Hillview Care Limited

Cornelia Manor RCH

Inspection report

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Date of inspection visit:
05 April 2017
07 April 2017

Date of publication:
07 June 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Cornelia Manor RCH is a care home registered to provide accommodation for up to 34 people, including people living with a cognitive impairment. At the time of our inspection there were 32 people living in the home. The home is set out over three floors, connected by two passenger lifts. There was a choice of communal rooms where people were able to socialise and some bedrooms had en-suite facilities.

The inspection was unannounced and was carried out on 5 and 7 April 2017. The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At our last inspection, in May 2016, we identified that risks to people were usually managed safely although special mattresses used to help manage the risk of pressure injuries were not always being used correctly. At this inspection we found a system was now in place for the pressure mattresses to be checked weekly by a senior staff member to ensure they were being used appropriately. However, new issues had been identified and not all risks to people and the environment were minimised meaning people were not always safe. By the second day of the inspection all new issues we identified had been addressed and appropriate action had been taken. We have made a recommendation about this.

At the previous inspection in May 2016 we found that care staff morale was low and that they felt there was a lack of consistency in management decisions. At this inspection we found there had been an improvement in staff morale and staff had increased confidence in the management decisions. There was a clear management structure in place and staff and people were encouraged to raise issues of concern with the registered manager, which they acted upon.

People, their families, staff and health professionals felt the home was well-led and were positive about the registered manager who understood the responsibilities of their role. Staff were aware of the provider's vision and values and how they related to their work.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People and their families told us they felt the home was safe. Staff and the registered manager 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.

People were supported to receive their medicines safely. However, the medicine fridge temperature was regularly recording as being outside the safe range which meant the medicine may not always be stored at the correct temperature. In addition, there was no individual guidance specific to a person as to when their

'as required' medicine should be administered.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided sufficient information to allow staff to protect people whilst promoting their independence.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs. There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner.

Staff followed legislation designed to protect people's rights and ensure decisions were the least restrictive and made in their best interests. People and when appropriate their families were involved in discussions about their care planning, which reflected their assessed needs.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to maintain relationships that were important to them.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported people, when necessary in a patient and friendly manner.

There was an opportunity for families to become involved in developing the service and they were encouraged to provide feedback on the service provided both informally and through an annual questionnaire. They were also supported to raise complaints should they wish to.

There were systems in place to monitor quality and safety of the home provided. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

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.

Environmental and individual risks to people were not always managed and mitigated effectively.

People were supported to receive their medicines safely. However, the medicine fridge temperature was regularly recording as being outside the safe range which meant the medicine may not always be stored at the correct temperature. In addition, there was no individual guidance specific to a person as to when their 'as required' medicine should be administered.

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

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

Is the service effective?

Good

The service was effective.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

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

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Is the service caring?

Good

The service was caring.

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

Staff understood the importance of respecting people's choices

and their privacy.

People were encouraged to maintain friendships and important relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

Care plans were personalised and focused on individual needs and preferences.

The registered manager and provider actively sought and acted on feedback from people using the service and their families.

There was a clear process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well-led.

The provider's values were clear and understood by staff.

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

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment.

Cornelia Manor RCH

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 5 and 7 April 2017 and was unannounced. The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 12 people using the service, six visitors and two visiting health professionals. We also spoke with the registered manager, the head of care, nine members of the care staff team, the cook and the activities coordinator. We observed care and support being delivered in the communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at care plans and associated records for 12 people, staff duty records, staffing records, records of accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in May 2016 when it was rated as 'Requires Improvement'.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in May 2016 we found risks to people were usually managed safely although special mattresses used to help reduce the risk of pressure injuries were not always being used correctly. At this inspection we found a system was now in place for the pressure mattresses to be checked weekly by a senior staff member to ensure they were being used appropriately for the person.

