in place to ensure medicines were administered safely and they were not always stored and disposed of effectively.

Staff did not always interact with people in a positive way or treat them with dignity and respect. Although, on other occasions we saw staff providing positive support to people who were anxious and distressed.

People were at risk of receiving unsafe or inappropriate care because care records were not always up to date and did not contain sufficient information to inform staff as to people's individual needs.

Risks relating to people's care and welfare were not always managed effectively and risk assessments were not up to date. We pointed these out to the deputy manager and by the end of our inspection all of the risk assessments were updated and relevant.

There were not sufficient staff available on the morning shift to meet people's individual needs. Staff were task focused and did not have time to respond to people effectively. We pointed this out to the provider and following our intervention, additional staff had been rostered from within their team to support the morning shift.

There were systems in place to monitor quality and safety, however, these were not always effective and drive forward improvements within the service.

The provider had arranged for a structured activities programme, which was delivered by an activities coordinator who also supported people on a one to one basis, particularly those who chose to stay in their rooms.

People were supported by staff who had received the appropriate training, professional development and supervision to enable them to meet their individual needs. Staff and the management team had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

The provider had established a safe and effective recruitment process, which meant staff were knowledgeable, skilled and safe to work with older people. There were processes in place to manage short term absences of staff.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found the home to be meeting the requirements of DoLS

People and visitors told us they felt the service was well-led and were positive about the management team. The provider was proactive in promoting good practice, and had developed links with organisations such as 'Research Ready Care Home Network' and the 'National Institute of Health Research'. Healthcare professionals such as GPs, chiropodists, opticians and dentists were involved in people's care where necessary.

The provider had assessed the health and environmental risks related to supporting people at the home and sought regular feedback from people in respect of their experiences and the service provided. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence. There were suitable arrangements in place to deal with complaints.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked 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?

Requires improvement

The service was not always safe

Medicines were not always stored, administered and disposed of safely.

Risks relating to people's care and welfare were not always managed effectively and people were not always protected from the risk of infection.

The provider had a safe and effective recruitment process, however there was not always enough staff available to meet people's needs.

People felt safe and staff had a good understanding of procedures for safeguarding people.

Is the service effective?

Good

The service was effective.

Both management and care staff understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People were involved in decisions about their care and support and were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Staff received an appropriate induction and ongoing training to enable them to meet the needs of people using the service.

Is the service caring?

Requires improvement

The service was not always caring.

Staff did not always respect and interact with people in a positive way. We saw a mixture of both poor and positive interactions by staff.

People indicated they were happy at the home and liked the staff who looked after them. Staff were aware of people's likes and dislikes and respected their choices.

People's privacy was respected and staff knocked on people's doors and waited before entering.

People's bedrooms were personalised with pictures and personal items. People were supported to maintain their independence.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans and activities were not always up to date, person centred or focussed on individual needs.

Summary of findings

People were supported to maintain friendships and were encouraged to maintain their independence.

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

Is the service well-led?

The service was no always well-led.

The systems in place to monitor the quality and safety of the service were not always robust enough to drive improvements and identify areas of concern.

The providers' values were clear and understood by staff, although not always applied in practice. The management team adopted an open and inclusive style of leadership.

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

The manager understood the responsibilities of their role and notified the Care Quality Commission (CQC) of significant events regarding people using the service.

Requires improvement

Cornelia Heights

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 checked 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.

The inspection was unannounced and was carried out on 27 and 29 April 2015. The inspection team consisted of two inspectors, a specialist advisor and an expert by experience. A specialist advisor is someone who has clinical experience and knowledge of working in the field of older people and in particular those living with dementia. 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 this inspection, we reviewed the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the provider is required to send to us by law. As a result of the short timescale before the inspection, we did not request the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with the 18 people using the service and four visitors. We observed care and support being delivered in communal areas of the home. We carried out pathway tracking of two people using the service, which meant we observed them and how staff interacted with them, looked at their care records and spoke with them and members of their family. We spoke with eight members of the care staff, the cook and their assistant, the senior housekeeper, the deputy manager, the manager and the two providers.

