The Regard Partnership Limited

Cornerleigh

Inspection report

Cornerleigh
1 Fourth Avenue, Denvilles
Havant
Hampshire
PO9 2QU

Tel: 02392470457
Website: www.regard.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

This unannounced inspection took place on 21 April 2016 and was bought forward following concerns CQC had received about the care people were receiving.

Cornerleigh is a care home without nursing that provides support and accommodation for up to 14 adults who live with a learning disability. At the time of our inspection there were 10 people living in the home.

Although our register showed a registered manager was in place, this person had resigned and was no longer working in the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A temporary manager was working in the home, five days a week to provide management and support while the provider recruited to this position.

People who lived in the home told us they liked living at Cornerleigh. They said they felt safe, could make their own decisions and that staff supported them well.

The provider was using agency staff while they recruited new staff. At times the staffing levels did not support people's needs or keep them safe. Not all risks associated with peoples care had been assessed and plans to reduce the risks developed. Whilst permanent staff's knowledge of people was good, a lack of clear assessment and guidance available meant risks associated with people's care and support may not always be identified and appropriate action taken. Not all plans of care were personalised or followed by staff. A lack of accurate, clear, person centred and individualised plans meant people may not receive care and support in a way they require. The provider was unable to demonstrate that medicines were stored at safe temperatures and we have made a recommendation about this.

The provider was unable to demonstrate that appropriate supervision and training had supported staff to be effective in their roles. Records associated with peoples care were at times inconsistent or could not be found. The systems used by the provider to monitor and assess quality had been ineffective and concerns had not been identified until these were raised to them, externally. A lack of clear, accurate and contemporaneous records and ineffective quality systems placed people at risk of receiving a service that was ineffective.

Staff described a low morale and a feeling of being unsupported by the provider. However, despite this they demonstrated a kind, caring and compassionate approach to people who they knew well. They interacted positively and were motivated. They demonstrated an understanding of the need for respect and consent. Where required the Mental Capacity Act 2005 had been applied. The locality manager was open and honest about the failings in the service and demonstrated a commitment to making positive changes for staff and people.

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

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.

Risks associated with people's care were not always assessed and plans developed to mitigate such risks.

Staffing levels did not always meet people's needs and ensure their safety.

Medicines were administered as prescribed but the provider could not demonstrate these were stored within safe temperatures. We have made a recommendation about this.

Safe recruitment practices were being operated.

Staff understood safeguarding people at risk and knew what action to take if they had concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not supported to be effective in their roles through supervision and training.

Consent was sought from people and where people lacked capacity to make certain decisions the Mental Capacity Act was applied correctly.

People's nutritional needs were met and they had access to healthcare professionals when they required this.

Is the service caring?

Good

The service was caring.

People were supported by staff who understood their needs and were caring and compassionate.

Staff demonstrated an understanding of respect, privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff understood people's needs and preferences but care records were not always personalised or followed.

A complaints procedure was in place and people knew how to use this.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems in place to monitor quality and drive improvement were not always effective and records were not always accurate.

A temporary manager was in place to support the service. They and the locality manager were open and transparent about the concerns within the service. They demonstrated a commitment to making positive changes for staff who felt unsupported and undervalued and for the people they supported.

Cornerleigh

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 April 2016 and was unannounced.

The inspection team consisted of one inspector. 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 improvements they plan to make. We also reviewed previous inspection reports and looked at our own records such as any notifications of incidents which occurred (a notification is information about important events which the service is required to tell us about by law). This information helped us to identify and address potential areas of concern.

During the inspection we spoke with three people, five staff, the manager and the locality manager. It was not always possible to establish people's views verbally due to the nature of their disability. To help us understand the experience of people who could not talk with us we spent time observing interactions between staff and people who lived in the home.

We looked at care records for three people in depth and sampled the records of a further two people. We looked at the medicines records for four people. We looked at recruitment, supervision and appraisal records for five staff. We also looked at a range of records relating to the management of the service such as incidents and accidents, complaints, service user feedback surveys and team meetings. We asked the locality manager to send us further information including policies and procedures, additional quality audits and the staff training matrix which we received.

Requires Improvement

Is the service safe?

Our findings

People spoke positively about living in the home. Permanent staff demonstrated a good knowledge of the people they supported. They knew about the risks associated with people's care and how to reduce these.

Risks associated with people's care were contained within their care records, however these did not always contain the information staff would need to support people according to their needs and some identified risks had not been planned for.