However, not all other risks to people were minimised meaning people were not always safe. For example, one person who had a cognitive impairment frequently entered the bedroom of another person, which resulted in them, becoming anxious and distressed. This was known to staff yet action had not been taken to reduce the risk. Daily records showed that a person had entered another person's bedroom several times in the days prior to the inspection. No alert system was in use to inform staff that this was occurring. Staff told us they did not have any spare alert equipment to inform them when the person was leaving their bedroom and may be entering other people's bedrooms. For another person their risk of choking had been assessed by a Speech and Language Therapist (SaLT) who had provided specific guidance as to how this risk should be minimised. This included that they should be supervised with all meals and any tablets should be swallowed with food such as yogurt. During the inspection we observed the person eating their desert unsupervised and their guidelines for medicines stated the person took these with water. By day two of the inspection both these issues had been addressed, additional alert equipment was in place and further guidance from SaLT had been obtained.

Otherwise individual risk assessments that identified potential risks and provided information for staff to help them avoid or reduce the risks of harm were in place and followed by staff. Staff showed they understood people's risks and we saw people were supported in accordance with their risk management plans. Risk assessments clearly described how to recognise signs of deterioration and actions staff should take. Risk assessments in place included, safe management of people's physical health needs such as moving and handling, mobility, fluid and nutrition, skin integrity and falls and mental health needs such as self-neglect. Moving and handling assessments set out the way staff should support each person to move and correlated to other information in the person's care plan and described by staff. Staff had been trained to support people to move safely and we observed support being provided in accordance with best practice guidance. Where incidents or accidents had occurred, there was a clear record, which enabled the manager to identify any actions necessary to help reduce the risk of further incidents. Action had been taken in a timely manner to mitigate risks and this was clearly documented.

People were supported to continue some activities which carried a risk where this was their choice and would enhance their lives. For example, one person wanted to sit in the garden and a staff member encouraged this person to put on a sun hat, ensured they were safe, had access to their call bell, their walking frame and a drink before leaving them alone.

Environmental risks were not always managed safely. We found that a known risk associated with external fire escapes was not being managed safely. There was no system in place to alert staff that people or visitors were exiting the home via the fire exit and external stairs from one part of the home. This exit led down to an

area at the back of the home which had uneven surfaces. This would place people and staff at risk if they were evacuating the home from this area. The fire exit from another part of the home was via a ground floor door. This was locked and there were no directions to advise people where the key could be located. The key was found by a senior member of staff resting on the door frame of an adjacent door. This was an older door and the key was at a height that not all people, or staff members would be able to reach. Once the key was located there were complicated directions to open the door. The staff member struggled with this and the process took longer than would be desirable had there been an emergency. For another door on the ground floor an audible alarm had been fitted to alert staff people may be leaving the home. The key to the door was hanging on a hook beside the door. We used this to open the door and noted that the audible alarm did not work as it was not attached to the door frame. By day two of the inspection these issues had been addressed.

We recommended the provider review it's audit processes with regard to issues of environmental fire safety and take action to improve it. We will check this at the next inspection.

Overall people were supported to receive their medicines safely and people told us they did not have any concerns with how their medicine was managed. Medicine was stored safely with the exception of medicines that required to be kept at cooler temperatures. The home had a medicines fridge located within the treatment room. Staff were checking the maximum and minimum temperatures of the fridge daily. However, these were regularly recording outside the safe range and no action had been taken to investigate why the fridge was not keeping the correct temperature. When this was addressed with the registered manager immediate action was taken which resulted in a new fridge being sourced. All medicines were stored securely and appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines.

Medicine administration records (MAR) documented that people had received their medicines as prescribed. We undertook a stock check of some medicines and found that whilst most were correct for one medicine there was an additional tablet. Records showed this tablet should have been administered. A senior staff member stated they would investigate this discrepancy to try to understand how and when the error had occurred. Otherwise the stock check showed there were the correct numbers of tablets indicating that people had received these as prescribed and recorded on the MARs.

Some people needed, 'as required' (PRN) medicines for pain or anxiety. Staff had information about the PRN medicine for most people and there were individual guidelines as to when 'as required' medicines should be given. However, one person was prescribed medicine for when they were anxious or agitated but there was no individual guidance specific to the person as to when this medicine should be administered. This may lead to inconsistencies between staff as to when the medicine was administered meaning the person may not always receive it appropriately.