We looked at care plans and associated records for seven people using the service, staff duty rota records, five staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe. One person said "I like it here I feel quite safe; I've a nice room, I sleep well enough and the food is fine". Another person told us "I feel safe and I'm quite happy here; I know I can't look after myself". Relatives told us they felt their family members were safe at the home. One relative said "I can relax knowing [their relative] is here. I know they are safe; I have no concerns".

However, we found that medicines were not always stored and disposed of effectively and in accordance with the National Institute of Clinical Excellence (NICE) guidance. There were a number of items of medicines stored in a bag in the manager's office, which the manager told us were prescribed medicines awaiting disposal and therefore should have been stored securely. There had been occasions throughout the day when the office had been left insecure and was accessible to people using the service, some of whom have a cognitive impairment, who could have taken the medicine in error. We raised our concerns with the manager who ensured the medicine was placed in a secure location.

There was not an effective system in place to ensure that medicines were administered safely. The 8am medicines round was not completed until 11.35am and started again at 13:00. This meant some medicines may have been given too closely together which may have had a detrimental effect for people. The medicine administration record (MAR) charts for ten of the people using the service had not been completed correctly. For example three MAR charts were hand written, without a counter signature. One of these three MAR charts, which was pinned to another MAR chart for the person, did not have the person's name or other identifying details, and the other two did not have details of the person's date of birth or known allergies.

Arrangements in place for the management of topical creams were not adequate. Nine people had been prescribed topical creams to help protect their skin from pressure related injuries or other damage. There were no topical body maps or care plans to support staff in understanding where and how much cream should be applied. One person was having 'over the counter' topical creams administered by staff which were not detailed on their MAR chart. This cream was kept in their bedroom and there was no information available as to how this cream may interact with the other medication the person was receiving.

The failure of the provider to have an effective system in place to ensure the safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a system in place to manage the ordering of medicines. When medicines required cold storage, a refrigerator was available and the temperature was checked and recorded daily to ensure medicines were stored according to the manufacturer's instructions. Staff administering medicines to people were supportive and unhurried, allowing people to take their medicines in their own time.

Risks relating to people's care and welfare were not always managed appropriately. The provider had put in place risk assessments relating to people's health and wellbeing, such as risks relating to a person having diabetes or a person at risk of falls. However, not all risk assessments were up to date or related to current risks. For example, one person had a risk assessment in place in respect of self-medication. Staff told us this person had not been self-medicating for some time and the care plan had not been updated. Another person chose to eat certain foods, which put them at risk of choking. Although staff were aware of the risks there was no risk assessment in place to provide guidance to staff in how to support this person safely. We pointed this out to the deputy manager and by the end of the second day of our inspection people's risk assessments had been updated to meet their current needs.

At a previous inspection we identified that staff failed to follow procedures for the safe handling of laundry. During this inspection we found the provider had completed the actions required and we saw staff were following appropriate procedures. However, people were not always protected from the risk of infection. The sealant around the sink units in two of the bedrooms had split and the sink units were chipped and damaged, which meant they could not be cleaned effectively. The vinyl flooring in the downstairs toilet was stained with urine and peeling away from the floor. Piping on the ceiling in the same toilet was dirty and covered with mildew; and the sink unit chipped and not able to be cleaned effectively. We pointed our

Is the service safe?

concerns out to the deputy manager who told us the bathroom was due for refurbishment. On the second day of our inspection we saw the toilet had been refurbished and our other concerns rectified.

The provider had an up to date infection control policy, which detailed the relevant infection control issues and guidance for staff. An infection control risk assessment had been completed in March 2015 and an audit conducted in April 2015. The deputy manager was the infection control lead for the service. There were detailed daily cleaning schedules and checklists to confirm when the cleaning had been completed. The other communal areas of the service, the kitchen, the bathrooms and people's bedrooms were clean.

