Mr Sanjay Prakashsingh Ramdany & Mrs Sandhya Kumari Ramdany

Cornelia Heights

Inspection report

93 George Street
Ryde
Isle of Wight
PO33 2JE

Tel: 01983567265

Date of inspection visit:
11 August 2016
15 August 2016

Date of publication:
06 October 2016

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 11 and 15 August 2016 and was unannounced. The home provides accommodation for up to 23 older people with personal care needs. There were 22 people living at the home when we visited. All areas of the home were accessible via a lift or stair lifts and there was a lounge and conservatory dining room. There was also an accessible garden. Most bedrooms were for used for single occupancy and some had en-suite facilities.

At our previous comprehensive inspection in April 2015 we found the provider did not have an effective system to ensure the safe management of medicines, care records were inaccurate and not reflective of people's individual needs, people were not treated with dignity and respect and quality assurance systems were not robust. The provider sent us an action plan telling us how they planned to rectify this. At this inspection we found people were treated respectfully and their dignity maintained and action had been taken to improve the accuracy of care records. However, adequate action had not been taken to ensure medicines were managed safely and quality monitoring systems were not robust.

There was a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

The provider had failed to notify CQC about some significant events that happened in the care home involving an allegation of abuse and an injury to a person using the service which resulted in them requiring hospital treatment.

There were limited formal quality assurance systems which meant areas of concern had not been identified. The registered manager regularly worked with care staff providing informal monitoring of the care people received.

Medicines were not always managed effectively and care staff were not consistently following the provider's medicine management procedures.

There were enough staff to meet people's needs although staff were busy and the registered manager and deputy were working some care shifts. This impacted on their ability to undertake all management functions. Staff received appropriate training and were supported in their work. The recruitment process helped ensure staff were suitable for their role.

People felt safe and staff knew how to identify, prevent and report abuse. Legislation designed to protect people's legal rights was followed correctly although formal mental capacity assessments had not been completed. Staff offered people choices and respected their decisions. People were supported and encouraged to be as independent as possible and their dignity was promoted.

People, relatives and external health professionals were positive about the service people received. People were positive about meals and the support they received to ensure they had a nutritious diet.

Care plans provided information about how people wished to be cared for and staff were aware of people's individual care needs and preferences. People had access to healthcare services and were referred to doctors and specialists when needed.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. Visitors were welcomed and there were good working relationships with external professionals.

Staff worked well together, which created a relaxed atmosphere that was reflected in people's care. Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we have taken in the full version 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

Medicines were not managed effectively and care staff were not consistently following the provider's medicine management procedures.

Risks to people were assessed, although action had not been taken to ensure the environment was always safe.

Recruitment practices had not ensured that all pre-employment checks were completed before new staff commenced working in the home. Staffing levels were appropriate to meet people's needs.

People were protected from the risk of abuse; staff knew how to identify, prevent and report abuse. Staff understood how to keep people safe in an emergency.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to access healthcare services when required, although systems had not ensure that regular monitoring of people's diabetes was completed as identified in their care plans. Staff followed legislation designed to protect people's rights and freedoms but did not always complete mental capacity assessments.

The environment was supportive of people living with dementia and people had access to the outdoors and fresh air.

People received a varied and nutritious diet and they were supported appropriately to eat. Staff knew how to meet people's needs; they were suitably trained and supported in their work.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion. Staff knew people well, interacted positively and supported them to build friendships.

People and their relatives were positive about the way staff treated them. People were treated with respect. Dignity, privacy and independence were promoted.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support. Staff demonstrated a good awareness of people's individual needs and responded when people required support.

People were able to participate in a range of group or individual activities which provided both mental and physical stimulation.

The provider sought and acted on feedback from people. There was a complaints policy in place and people knew how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well led

CQC had not been informed of all notifiable incidents within the home. There were limited formal quality assurance systems although the registered manager regularly worked with care staff providing informal monitoring of the care people received.

The management team were approachable. People and visitors felt the home was run well. Staff understood their roles, and worked well as a team.

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 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 11 and 15 August 2016 and was completed by two inspectors and an expert by experience in the care of older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection was unannounced.

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 reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with 14 people living at the home, four relatives and two health care professionals. We also spoke with the provider's representative, the registered manager, five care staff, housekeeping and kitchen staff.