For example, two people were at risk of choking. Care plans were in place which detailed the action to take to reduce the risk of choking. For example, the consistency of diet and fluid they were to be supported with. However, at the time of our inspection there was no information about what staff should do in the event a person choked. Staff were able to describe basic first aid and said they would call emergency services. Following our inspection we were sent updated care plans which detailed the emergency action staff should take.

Staff confirmed that bed rails were used for one person, however no risk assessment had been carried out to ensure this was the most appropriate and least restrictive option. No plan was in place to guide staff about the use, management and monitoring of this equipment, to ensure any associated risks were minimised.

Staff told us about one person who could display behaviours which placed themselves and others at risk. Staff confirmed no plan of support was in place to guide staff about the risks of these behaviours, how to identify when they may present, how to reduce the likelihood of them occurring and what to do should they occur. Whilst staff could tell us how they would support this person, the provider was using agency staff while they recruited new permanent staff. Agency workers are staff that are not employed and trained directly by the provider. They provide temporary cover to the home. The lack of clear assessment and guidance available for agency workers and new staff meant risks associated with people's care and support may not always be identified and appropriate action taken.

The failure to identify risks and ensure these were appropriately assessed and plans implemented to mitigate such risks was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we also found areas where risks had been assessed and clear plans developed to guide staff. For example one person who had a diagnosis of epilepsy had clear guidance about how this presented and the action staff should take. Another person who displayed behaviours which presented risks to themselves and others, had clear plans in place which identified the risk, the strategies to implement which may help to prevent the behaviours and the action to take should the behaviours be present.

The provider had a core staffing level in the home of three care staff throughout the day, a waking night worker and a sleep in member of staff throughout the night. In addition the provider had negotiated with the local authority for additional one to one support hours for some people. However, feedback from staff was

that they did not feel the staffing levels were appropriate to meet all the needs of service users. They told us that often people may not be able to go out as they were unable to support this safely with only three staff available. We observed occasions when the staffing levels placed people at risk. For example, on one occasion we observed a person who was a known risk of choking left alone in the lounge with a food item. Staff were close by in an adjoining room and could hear what was happening in the lounge but could not see this person. We discussed the concerns with the locality manager for the provider who agreed that the core staffing level needed to be reviewed in line with people's needs and with the local authority.

The failure to ensure appropriate staffing levels at all times to meet people's needs and ensure their safety is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff supported people to take their medicines. People confirmed they received this when they needed it. The provider had a policy and procedure for the management of medicines and staff confirmed they had received training to be able to administer this safely. Records showed the amount of medicines received into the home was recorded and a stock check was maintained with daily and weekly audits. People were prescribed medicines to be given when required and there were protocols in place for their use. Medicine administration records (MAR) showed these were not used excessively and there were no unexplained gaps in the recording of regularly prescribed medicines. Storage arrangements for medicines were secure. However, the provider was unable to demonstrate that medicines were stored at a safe temperature as these checks were not carried out on individual medicines cupboards and were inconsistently carried out in the central medicines cupboard.

We recommend the provider review the systems in place to ensure medicines are stored at safe temperatures.

Staff demonstrated a good understanding of their roles and responsibilities in safeguarding adults at risk. They were able to describe different types of abuse and the action they would take if they had concerns. The manager had a good understanding of safeguarding. Following concerns we saw the provider's management team had worked in liaison with other external agencies including the local authority safeguarding team and the police to investigate these and take action. External agencies were working alongside the provider to address quality concerns as a result. The provider had contributed to an action plan which they were reviewing and adding to on the day of our inspection.

Recruitment records showed that appropriate checks had been carried out before staff began work. Potential new staff completed an application form and were subject to an interview. Following a successful interview, recruitment checks were carried out to help ensure only suitable staff were employed. Staff confirmed they did not start work until all recruitment checks had taken place.

Requires Improvement

Is the service effective?

Our findings

People told us they felt staff knew how to support them and they made their own decisions about what they wanted to do.

The locality manager was very open with us about the supervision, training and appraisal of staff. They confirmed that during the recent safeguarding concerns it had been established that supervisions and appraisals had not taken place regularly. Staff and records confirmed this.