There were not always enough staff available to meet people's needs. The manager told us that staffing levels were based on the needs of people using the service. People told us if they needed staff and used their call bell, staff responded quickly. The deputy manager told us their minimum staffing was one senior and three care staff on the morning shift and one senior and two care staff on the afternoon shift. There were two members of care staff working a waking night shift. The care staff were supported by separate housekeeping, maintenance and kitchen staff, which meant they were not distracted from their day to day care duties.

However, staff during the morning shift were primarily task focussed going from one event to the next and did not always have time to respond to people's personalised needs. For example, one person was in the lounge calling for staff to help them find some paper, three staff walked through the lounge area, carrying out different tasks but did not respond to him. Staff told us there were not enough staff available to support people in the morning. One member of staff said that some people sometimes had to wait until mid-morning to get up. They added "it is not their choice; there is just not enough staff". Another member of staff told us that "during the medicine rounds it could be difficult to respond to individual needs because if you are called to support someone who needed two staff then you have to stop other tasks and the floor could be left without any staff, which was a risk to people some with mobility issues and others had dementia". It took staff three and a half hours to administer the morning medicine round. We raised this with the provider and on the second day of our inspection we saw that additional staff had been rostered and were on duty. We saw that an addition member of staff was shown on the duties for the rest of the month.

There was a duty roster system, which detailed the planned cover for the home. Short term absences were managed through the use of overtime, staff from another home owned by the provider or cover provided by senior staff, the manager and the providers.

The provider had a safe and effective recruitment process in place to help ensure that staff who were recruited were suitable to work with the people they supported. All of the appropriate checks, including Disclosure and Barring Service (DBS) checks were completed on all of the staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

The staff and the manager had the knowledge necessary to enable them to respond appropriately to concerns about people. They had received safeguarding training and knew what they would do if concerns were raised or observed in line with their policy. In addition some staff had also completed, or were in the process of completing a vocational qualification in care, which contain a section relating to safeguarding. Where safeguarding concerns were identified, they worked with the local authority and where requested investigated the matter internally and reported to the appropriate authority. The provider had a safeguarding policy and procedure, which provided a framework of support and guidance to staff on how to prevent, identify and report safeguarding concerns. Both of the providers used their frequent visits to the home as an opportunity to engage with people, observe staff interactions and monitor for any safeguarding concerns.

There were arrangements in place to deal with foreseeable emergencies. There was also a fire safety plan for the home. Staff were aware of the plan and were able to tell us the action they would take to protect people if the fire alarm went off. People's care plans contained information to enable staff to support them should a fire alarm go off.

Good

Is the service effective?

Our findings

People told us they felt that the service was effective and that staff understood their needs and had the skills to meet them. One person said "Staff are all very good they know exactly how I like to be cared for." Relatives told us they felt staff were knowledgeable about the care they provided and said their family member's needs were met to a good standard.

Each member of staff had undertaken an induction programme based on the principles of the Skills for Care common induction standards. Since April 2015 staff have undertaken and induction based on the care certificate, which is a set of standards that health and social care workers adhere to in their daily working life. They spent time shadowing more experienced staff, working alongside them until they were competent and confident to work independently. The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as, fire safety, infection control, manual handling and safeguarding vulnerable adults. Staff had access to other training focussed on the specific needs of people using the service, such as, palliative care. Staff were also supported to achieve a vocational qualification in care. One member of staff said "training here is good, I am always doing it. I've just done safeguarding through the college". Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, we observed staff supporting people to mobilise using appropriately manual handling skills.

Staff received regular supervisions in line with the provider's policy. Supervisions provide an opportunity to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop. Staff said they felt supported, and the manager had an open door policy which meant staff could raise any concerns straight away.

People told us that staff asked them for their consent when they were supporting them. The manager, and care staff understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. When appropriate people's ability to make decisions was assessed and if they lacked capacity, decisions were made in their best interest. For example, the use of bed rails to support a person living with a cognitive impairment and was at risk of falling.

DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards. The manager told us they had successfully applied for a DoLS authorisation for some people at the home and these authorisations were monitored on a regular basis to ensure they were still relevant and necessary. We look at the records of these DoLS and saw that there were in date and relevant to the person the referred to. None of the DoLS authorised had any additional conditions attributed to them. Staff were aware of which people were subject to the DoLS authorisation and the restrictions imposed.

People were supported to have enough to eat and drink. Meals were appropriately spaced and flexible to meet people's needs and drinks were available throughout the day. People were complimentary about the food. One person said "You can tell the vegetables are freshly bought and cooked, and the meat is very good." Another told us "The chef is very good, and her deputy is even better". A third person told us they were vegetarian and said "the kitchen always provided a vegetarian option for me".

The kitchen staff were aware of people's likes and dislikes, allergies and preferences. People were offered two choices daily; a menu was displayed of the day's choices. People were asked for their choice of the next day's menu and were all asked again on the day, in case they had forgotten, or changed their minds. People were offered a variety of drinks with their meal and were able to choose where they ate their meals, for example, at the dining table, in the conservatory or outside on the patio. People who chose to eat in their rooms told us they enjoyed their food, which was served promptly and always hot.

Staff were aware of people's needs and offered support when appropriate. One person required assistance with their meal and staff supported them in a relaxed and unhurried way, sitting beside them and engaging them in conversation.

Good

Is the service effective?

Healthcare professionals such as GPs, district nurses and chiropodists were involved in people's care where necessary. Records were kept of their visits as well as any instructions they had given regarding people's care. During our inspection one person told staff they were feeling unwell and would like to see a doctor. A doctor visited the person later that morning and left a prescription which staff obtained on behalf of the person.

Requires improvement

Is the service caring?

Our findings

People and visitors told us they felt the staff were caring. One person said "I've been happy here from the beginning. The staff are good they listen to you". Another person told us "I don't have a worry in the world, here. I'm happy. Otherwise I'd say so". Other comments made by people about staff included "They're very, very, very sweet, couldn't be better", "You can have a laugh with the girls as they come and go", "Staff lovely" and "They are all very kind to me". A family member told us they were "happy with [their relative's] care" and added that her relative "does well here, and seems to have made some friends, and the staff are good to her".

However, we observed care in the communal areas of the home and saw staff did not always interact with people in a positive way. One person was sat in the lounge area of the home asking for a window to be shut as they were cold. A member of staff was nearby writing. We spoke with the member of staff and pointed out the person was cold. They told us "oh she is always saying that" and added "I am trying to write the handover". The person then became apologetic to the member of staff. After further prompting the member of staff assisted the person.

Another member of staff came into the lounge area wearing an apron and putting on latex gloves. They said in a loud voice, which could be heard by other people in the lounge, "I'm just going to get her (a person using the service) off the toilet".

On a separate occasion a person was sat in the lounge who had a runny nose. They did not have a handkerchief and had run out of tissues; there were a number of used tissues discarded on the floor and chair around them. They looked uncomfortable and had a large drip visible on their nose. A number of staff passed through the lounge close to this person but did not appear to notice their discomfort until we intervened.

The failure to ensure people were treated with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On other occasions staff provided positive support to people. One member of staff spent time reassuring one person who was feeling anxious and distressed. They spoke gently to them providing continual reassurance and stayed with the person until they had calmed down. Another member of staff supported a person to maintain their independence while mobilising. They allowed the person to move at their own pace, while providing gentle encouragement and verbal reassurance.

People, and when appropriate their families, were involved in the planning of their care. The care plans covered a number of areas of a person's support needs and reflected people's preferences and choices. For example, whether they preferred a shower or bath, what time they like to wake up and when they like their breakfast. People or where appropriate their representative signed at the end of their care plan to confirm they had been consulted in its development. They also signed each of their risk assessments to confirm they agreed with the content.