One person was being supported to manage some of their own medicines. They had been provided with a secure place to keep these and an assessment was in place demonstrating they understood how they should manage their medicines. Safe systems were in place for people who had been prescribed topical creams and these contained labels with opening and expiry dates. This meant staff was aware of the expiration of the item when the cream would no longer be safe to use. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them. Training records showed staff were suitably trained and had been assessed as competent to administer medicines.

People told us and indicated they felt safe. One person said, "I feel safe because of the amount of people

who are here". Another person told us, "Yes, I feel very safe; there are lots of people around if I need them. A family member said, "I'm not worried about [my loved ones] safety". People appeared relaxed around care staff and felt able to say if they needed something.

The provider had appropriate policies in place to protect people from abuse. Staff were required to complete safeguarding training as part of their induction and received annual updates. Staff were knowledgeable in recognising signs of potential abuse, knew how to raise concerns and how to apply the provider's safeguarding policy. Staff said they would have no hesitation in reporting abuse and were confident the registered manager would act on their concerns. One staff member told us, "I would speak to [named registered manager] or whoever was in charge that day". Another staff member said, "I would make sure the person was safe and speak to the senior. If nothing was done I could contact you [CQC] or social services". All staff were confident the manager would take the necessary action if they raised any concerns and knew how to contact the local safeguarding team if required. The registered manager explained the action they would take when a safeguarding concern was raised with them and the records confirmed action had been taken when a safeguarding concern had been identified. The registered manager had reported concerns to the appropriate authority in a timely manner.

There was sufficient staff available to meet people's needs. Care staff were augmented by other ancillary staff, such as housekeeping, maintenance and catering. This meant they were able to focus on providing care and engaging with the people they supported. Staff responded to people's needs promptly. People and their families told us there were usually enough staff to meet people's needs. Comments included, "There is plenty of staff", "I think there is enough staff", "Staff respond quickly to the call bell most of the time" and "[Name of relative] is happy to ring the call bell when they require assistance and the care team respond as quickly as possible". One person said, "There are not always enough staff, if someone is taken ill we may have to wait longer". However, when questioned further, this person implied that there was little effect on the personal care they received. Staff we spoke with had mixed views on the staffing levels and felt that they did not always have time to just, "Sit and talk to people". A staff member said, "The care we give is safe, but I would like to give people a bit more time, there is no time for extras". Another staff member said, "It can all be a bit of a rush". A third staff member said, "There is enough staff and people get the care they need but sometimes it can be a struggle". The registered manager was aware of the staff's views on staffing levels and was actively looking at ways to reduce paperwork to allow them to spend more time interacting with people living at the home.

Staffing levels were determined by the registered manager who used a dependency tool to support this. This dependency tool took into account the level of support people using the service required. The registered manager told us the tool did not consider the size or layout of the building, but said they took account of this by listening to feedback from people and staff and observing care and response times. For example, staffing levels had recently been changed due to identification of increased needs early in the morning as more people wanted to get up early and required assistance before day staff commenced their shift. This meant that one of the morning staff now started their shift at 7am providing additional support during this busy time.

There was a duty roster system, which detailed the planned cover for the home. Staff absence was usually covered by existing staff working additional hours. Both the registered manager and head of care regularly worked alongside the staff to provide support if needed and said that this also allowed them to see any areas of particular pressure.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited was suitable to work with the people they supported. All potential new staff completed an application form

and underwent an interview before being offered employment at the home. People were given the opportunity to be involved in the recruitment process and offered the opportunity to participate in interviewing potential new staff. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff confirmed this process was followed before they started working at the home.

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Staff were aware of the fire safety procedures and the action they would take if an evacuation was necessary.

Good

Is the service effective?

Our findings

People and their families told us they felt the service was effective; staff understood people's needs and had the skills to meet them. One person said, "The staff do what I need them to do, they are pretty good". Another person told us, "I never thought a care home could be as good as this". A third person said, "I have everything I need here". Comments from family members on a care home review website included, 'Staff check on [my loved one] constantly, listening to them and makes sure they has everything they need', and 'I have found Cornelia Manor to be somewhere I have complete confidence in and am grateful for all they provide'.