We looked at care plans and associated records, including those for medicines, for six people and records relating to the management of the service. These included staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records. We observed care and support being delivered in communal areas and 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.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in April 2015 we found the provider did not have an effective system to ensure the safe management of medicines. People did not always receive their medicines in a timely way, Medicines Administration Records (MARs) were not fully completed, prescribed topical creams were also not managed appropriately and not all medicines were stored securely. The provider sent us an action plan telling us they had taken the necessary steps to ensure medicines were managed safely. However, at this inspection, we found that these were not always followed placing people at risk of not receiving their medicines as prescribed.

Medicines administration records had not been fully completed with staff having not recorded whether they had administered all medicines or not. Subsequent staff had not taken any action to bring the recording errors to the attention of the management team or address the issue directly with the staff member concerned. Where additions or amendments were required to the MARs these had been handwritten. There was no signature of the staff member making the amendment or a second staff member to verify the amendment was correct. This is recommended by guidance issued by the National Institute for Health and Care Excellence (NICE) to help ensure errors are not made. For one person, the handwritten addition did not reflect the information on the medicine box as dispensed by the pharmacist. The MAR did not state the maximum dose per day of a variable dose, 'as required' medicine.

Some medicines were prescribed to be administered only when the person required these (PRNs). A form was in place to inform staff when these should be administered, but these had not been used for all people. One person was prescribed a medicine for use when they were agitated. There was no information to guide staff as to when they should administer this medicine or other action they could take to reduce the person's agitation. Other people were prescribed medicines for constipation and, again, there was no guidance for staff as to when these should be administered meaning people may not receive these consistently.

Prescribed topical cream charts were in use; however, there was inadequate information to direct staff as to when these should be applied. Records of application showed that these were not applied on a regular and consistent basis. Staff were recording the date prescribed topical creams containers were opened but had not discarded these in a timely way. The creams may not have been effective as the manufactures guidance for disposal once opened had not been followed.

Some tablets had been found on the floors of people's bedrooms or communal areas. These had been stored securely awaiting return to the pharmacist. However, the registered manager was unable to say what action had been taken to identify why people had not been observed to have swallowed these. Whilst visiting one person in their bedroom with the registered manager, we found the remains of a tablet on a person's bedside table. Staff were therefore not ensuring that people were taking tablets they had administered to the person. Also awaiting disposal were four small plastic bags, each containing one or more tablets which had been removed from their packaging but not taken by the person. The registered manager was unable to say why these had not been administered as there was no information to say who the tablets had been prescribed for or why they had not been administered.

The failure to ensure medicines were managed safely was a breach of regulation 12 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Suitable arrangements were in place for obtaining and storing of medicines. Staff administering medicines had received training and had their competency assessed. The registered manager told us they were considering moving to an electronic medicines management system which they felt would help ensure the safe management of medicines and that recording errors did not occur. We saw they had had an initial meeting about the new system with the dispensing pharmacist during the inspection.

An appropriate system was in not in place to assess and analyse accidents and incidents across the home and action lessons learnt from them. When staff noted a bruise or injury to a person they recorded this on body maps which were then stored within the person's care file. When accidents occurred, care staff completed accident forms detailing the accident and any injuries. However, there was no process whereby the registered manager reviewed the body maps or accident reports to identify the cause of the injury or if there were any patterns or trends for the individual or other people living at the home.

Environmental risks were not always managed appropriately. We noted an upstairs bedroom window which was wide open and then checked the remaining upstairs windows with the registered manager. With the exception of two windows, these could all be opened wide meaning people could climb or fall from these. Individual risk assessments had not been completed. The registered manager said they thought all windows had safety restrictors in place and immediately arranged for these to be fitted. There was a range of environmental risk assessments which were individual to the home. Where risks had been identified action was taken to manage the risk although this was sometimes reactive following an incident and not part of an overall review of procedures and risk. For example, after a person left the home unaccompanied in December 2015 and January 2016, door alarms were fitted to some doors. However, a full review of the home had not been completed, meaning that other doors and the rear gate were not secured until after another person left the home in June 2016 and again in July 2016.

The failure to ensure all environmental risks were assessed and managed safely was a breach of regulation 12 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks to individual people were managed safely. All care plans included risk assessments, which were relevant to the person and specified the actions required to reduce the risk. These included the risk of people falling in the home, nutrition, moving and handling and developing pressure injuries. Risk assessments had been regularly reviewed and were individualised to each person. These procedures helped ensure people were safe from avoidable harm, whilst promoting their independence. We observed equipment, such as stair lifts and pressure relieving equipment being used safely and in accordance with people's risk assessments. On an individual basis the day to day risks of people falling were managed effectively. Staff knew the support each person needed when mobilising around the home and provided it whenever needed. Where necessary equipment to alert staff that people at high risk of falls were moving around the home was in place and in use.