Staff knew the people they were supporting and were able to tell us about people's life histories, their interests and their likes and dislikes. Staff used the information contained in people's care plans to ensure they were aware of people's needs and preferences. Staff understood the importance of respecting people's choice and privacy. They spoke to us about how they cared for people and we observed that staff knocked on people's doors and waited before entering. One person said staff were "very respectful" and "I like my door open but if it is shut they always knock first". The movement of the people at the home was unrestricted and they were able to choose where they spent their time. We spoke to some people who chose to spend their time in their own rooms. They said the staff respected this and offered them opportunities to join others if they wished. One person who preferred to stay in their own room told us "The girls are wonderful, I can't complain. I do what I like, when I like. I like it up here [in their bedroom], I could go to the lounge, but I don't bother". People's bedrooms were individualised and personalised with their own pictures and personal items.

Requires improvement

Is the service responsive?

Our findings

People told us staff were responsive to their needs. One person said "I've no complaints. Staff know me very well and know what I need". Another person told us "Staff are kind they come in and chat and because I stay in bed they turn me regularly; they are very gentle". Family members told us that people received good care and staff understood their relative's needs. One family member said "We are very happy with the home. [Their relative] has only been here a short while and we can already see an improvement".

However, during our inspection we found that people were at risk of receiving inappropriate care. Care records were not always up to date and did not always contain sufficient information to provide support to new members of staff who may be unaware of people's individual needs. The care records for one person identified that in June 2014 the person was being treated for a grade 3 pressure sore. Subsequent reviews of the care records recorded "no change". We spoke with a member of staff who told us "that healed ages ago". Care plans were generic in style and were not always sufficiently personalised to allow staff to understand people's individual needs. For example the care plan for one person, who was registered blind, did not contain information and guidance to assist staff in understanding how to provide support for a person with a visual impairment. As a result of a change in their medication, another person was required to keep their legs elevated and needed assistance to stand every two hours. Although, staff were aware of the need to support this person to stand they were not clear as to the frequency and the duration they needed to stand for.

The failure to ensure people's care records were accurate and reflected people's individual needs was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a structured approach to activities, which included activities led by an activities co-ordinator twice a week, such as bingo, sing-alongs, quizzes, scrabble and painting. There was also a programme of visiting musicians. One person told us they enjoyed the weekly games: "we play quoits, like on board ship, and magnetic darts". Another person said the activities coordinator was "nice" and "gives us things to do, and talks to people". People who chose to stay in their rooms told us the activities coordinator was a frequent visitor and was good at nail painting, helping people with their mail and other one-to-one activities. One person told us the activities co-ordinator "comes to see me in my room and does exercises two or three times a week; we do painting together, and finger exercises. Now I can knit again, crochet, and sew".

People were supported to maintain friendships and important relationships with their relatives; their care records included details of family members and other important relationships. One relative told us that they were able to visit at any time, take them out or talk with them in private if they wanted. One person said "It is nice here; my son comes twice a week to take me out."

People were encouraged and supported to maintain their independence. The provider had created raised flower beds to enable people, who wanted to engage in gardening, to stand and support themselves while enjoying this activity. People had voluntarily taken responsibility for watering the beds, and being "in charge of" hanging baskets and window boxes. One person said "It's been good here for me; I like the little garden".

The provider sought feedback from people or their families. The provider arranged regular resident's meetings to give people an opportunity to express their views about the service. For example, in the minutes of a recent meeting we noted the people's views were sought on how to spend funds raised during a recent event; the menu had been discussed, with people expressing their choices about what food they would like to eat; the likely impact of on going maintenance work at the home. In addition, the provider carried out an annual quality assurance survey. Most of the responses to the latest survey from February 2015 were positive. Where issues were identified, action was taken to respond to the concerns. For example people identified there had been a lack of activities available for them and as a result the provider had arranged for a local organisation to deliver a variety of sessions including chair based exercises, reminiscences and entertainers. The results of the survey and the action plan were posted on a notice board in the hallway of the home for people to see.

The provider had arrangements in place to deal with complaints and provided detailed information on the action people could take if they were not satisfied with the service being provided. This was published in the service

Requires improvement

Is the service responsive?

user's guide given to everyone using the home. Since our last inspection there had been one complaint, which was investigated and remedial action taken. People and relatives knew how to complain.