Staff assessed people's abilities to make decisions in line with the Mental Capacity Act (MCA) 2005. 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. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. For example, when alert mats or bed rails were used to keep people safe. People's care plans included information about their ability to make decisions, one care plan stated, 'I am unable to make big decisions but can make choices about what to wear, what I want to eat and when I would like to get up and go to bed'.

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 providers were following the necessary requirements. DoLS applications had been made where needed. Staff understood their responsibilities and knew how to keep people safe in the least restrictive way.

Care staff told us how they offered people choice and sought consent before providing care and were clear about the need to seek verbal consent before providing care or support. We heard care and other staff seeking verbal consent from people throughout our inspection. One care staff member said, "We ask them, if they said no we would try later; if that didn't work we'd ask another staff member to try." Daily care records showed that where people declined care this was respected and comments included, '[Person] declined personal care, numerous attempts made and reassurance given' and '[Person] declined a bath this morning, personal care given'.

People were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. The registered manager told us the length of the induction period was dependent on the experience and abilities of the staff member. All inductions included

a period of shadowing an experienced staff member and mandatory training which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. Staff confirmed they received an induction in line with the provider's policy. A member of care staff said, "I had an induction when I started here, it was helpful".

Staff had the skills and knowledge to carry out their roles and responsibilities effectively and people and their families described the staff as being well trained. A person said, "The staff are very well trained". Another person told us, "They know what I need". A family member said, "I am confident that the staff know what they are doing". The provider had a system to record the training that staff had completed and to identify when training needed to be updated. On viewing these records all staff had received relevant training which was up to date. Training included essential training, such as medicines training, safeguarding adults, fire safety and first aid. Staff had access to other training which focused on the specific needs of people using the service, such as, dementia awareness and mental health awareness. Staff understood the training they had received and how to apply it. For example, they explained how they would support a person to mobilise, how to use moving and handling equipment appropriately and how they provided care to people living with dementia. Training provided to staff took into account staff's individual training styles and needs. Staff comments included, "I get lots of training", "If I felt I needed more training in a particular area, I would ask the manager who would arrange this" and "We are always doing training".

All staff received one-to-one sessions of supervision every eight weeks. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Staff who had worked at the home for over a year had also received an annual appraisal, with the manager or head of care, to assess their performance and identify development needs. Staff told us these sessions were helpful and spoke positively about the support they received from management on a day to day basis. One staff member told us, "I have a 1:1 meeting with my senior every six weeks, but could approach any of the management if I needed to". Another staff member said, "We are always having supervision".

People's nutrition and hydration needs were met and they were supported to have enough to eat and drink. People told us they enjoyed their meals. One person said, "The food is great, it is like home cooking". Another person told us, "The food is pretty good". A third person said, "I eat a variety of food which is nice". Family members were complimentary about the food. One family member said, "The food seems very good". Where people required support to eat this was done in a kind, unhurried way. Care staff encouraged people to be as independent as possible by ensuring food was cut up and appropriate cutlery was provided if required.

People were supported to have a meal of their choice and alternatives were offered if they did not wish to have the main choices on the menu. People were told clearly what was on their plate and they were supported to make informed choices through the use of written menus and photos of the main meals. The cook was aware of people's preferences and dietary needs. They told us that where people had dietary needs linked to medical conditions, such as diabetes, they ensured options suitable for the person were provided. A catering staff member served the meals from a hot trolley in the dining room as people were ready to receive them. This not only meant that people would receive their meals hot but also individual preferences could be met such as size of portions. We saw people were offered 'seconds' [a second helping] once they had finished their first meal. Drinks, snacks and fresh fruit were also offered to people throughout the day with a fresh fruit bowl being available in the main lounge. Staff told us they could provide people with food at any time this was requested or required.