We saw people were encouraged and reminded to use walking aids where necessary. Staff said that the use of moving and handling equipment and repositioning was always undertaken by two staff and we saw that two staff were available to support people when required. Risk assessments had been conducted and measures had been put in place to reduce the likelihood of people developing pressure injuries. Staff were aware of people who needed to use special cushions or mattresses and we saw these being used consistently.

Recruitment procedures were in place to help ensure staff were suitable to work at Cornelia Heights. However, these had not been followed for all new staff. Procedures should have included a full employment history, reference checks from previous employers and a criminal record check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions. Staff confirmed this process was followed before they started working at the home. However, references for two new staff had not been sought from the applicant's most recent employer and for one new staff member only one reference was available.

Despite the concerns we identified, people told us they felt safe at Cornelia Heights. One person said, "Yes I'm safe here". Visitors also felt their relatives were safe at the home. One visitor said "I don't worry if I can't get in [to visit]; I know they will be safe and I will get a phone call if there are any problems". Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse, and how to contact external organisations for support if needed. The registered manager described the action they would take should a safeguarding concern be brought to their attention. The actions described would help ensure people remained safe. Investigations into safeguarding incidents were thorough and where necessary, appropriate steps had been taken to protect people.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. People told us care staff were available when they needed them and we heard call bells were responded to promptly. One person said "There are enough staff", they added "they usually come quickly". Another person told us "You don't have to wait long for anything". Staff said they felt there were usually enough staff to meet people's needs. One staff member said "The staffing levels are ok most of the time although it can be a bit difficult if someone is agitated". Staffing levels were determined by the registered manager who said they listened to care staff and worked some direct care shifts, which enabled them to assess if staffing levels were adequate. All staff, including ancillary staff such as housekeeping, told us they undertook the same training as care staff and said they were able to support people when necessary, such as if care staff were busy. We observed this occurring during the inspection.

There were arrangements in place to keep people safe in an emergency, such as in the event of a fire. Staff were aware of the correct procedure to take should the fire alarms sound. Fire detection and emergency equipment was in place and was checked regularly to ensure it would work in an emergency. Personal emergency evacuation plans were available for people; they included details of the support each person would need if they had to be evacuated and were kept in an accessible place. Staff had been trained to administer first aid; however, the home did not have equipment which could be used to assist people who had fallen if they were not able to get up from the floor unaided. This had resulted in paramedics being call to assist an uninjured person who could not get up from the floor on their own. Staff had access to essential emergency phone numbers and a business continuity plan which detailed the action staff should take in a variety of potential emergencies.

Requires Improvement

Is the service effective?

Our findings

Where people had a known medical diagnosis requiring regular monitoring, this had not always occurred. Several people were living with diabetes which was being managed in a variety of ways either via diet, tablets or insulin injection. This was recorded in their care plans along with risk assessments with details as to how this should be monitored and managed. However, there were inconsistencies between the care plans, the risk assessments and the procedures followed by staff. As a consequence the monitoring of people's blood sugar levels had not been completed for six weeks prior to the inspection and not consistently prior to that time as detailed in people's care plans. After we identified this, the registered manager took action to consult with external health staff and ensure that care plans and risk assessments were rewritten and followed by care staff.

People were supported to access healthcare services when needed. One person told us "If you need a doctor you only have to ask". One visitor told us how staff managed a particular medical care need for their relative and said "The staff have done wonders with it". Visitors said staff consulted doctors when necessary and kept them informed about any changes in their relative's medical care needs. One visitor told us how staff had supported their relative following hospital treatment. General health information such as people's medical history was known and when required, staff consulted GP's and out of hour's services, such as paramedics and 111. Staff had sought advice when they had identified concerns, such as changes to people's skin condition or when they thought people may have had a urine infection. People were seen regularly by doctors, specialist nurses and chiropodists. The registered manager had arranged for an optician to visit the home enabling everyone to have their vision checked and purchase new spectacles if required. The registered manager told us they supported people to attend the nearby dentist when this was needed. We spoke with three visiting health professionals. They were all positive about the way Cornelia Heights met people's health care needs.