Requires improvement

Is the service well-led?

Our findings

People and family members told us they felt the service was well-led. One person said "the owner and his wife are very concerned and very hands-on."

However, we found that the quality assurance system adopted by the manager did not always provide an opportunity for organisational learning or enhance the provision of care people received. The monitoring process included regular dip sampling of medicine management, staff records, environmental health and safety, fire safety and compliance with the requirements of the mental capacity act. There was also a system of daily audits in place to ensure quality was monitored on a day to day basis, such as daily audits of the fridge and freezer temperatures. However, this approach to quality assurance may not always be robust enough to ensure errors and omissions were identified, such as concerns in respect of the accuracy of records, infection control practices and medicines management, staffing levels and risk management, which may put people at risk.

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.

As well as the audits carried out by the manager and deputy manager, the providers carried out a quality assurance process twice a year. Where issues or concerns were identified remedial action was taken. For example, the providers carried out an unannounced spot check of the home in the early hours of the morning and identified a number of inappropriate practices being carried out be staff. As a result of their findings the staff involved were subject of a supervision and internal discipline process. The areas of concern were raised and discussed with all staff at the next staff meeting.

The provider's vision and values were set out in the 'service user's guide'. There were posters reinforcing the provider's expectations with regard to people's experiences of the care displayed on the notice board in the staff room. One member of staff told us the providers lead by example "The owners come in often and have a chat and when they are here they are happy to help out and take part in giving care. For example the other day one of the owners helped to support a person to have a bath".

Staff were aware of the provider's vision and values and how they related to their work. However, their approach to care did not always reflect the providers' vision in practice, leading to poor interactions with people using to service. Regular staff meetings provided the potential for the management team to engage with staff and reinforce the provider's value and vision. They also provided the ability for staff to provide feedback and become involved in developing the culture of the service. There was an opportunity for staff to engage with the providers on a one to one basis through supervisions and informal conversations. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. One staff member said "the management are very approachable. They are always on call and always listen". Another member of staff said "At the moment it is really good here. The managers all work well together". Staff confirmed they were able to raise issues and make suggestions about the way the service was provided in one to one supervisions or staff meetings and these were taken seriously and discussed. One member of staff said "Staff meetings are interactive and you are encouraged to take part".

The provider had developed links with external organisations and professionals to enhance the staff's and their own knowledge of best practice and drive forward improvements. These included links with 'Research Ready Care Home Network' and with the National Institute of Health Research through the university at Southampton. The Research Ready Care Home Network brings together care home staff, residents and researchers to facilitate the design and delivery of research and to improve the quality of life, treatments and care for all residents. The provider told us that both organisations provide the opportunity for networking, sharing ideas and identifying new ways of working.

There was the potential for people and their relatives to comment on the culture of the service and become involved in developing the service through regular feedback opportunities such as residents' meetings and the annual feedback survey. The providers were also regular visitors to the home and engaged with people using the service and their families to seek their views.

Requires improvement

Is the service well-led?

There was a clear and visible management structure established by the providers though the manager and deputy manager. Staff understood the role each person played within this structure.

The home had 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, staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary. The staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example where abuse was suspected.

There was an established maintenance and renovation plan, which identified areas requiring redecoration, repair or replacement. This was overseen by the manager and the deputy manager and there was evidence of the work being completed in a timely fashion.

At the time of our inspection the manager was not registered because they had only been in post for a short while and were just undertaking the registration process. Although not registered the manager understood the responsibilities of a registered manager and was aware of the need to notify the Care Quality Commission (CQC) of significant events regarding people using the service, in line with the requirements of the provider's registration. They told us that support was available to them from the manager of another home owned by the providers who was acting as a mentor. In addition, both of the providers frequently visited the home to offer support and were available to be contacted at any time.

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 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 provider failed to have an effective system in place to ensure the safe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider failed to ensure people were treated with dignity and respect**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider failed to ensure people's care records were accurate and reflected people's individual needs**