Staff were all aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were also recorded in

their care plans. Some people were at risk of not eating or drinking enough, so staff used food charts to monitor their intake and we saw these were completed fully. People were also weighed regularly to help identify unplanned weight loss; when this occurred, staff took appropriate action, including referring people to their GP or to speech and language therapists; they also provided people with high calorie drinks, where needed.

The environment was suitable for the people living at Cornelia Manor. Where necessary, action had been taken to support people living with dementia to understand their environment and move around freely. For example, toilets and bathrooms were easily identifiable due to large signs and brightly coloured doors and bedroom doors had signs and pictures or objects relevant to the person on them to help them recognise their rooms. Within the main corridor brightly coloured boards were used which displayed the day, the date, the weather and planned activities for the day.

When people moved to the home, they or their family if appropriate were involved in assessing, planning and agreeing the care and support they received. The registered manager told us that when assessing people they considered the person's needs and if the home were able to meet these needs effectively. When people moved to the home they were encouraged to make their bedrooms their own by bringing in personal items that were familiar to them.
People were supported to access appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail. Staff knew people's health needs well and were able to describe how they met these needs. During the inspection we heard staff talk about a change in a person's physical health and actions they were going to take, which included close monitoring and contact with healthcare professionals. We spoke with two visiting health professionals who were complimentary about the home. They said they were consulted appropriately and in a timely way and felt people's health care needs were met. One person said, "They [staff] will get me a doctor if I need one".

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. People's comments included, "All the staff are lovely" and "The staff are excellent and very kind". Comments from family members on a care home review website included, 'At all times the staff have been gentle, kind and caring, treating [loved one] with the utmost respect' and 'The staff are friendly, caring and polite'.

People were cared for with dignity and respect. Staff members demonstrated that they cared about people and respected them as individuals. A care staff member said, "I want to improve people's lives and I really try and do that". Another told us, "When helping people with personal care I remember that things that may not be important to me can be really important for them, for example, which side they want their hair parted".

Staff were heard speaking to people in a kind and caring way, with interactions between people and staff being positive and friendly. Staff knelt down to people's eye level to communicate with them and we heard good-natured banter between people and staff. Staff did not rush people when supporting them and regularly checked whether they required any support or needed anything. For example, a member of care staff asked a person if they were warm enough and returned shortly after with a blanket for the person's knees. People were frequently asked by care staff members, "Do you feel comfortable" or "Do you need anything" and when required staff took appropriate action. Staff demonstrated a detailed knowledge of people as individuals and knew what their personal likes and dislikes were. We saw a member of the kitchen team serving hot drinks in the morning. They knew people's names and were aware of their preferences for drinks and biscuits. They said, "I've kept one of your favourite biscuits here for you" and "I'll get you a couple of your favourite". At all times staff showed respect for people by addressing them using their preferred name and maintaining eye contact.

People's privacy was respected when they were supported with personal care. Staff were able to describe the practical steps they took to preserve people's dignity and privacy when providing personal care. One care staff member said, "We make sure people are covered as much as possible when we are providing personal care". Another care staff member told us, "I shut the curtains and tell the person what I am doing to make sure they are okay with it". Staff knocked on doors and waited for a response before entering people's rooms. We observed staff assisting a person to move to a lounge chair using moving and handling equipment. A screen was used to preserve the person's dignity and staff explained to the person what they were about to do throughout the transfer and gained consent before commencing the procedure. Confidential care records were kept securely and only accessed by staff authorised to view them.

Staff understood the importance of respecting people's choice. They spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what they preferred to eat and where they wanted to spend their time. Choices were offered in line with people's care plans and preferred communication style. Where people declined to take part in an activity or declined care this was respected. A care staff member said, "I really like working here, people get so much choice and they can do as they please". 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. This information was also recorded

within care records.

People were supported to maintain friendships and important relationships. Care records included details of their circle of support and identified people who are important to them. All of the families we spoke with confirmed that the registered manager and staff supported their loved ones to maintain their relationships. A family member said, "We are happy with the care and the respect the staff show [love one], they [person] are pleased because we are made to feel welcome. Staff always offer us a cup of tea". Another family member told us, "Visitors are warmly welcomed and encouraged". Where people had religious or cultural preferences these were known and met. Care plans contained information about people's religious needs and how these should be met.