The locality manager confirmed they were unclear about and could not confidently demonstrate who had completed the eLearning training the provider required. As a result they had proposed for a number of eLearning subjects to be reset and for all staff to undertake these. These topics included safeguarding, mental capacity and deprivation of liberty safeguards, communication, record keeping and various other topics. At the time of our visit this had just been proposed to the provider by the locality manager.

The failure to ensure staff were supported to be effective in their roles through supervisions and training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff also undertook face to face training and they described this positively. They felt this supported them in their role and one told us about the recent course they had undertaken on how to support people who display behaviours that may challenge.

The Care Quality Commission monitors the operation of Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (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 made on their behalf must be in their best interests and as least restrictive as possible.

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 and hospitals 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.

Staff demonstrated an understanding of the need for consent, and of the Mental Capacity Act 2005. Staff told us how people could make their own decisions and staff would provide guidance and support to make these decisions. We observed staff support people to make their own decisions and respect the choices they made. People confirmed they made their own decisions and could do what they wanted to do. We saw the provider had sought written consent for aspects of support such as sharing of information and care plans were in place that guided staff about how to support a person to make choices and decisions. Assessments

of people's capacity to make certain decisions had been undertaken and best interest decisions had been recorded.

The manager demonstrated knowledge of Deprivation of Liberty Safeguards (DoLS) and understood their responsibilities in relation to this. They confirmed applications to the supervisory body had been made for some people living in the home and they were waiting for these to be reviewed.

People were supported to have enough to eat and drink. People said, and we observed that, they were given a choice of what they wanted to eat. People had no concerns about the food. People worked alongside staff to prepare their meals and support them to maintain independence. Where needed specialist input from speech and language therapists, this had been sought. Plans of care had been developed based on this advice and staff were aware of this. Other guidance was available however, this was not always stored with the care plans making it difficult to find quickly and easily.

Staff told us how they monitored people's weight and if they had any concerns they would raise this with the appropriate health professionals. They told us about how they support one person to eat a high calorie diet to maintain a suitable weight following consultation with a dietician.

Staff and people confirmed they have regular access to healthcare services and records confirmed regular check-ups with the GP and the dentist took place. In addition, and where needed, other professional input was sought; for example the psychiatrist, dietician and speech and language therapy. Staff supported people to attend these appointments and help them understand what was being said.

Good

Is the service caring?

Our findings

Staff knew people well and treated people with kindness and compassion. Staff were cheerful and the atmosphere at the home was relaxed. Staff were seen to be caring. Observations showed staff treating people with kindness and affection. During conversations with people, staff spoke respectfully and in a friendly way. They chose words that the people would understand. Staff explained what they were doing and why. They used people's preferred form of address and got down to the same level as people and maintained eye contact. Staff spoke clearly and repeated things so people understood what was being said to them. They treated people with respect and people felt listened to. One person told us how they liked living at Cornerleigh and that staff treated them well.

Staff responded positively and calmly when situations that occurred had the potential to cause anxiety for people. They responded quickly, using distraction techniques, reassurance and clear explanations.

Staff demonstrated a good understanding of the need to respect people's dignity and privacy. They were able to tell us how they ensured doors were closed and curtains were drawn when supporting with personal care. Staff were discreet when offering support.

Staff recognised the importance of encouraging people's independence. Observations showed people being encouraged to maintain their independence, including when moving around the home and engaging in activities. Two people living at the home accessed the community independently and plans were in place to support this. Staff told us about one person who wanted to access the community independently so following a review with the social worker it was agreed to start a community training programme with this person to help them achieve this.

Staff told us about how they hold monthly 'house' meetings with people. We saw records that confirmed these provided people with the opportunity to make suggestions about the service, the meals and activities. Following recent safeguarding concerns, staff had held a meeting with people in the home to talk about safeguarding, what this meant and any concerns people may have.

Requires Improvement

Is the service responsive?

Our findings

Everyone had lived at Cornerleigh for a number of years. People told us they were involved in decisions about care all the time. People said staff knew how to help them.

Staff had a good knowledge of person centred care and were able to tell us what this meant. They knew the people they cared for and the support they needed. They were able to explain what care and support was required for individuals in depth.

Care records included information about people's history, including their personal and medical history. Information about people's likes and dislikes was also maintained.

Most care plans developed had been personalised however, at times they were worded exactly the same and were not followed by staff. For example, for one person their care plans described how they needed visual aids and timetables to support them throughout the day. However, we observed these were not used and staff confirmed these were not in place and used to support this person. One plan described how the person would not attend to personal care if they did not have a schedule in place. Staff told us this was not in place but described the support they did provide which involved a 'reward' chart when they had completed personal care. The person showed us this chart and told us staff signed this following their personal care. The care plan did not reflect this.