Staff followed the principles of the Mental Capacity Act (MCA) although information about people's ability to make decisions was not always assessed or recorded. 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. Some people had a cognitive impairment and were not able to make certain informed decisions. These included decisions around the delivery of personal care and the administration of medicines. However, there was no assessment of the person's inability to make these decisions. For another person, who had the ability to make some decisions, we saw a family member had been asked to agree to their care. Staff had not checked that the family member had the authority to do this.

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. We found the provider was following the necessary requirements. The registered manager had applied for DoLS authorisations where necessary and was waiting for these to be assessed or reassessed and approved by the local authority. Staff understood their responsibilities and knew how to keep people safe in the least restrictive way. For example, one person was waiting for their DoLS to be reassessed by the local authority. Staff were aware a DoLS had been in place and were monitoring the person discreetly on a regular basis.

Staff sought verbal consent from people before providing care and support by checking they were ready and willing to receive it. One person said "They always ask before they do anything". Records confirmed that staff complied with people's wishes. For example, daily records and medicine administration records recorded when people had declined care or medicines. Staff described how they respected the person's decision and would then return shortly after and try again. A care staff member said "If people say no, well it's their choice, we just go back later, or someone else [another care staff member] will try".

People had confidence in the knowledge and the ability of staff to provide effective care. Staff demonstrated a good understanding of the needs of the people they cared for and how to communicate with them effectively. A visiting health professional said "I think they [people] are well cared for". New staff had all previously worked within a care setting and had achieved a recognised care qualification. New care staff members told us they had undertaken 'shadow shifts' where they worked alongside and in addition to the usual number of staff for up to two weeks before being included on the duty roster. The registered manager showed us the induction process which was comprehensive. However, they were unable to show us completed induction records for any of the four most recently recruited staff as they said they were unable to find these. We were told staff who did not have a care qualification would undertake the care certificate via an external trainer. The Care Certificate is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. Most staff had also obtained vocational qualifications relevant to their role or were working towards these. Training for experienced staff was refreshed regularly via an external trainer. A senior staff member was due to undertake a train the trainer course for moving and handling, meaning they would be able to provide this training when required.

People were cared for by staff who were appropriately supported in their work. Staff received a range of supervisions with the registered manager or deputy manager. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. The management team also worked some care shifts, which they said enabled them to directly supervise how staff provided care for people. Staff who had worked at the home for in excess of a year had received an appraisal.

People were positive about the meals at Cornelia Heights. They said they liked the food and they were able to make choices about what they ate. One person said, "The food here is good. I have a big appetite so I get large portions". Another person told us they looked forward to meal times and added "The food is lovely, it is good. When I see it on the plate I eat it all up". A third person said "I think we have a fairly good diet, fresh tomatoes and vegetables". People received a varied and nutritious diet including fresh fruit and vegetables and appeared to enjoy their meals, which looked appetising and were nicely presented on the plates. Staff were aware of people who needed special diets or had particular food preferences and we saw these were provided. The cook was also aware of people's preferences and specific dietary needs, which they said they were able to meet. People told us they could receive drinks and snacks at night if required. This was confirmed by records viewed. There was a large bowel of fruit on the table in the conservatory. During the day a care staff member offered people fruit and offered to cut it up for them. People had drinks of water or fruit squash on their tables and hot drinks were offered mid-morning and afternoon as well as at other times when people requested them.

When necessary, care staff monitored the amount people ate and drank using food and fluid charts which were fully completed. Some people needed to be encouraged to eat and this was done in a discreet and supportive way. Staff said they had time to support people and we saw they did not rush people with their meals. People were offered choices; for example, staff showed people both lunch time drinks options before pouring these for them.

The provider had undertaken refurbishment and redecoration of areas of the home. They told us they had recently attended training about dementia which had included guidance as to how environments in care homes could better support people living with dementia. Action had been taken to implement this including repainting doors specific colours to help them stand out. A passenger lift was available with other parts of the home accessed by short flights of steps which were provided with stair lifts. Records viewed showed essential checks on the environment, such as fire detection, gas, electricity and equipment, such as hoists and the lift were regularly serviced and safe for use. The registered manager said consideration was made to the available rooms and mobility needs of people when deciding if the home could accommodate new people. People had access to the garden, which had suitable outside furniture including a sun shade, providing an opportunity for fresh air. We saw several people enjoying the garden during the inspection.