Good

Is the service responsive?

Our findings

People and their families told us they felt the staff were responsive to their needs. A family member said, "Any issues we have had have always been dealt with straight away". A person said, "I only need to ask, they [staff] will always respond to my needs". A comment from a family member on a care home review website stated, 'I have been impressed that medical help is sought properly when needed'. A healthcare professional had stated on their completed provider survey in March 2017, 'Staff are very proactive if they are worried about a patient'.

Staff were responsive to people's communication styles and gave people information and choices in a way they could understand. Staff spoke clearly and repeated messages as necessary to help people understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond. People's care plans contained a 'communication care plan' which provided information about their communication style. For example, one person's communication care plan identified that a person could not always follow the flow of a conversation and found it difficult to follow instructions and therefore highlighted to staff that, 'Instructions and information should be given in simple terms and repeated'.

People experienced care that was personalised and care plans contained detailed information specific to each person. Care plans included information about people's preferences, likes and dislikes, described how people wished to be cared for and contained specific individual information to ensure medical needs were responded to in a timely way. Comments in care plans included, '[Person] likes to get up between 08.00 and 09.00', 'I would like my medication to be offered to me on a spoon' and 'I usually have a good appetite but like small portions'. This information allowed people to receive care in a consistent way. Records of daily care confirmed people had received care in a personalised way and in accordance with their care plans. Daily records were detailed and informative which provided staff with clear and up to date information about people's needs. Care staff members were able to describe the care and support required by individual people. For example, one care staff member was able to describe the support a person required when repositioning and described how this was undertaken.

People were supported without restricting their independence. We saw two staff assisting a person with a walking frame, staff provided good verbal guidance and prompts and did not rush the person. People were provided with suitable eating and drinking utensils to enable them to be as independent as possible. Care plans included information about what aspects of their care people could do themselves, tasks they may require verbal reminders for and when physical assistance would be required. For example, one care plan stated, 'Please help me to remember to brush my hair' and another said, 'Person can wash their face, arms and body but will require assistance from one to support with all other areas'. This helped ensure care staff members only provided help when needed and avoided people becoming more dependent on staff than was necessary. A care staff member said, "I will encourage people to do things for themselves if they can". A visiting health care professional told us staff were promoting independence for a person who was staying at the home for a period of respite.

Staff were kept up to date about people's needs through handover meetings which were held at the start of every shift. These meetings provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting. Relevant individual information was provided to staff during this meeting which included information about; contact being made with the GP in relation to a person with a possible infection, people that required their fluid intake to be monitored and where a person had declined care. During this handover meeting staff shared ideas and knowledge of how best to provide support to individual people.

Staff responded promptly when people required support and were patient when providing people with assistance. For example, a person required assistance to move into a lounge chair, the care staff member supporting with this gave clear, concise instructions and on going reassurance throughout this task, which gave the person confidence and helped them to feel safe. Another person was worried about some children. A care staff member spoke kindly with the person and established that they had had a dream. The person was offered some tea to distract them and they went off together to get some tea after finding the person's slippers.

People's daily records and care plans demonstrated that staff sought medical advice when required. For example, staff had identified that a person may be experiencing constipation and that another person required their medicines to be given in liquid form. The GP had been contacted to discuss these issues. Care records showed that on admission to the home people were screened for diabetes and a urine sample was taken (with people's consent) to help identify people at risk of diabetes or infections. This allowed people to then be referred to the GP for a full medical assessment if required. In addition all people admitted to the home had their fluid intake monitored for the first month to allow staff to have a clear understanding of people's fluid intake to prevent people experiencing dehydration. One external health professional told us staff would identify additional needs and gave us examples of how they had been asked to check a couple of extra people that morning.