For two people we found their care plans for supporting them to make decisions was exactly the same. Both said that people needed information to be provided to them in pictorial format however, we observed staff supporting both of these people. Staff did not use pictorial communication aids. They used verbal communication to support people to make decisions.

Whilst permanent staff could tell us how they would support people and we saw this provided in a person centred way, the provider was using agency staff while they recruited new permanent staff. The lack of accurate, clear, person centred and individualised plans available for agency workers and new staff meant people may not receive care and support in a way they require. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a clear complaints procedure display in the home and in pictorial format. People said they had no complaints and if they did they would talk to staff. Staff knew how to support people and their relatives to raise complaints. There were no records of complaints having been made to the home in the last 12 months.

Requires Improvement

Is the service well-led?

Our findings

People were confident to talk to staff and appeared comfortable being around them. They told us they would talk to staff if they had any concerns.

Although our register showed a registered manager was in place, this person had resigned and was no longer working in the home. A temporary manager was working in the home, five days a week to provide management and support while the provider recruited to this position. The locality manager told us the new manager would be starting the week following our inspection and would apply to CQC to become registered.

Records were not always consistent and accurate. For example, two people's self-medication competency assessments were unclear and provided inaccurate information. These had been signed by the previous registered manager as the person being competent to self-administer their medicines. However the notes section indicated this was not accurate. Staff told us no one in the home self-administered their medicines as they all required support. Records were not always available. For example, for one person their mobility care plan referred staff to look at their falls care plan. However, this was not in the file and staff were unable to find this.

The locality manager told us about a system of audits and provider visits that formed the provider quality assurance processes. However, following the recent safeguarding investigation, a number of issues were bought to the attention of the local authority and provider including accurate and up to date care and finance records for people. The locality manager provided us with a copy of the last service manager monthly review audit that was carried out in December 2015. They told us this was carried out by them, and then reviewed after two weeks and a final review took place two weeks after that to ensure any actions were completed. This review did not identify the concerns around supervisions and eLearning training. It did not identify the concerns around finance records. This audit did not look at people's individual care records and therefore did not identify the concerns regarding inaccurate and missing records. This meant this system of ensuring quality was ineffective at identifying concerns and driving improvement.

The locality manager explained that following the safeguarding alert the provider's quality team undertook a thorough internal audit over two days. They advised this was held on a central computerised system that they would email to us. However, following our inspection they advised they were unable to send this to us but provided us with a list of the areas that had been identified as compliant and non-compliant by the provider. However, what we were sent did not include any information about people's care records. We could therefore not be assured the provider had an effective system in place for assuring the quality of the service and identifying areas of improvement.

The lack of clear, accurate and contemporaneous records and ineffective quality systems was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The locality manager told us the provider's quality team would be reviewing the systems to find out why the

systems did not work in identifying the issues raised within the safeguarding alert. They also advised they were currently using the action plan devised during the safeguarding meetings to ensure they took appropriate action to address concerns. We were sent an updated copy of this, five days after our visit and noted that this included a review of all service user care records by end June 2016 and ensuring staff supervisions and training.

Staff meetings had not taken place regularly and the locality manager told us this would be addressed when the new manager commenced their role. The last recorded staff meeting had been held in February 2016 and provided a brief update on the safeguarding. Staff had been made aware of and involved in the investigation of recent safeguarding concerns in the home. They told us this had left them feeling unsupported by the provider. Staff stated they completely understood the need for confidentiality but felt they had no one to talk to during this, until the temporary manager was introduced. They told us morale was low and whilst they felt things were improving because of the temporary manager, they were reserving judgement about how things would be when the new manager started. Despite these feelings, our observations of staff supporting people were positive. Staff were cheerful and motivated throughout.

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 9 HSCA RA Regulations 2014 Person-centred care The registered person had not ensured that care planned and delivered was appropriate and met people's needs. Regulation 9(1)(a)(b)(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured that risks associated with people's care had been assessed and plans developed to mitigate such risks. Regulation 12(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured accurate records of care were maintained and systems to assess quality were effective. Regulation 17(1)(2)(a)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured suitable numbers of appropriately trained and supervised staff were available to meet people's needs at all times. Regulation 18(1)(2)(a)