Good

Is the service caring?

Our findings

At the last inspection in April 2015 we found the provider had failed to ensure people were treated with dignity and respect. The provider sent us an action plan telling us they had taken the necessary steps to ensure this was rectified. At this inspection we found people were treated respectfully and their dignity maintained.

People were cared for with kindness and compassion. One person said of the staff, "The staff are very friendly" they nodded towards the care staff and said "They are very caring". Another person said "The carers are nice here, you don't get hassled". Visitors also spoke positively about care staff. One said "The carers are really lovely, and are so helpful". These comments were echoed by other people and visitors we spoke with. A visiting health professional said "The staff do seem to really care about the people here".

Without exception, all the interactions we observed between people and staff were positive and friendly. Care staff appeared friendly and spoke with people in a caring and dignified way. We saw staff kneeling down to people's eye level to communicate with them. Staff gave people time to process information and choices were offered. Staff did not rush people when supporting them. We heard good-natured banter between people and staff showing they knew people well. People were clearly relaxed and comfortable in the company of staff. Staff spoke positively about people and knew what was important to them. For example, we saw a person sitting with a visiting dog on their lap. Staff told us the person loved dogs and had worked with them previously. We saw one person who had been settled and happy in the morning became tearful and agitated in the afternoon. A staff member sat and talked quietly with them and used distraction. As a result the person became calm and cheerful.

People's privacy was respected at all times. Before entering people's rooms, all staff knocked, waited for a response and sought permission from the person before going in. Confidential care records were kept securely and only accessed by staff authorised to view them. Two bedrooms were each shared by two people. Privacy screens were available in these rooms and bedroom doors were always closed whilst staff provided personal care. A visitor told us they had been aware their relative was to have a shared room prior to admission and that there had not been any issues with privacy. Subsequently a single room had become available but the person had chosen to remain in the shared room. People told us staff always remembered to close curtains and doors before providing care.

Staff treated people with dignity and respect and described the practical steps they took to preserve people's dignity when providing personal care. These included keeping people covered as much as possible and telling people what they were about to do. Staff were able to tell us if people preferred a specific gender of care staff to provide personal care and staff said they were able to meet these preferences. Care plans included specific individual information as to how people's dignity should be maintained. Staff were seen to respect people during interactions. For example, people were offered the choice, and informed, before clothing protectors were used at lunch time.

People were supported to express their views and offered choices about day to day events. One person told

us "You can stay in bed all day if you don't feel well". People told us they had a choice about meals and one said, "You have a choice; you don't have to have the same as everyone else". We saw in the afternoon people were asked by the cook what they would like for their evening meal. The cook offered to prepare alternatives that were not on the menu if people preferred these.

People's independence was promoted. At lunch time staff encouraged a person to eat without taking over. Plates with higher sides, but which still looked like standard dinner plates were provided where necessary. These supported people to eat independently without appearing to be specialist equipment. Care plans specified what people could do for themselves and what they needed help with. For example, one stated what the person could do independently and what they required prompting and assistance to complete. People in bedrooms had easy access to a call bell meaning they could summon staff when required.

When people moved to the home, they and, when appropriate, their families were involved in assessing, planning and agreeing the care and support they received. Family members told us they were kept up to date with any changes to the health of their relatives. Cornelia Heights supported people to maintain family relationships. Family visitors said they were always made to feel welcome and could visit at any time. For example, one visitor told us how the home had supported their relative following hospital treatment. They told us their relative had been restless and took a while to settle once back at the home. The relative said, "The staff here were very kind to me; they let me stay with him for two nights and gave me a lovely breakfast in the mornings". It had obviously meant a lot to the visitor that they had been able to stay with their relative. They confirmed it was not that they felt staff would not have looked after their relative but admitted it was "More about my need to be with him". Another family member described how care staff distracted their relative, making it easier for them to go home after visiting. This showed staff considered the needs of family members and understood how hard it could be for them.

Care files contained information about people's lives, preferences and what was important to them. Discussions with care staff showed they were aware of people's occupations and other details about their lives. One person told us "I hate fish, don't eat it, they know this". Care plans also detailed any spiritual beliefs or needs a person may have. For example, one care plan stated '[Name person] is C of E practising'. The local vicar visited the home and the registered manager was aware of how to access other religious leaders if required.

Good

Is the service responsive?

Our findings

At the last inspection in April 2015 we found the provider had failed to ensure people's care records were accurate and reflected people's individual needs. The provider sent us an action plan telling us how they planned to rectify this. At this inspection we found that action had been taken to improve the accuracy of care records.

Cornelia Heights was in the process of moving to a new computerised care planning and management system. Most care plans had been transferred to the new system although not all aspects of this were yet in use. The registered manager felt that once the system was fully in use the discrepancies, such as how the home was monitoring blood sugar levels, between care plans and risk assessments should be eliminated. Care plans contained specific individual guidance where necessary. For example, in one care plan there was guidance for staff if the person was agitated including 'talk 1-1 about topics of interest, art and music'. The care plan also included specific information such as how the person liked to have their hair managed and that they were reluctant to bath and should be offered a full wash.

Staff responded when people required support. For example, one person kept standing up in the lounge and attempting to walk unaided. Care staff checked with the person to see if they needed the toilet or were uncomfortable and reassured them. The person later told us "The carers are kind to me, they are helpful". Another person told us they could decide what time to get up or go to bed and if they told staff they were not ready staff would return at a later time. Staff noted and prompted people to use walking frames if they initially forgot to do so.

Staff demonstrated a good awareness of people's individual support needs and how each person preferred to receive care and support. For example, they knew which people needed to be encouraged to drink; the support each person needed with their continence; and when people liked to get up and go to bed. They recognised that some people's mobility or cognitive ability varied considerably from day to day and were able to assess and accommodate the level of support they needed at a particular time. Care staff told us they felt they had enough information to meet the needs of people at Cornelia Heights.

People were able to join in group activities or receive individual mental stimulation. One person told us about an activities organiser who attended the home on Tuesdays and Fridays. The person said they enjoyed the physical activity and art sessions. They added that the activities organiser would also visit them in their bedroom if they did not feel like going to the lounge. Examples of art activities people had taken part in were seen around the home and people had been included in growing some vegetables in the home's garden. The registered manager explained that they also purchased activities staff from external providers and we saw invoices for sessions which had been provided in July 2016 and were booked for September 2016. These covered activities such as art, music, reminiscence and craft. Ad hoc activities were also provided by care staff who had access to a range of puzzles and games. The registered manager told us about a new service which was also being offered by an external organisation which was providing volunteer visitors for people who were socially isolated. The registered manager said they had identified people who would benefit from a regular individual visitor. One staff member told us they felt more activities were

required.

The registered manager sought and acted on feedback from people, such as in the colour they would like their bedroom doors painted. The registered manager had also sought people's views via meetings. One relative said "I came to a meeting recently". Minutes of the residents meeting held in April 2016 showed people and relatives were provided with information about actions taken following the previous meeting. They were also told about the new fire alarm system which was to be fitted and asked if they had any concerns about privacy or dignity. The registered manager said that people had the opportunity to meet prospective staff when they came for interviews. They added that following interviews, they asked people what they had thought of the applicants and this information was used when deciding who to offer jobs to.

People knew how to complain and there was a suitable complaints procedure in place. One person told us, "If I have any small worries about anything I go to the staff, they are so caring". Another person said they had never had any complaints and didn't think anyone else did either. A relative told us they had had a concern about a staff member. They said they had spoken with the registered manager and were putting the concerns in writing to make a formal complaint as requested by the registered manager. They added that all the other staff were lovely and the registered manager had spent time listening to their concerns. They seemed happy with the way this was being handled. There was information about how to complain available for people or visitors in the home's hallway. The registered manager said there had been one formal complaint in the preceding year. We viewed the record relating to this complaint, which showed it had been investigated appropriately. The person raising the complaint was provided with a written response, detailing the action the registered manager had taken to rectify the problem. The registered manager identified that by speaking with people on a daily basis, and relatives when they visited, they were able to rectify most minor concerns before they became formal complaints.

Requires Improvement

Is the service well-led?

Our findings

Providers are required by law to notify CQC of significant events that occur in care homes. This allows CQC to monitor occurrences and prioritise our regulatory work. We identified incidents where people required hospital treatment of injuries following falls which had not been reported to us. The registered manager told us about a safeguarding incident which we had also not been notified about. We raised the lack of notifications with the registered manager who had not realised that these incidents had not been reported to us. We had been notified about other events in the home where necessary.

The failure to notify CQC of incidents of serious injury and allegations of abuse was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following the previous inspection in April 2015, we identified that quality assurance systems were not robust and errors or omission were not identified meaning there was no action taken to improve the service. At this inspection we also found that the quality assurance systems had not identified the concerns we found with the management of medicines and that people's diabetes was not being monitored as per their risk assessments. Audits such as water temperatures were not being completed according to the provider's policy.

The provider had contracted with an external quality assurance provider who had undertaken an assessment of the service in May 2016. Following the inspection we were sent part of the report relating to medicines management, staffing levels and recruitment. The audit identified that 'recording in cream charts also continues to require significant improvement to evidence appropriate skin care'. This was also our finding three months later and therefore we could not be assured that action required from the comprehensive external audit had been completed by the provider.

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.

In June 2016 the provider had undertaken an audit of beds and bedding. This identified the need to replace some items and this was completed in a timely way. In April 2016 a new quality monitoring system was introduced which involved the provider or registered manager assessing the home based on the same questions we ask (i.e. Is the service safe, effective, caring, responsive and well- led). This had identified some areas for improvement which we were told were being completed.

The registered manager said that working directly with care staff enabled them to informally monitor the way staff worked and thus monitor the quality of care provided. We saw this occurred during our inspection with both the registered manager and deputy manager being rostered to work care shifts. The registered manager identified that the main pressures on the service were the recruitment of care staff and ensuring there were adequate staff due to the increased needs of people living at the home. They said that this would then enable them and the deputy manager to focus more on the management of the home and ensuring the new care planning computer system was fully implemented. The registered manager identified that this

would help ensure inconsistencies in records would not occur.

After the first day of the inspection the registered manager took action to address the issues we identified. Following the completion of the inspection the provider wrote to us informing us of the action they were taking to address the areas of concern we found during the inspection. They acknowledged that there needed to be improvements in the areas identified and showed an openness to addressing these for the benefit of people living at the service.

The provider's representative was present at Cornelia Heights during the inspection and said they worked at the home most weekdays and was available by telephone at other times. The provider's representative had a background in nursing and told us they attending relevant training to give them an understanding of the way the service should be provided. They told us about a four day dementia training course they had attended and how they planned to implement learning from this within the home.

Policies and procedures were available to all staff at all times with a copy available in the main office. This ensured that staff had access to appropriate and up to date information about how the service should be run. The registered manager said they received updates from websites about any medical or equipment alerts and changes in guidance from the National Institute for Health and Care Excellence (NICE). The provider's representative was a member of the local care home's association and they had links with other providers in the area to help keep up to date best practice guidance.

People and relatives were positive about their experience of living at Cornelia Heights and felt that it was well run. Everyone said they were happy with the service they received. One person said they would recommend the home to other people. They added "The rooms are spacious and it's very airy, I don't feel shut in". A relative commented "[My relative] is happy to come back here after a hospital appointment or outing". A visitor told us how hard it had been to let others care for their relative. However, they were confident that they were looked after well. Another visitor said that they and their family were very pleased with the care their relative received. Relatives were aware of who the registered manager was. We saw the registered manager and provider interacted positively with people who lived at Cornelia Heights and people responded well to them.

Staff told us they enjoyed working at the home. We observed staff worked well together, which created a relaxed atmosphere and was reflected in people's care. Staff said the aim of Cornelia Heights was to provide a home for people where they were safe and looked after well. We saw positive, open interactions between the registered manager, staff, and people who appeared comfortable discussing issues in an open and informal way. The registered manager regularly worked as a member of the care staff team and was aware of people's needs. Staff spoke highly of the management team. One care staff member said "They [registered manager and deputy manager] are very supportive and will muck in when needed". Another staff member said "I'm confident that the manager and deputy would take any concerns that I had about the people seriously and would act on them".

The registered manager said they would like to increase the home's involvement in the local community. There were some links with a local primary school with some children visiting the home. There had also been a visit by a local history group and, where possible, local services were used, such as the nearby dentist.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person has failed to notify CQC of incidents of serious injury and allegations of abuse. Regulation 18 (1)(2)(a)(e)(f)

This section is primarily information for the provider

Enforcement actions

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

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 has failed to ensure the safe management of medicines and to ensure all environmental risks were assessed and managed safely. Regulation 12 (1)(2)(a)(b)(d)(g)

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person has failed to effectively assess, monitor and improve the quality and safety of the service. Regulation 17 (1)(2)(a)(b)

The enforcement action we took:

warning notice