Care and support was planned proactively and in partnership with people, their families and healthcare professionals where appropriate. The registered manager completed assessments of people before they moved to the home to ensure their needs could be appropriately met. Care plans were reviewed monthly or more frequently if people's needs changed. Families told us that they were fully involved in the development and reviews of care plans. A family member said, "We are always informed when there are any changes, such as when the doctor is called". A second family member told us, "The family are kept informed of any changes to [loved ones] care". Another said, "Staff always give me time to discuss my [name of relative]". Some people or their relatives had signed care plans demonstrating they had been involved in identifying how their needs would be met. The registered manager told us they aimed to involve all relatives (where appropriate) in care plan review meetings and there was a plan in place evidencing this.

People were provided with mental and physical stimulation through a range of varied activities. The service employed an activities co-ordinator who arranged activities for people both in groups and individually. People and their families were kept informed of up and coming events and daily activities though an activities notice board and verbally by staff. Activities included reminiscence, games, music, armchair exercises, quizzes, films and arts and crafts. During the inspection people were participating in a reminiscence quiz, which they seemed to enjoy. One person told us, "Yes, we have enough to do, the activities are good". A family member said, "There is plenty of choice of activities".

During the residents meeting which took place on the day of the inspection Easter activities were discussed and planned jointly with the people. For example, one resident had been a milliner so was asked to help with hat design. This person was pleased to be included and talked to us about this, it was clear they had

something to look forward to. There was also some planning for St George's Day and an explanation about what it celebrated. People were made aware that a BBQ was planned for July and that family and friends were welcome. The Activities Coordinator asked people if there were any other activities they would like to do.

Cornelia Manor had developed some links with the local community. These included visits from local school children at certain times of the year and regulars visits from the local church singing group. People received Holy Communion once a month if they wished. Staff supported people to visit the local dementia café and for shopping trips on a one to one basis when able.

The registered manager sought feedback from people and their families on an informal basis when they met with them at the home or during telephone contact. A family member told us "I haven't got any concerns but if I did I can always talk to the manager or head of care about these, they would act". Formal feedback was also sought through the use of quality assurance survey questionnaires sent to people, their families, professionals and staff. We looked at the feedback from the latest provider survey, from March/April 2016, which was all positive in respect of the care people received. Comments from family members included, 'The worry has been taken away from me', 'It is a weight off our minds' and 'Staff are wonderful and patient'. Another stated, 'The staff are always helpful and considerate'.

Residents meetings were held monthly to discuss all aspects of care, the environment and staffing issues. During these meetings people were given the opportunity to talk about any concerns or issues they had. Past meeting minutes were viewed which demonstrated that actions had been taken where required and people and their families had been fully involved in developing the service. Where concerns and issues had been raised action had been taken. For example, during a resident meeting people had requested more activities at weekends and musical entertainment had been arranged. Also one person had highlighted that they were having problems accessing hot water in their room and two new hot water cylinders had recently been installed.

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. People were reminded how to complain during the residents meetings and notices were displayed throughout the home. The registered manager told us they had received two complaints in the past 12 months, both of which had been investigated and appropriate action had been taken when required.

Good

Is the service well-led?

Our findings

At the previous inspection in May 2016 we found that care staff morale was low and that they felt there was a lack of consistency in management decisions. At this inspection we found there had been an improvement in staff morale and staff had increased confidence in the management decisions.

There was a clear management structure, which consisted of a registered manager, head of care, senior care staff and care staff. Staff understood the role each person played within this structure. The management team encouraged staff and people to raise issues of concern with them, which they acted upon.

People and their families told us they felt the service was well-led. Family members also said they would recommend the home to their families and friends. People knew who the registered manager was and told us they would be happy to approach them if they had any concerns. A person said, "Everyone is so kind including the managers". A family member told us, "The manager and the head of care are very approachable". Another family member said, "The home is very organised and everyone knows what they are doing". Comments from family members on a care home review website included, 'it is very efficiently run, clean, homely with a warm atmosphere' and 'With a new manager in place, the organisation and activities are continually improving'. Feedback from a healthcare professional stated, "The home seems well run and staff are professional". A staff member said, the management are proactive and are working hard to improve the service".

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. They confirmed they were able to raise issues and make suggestions about the service and care provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. Care staff members comments included, "Everyone is comfortable going to the manager", "I am able to make suggestions and know that the manager would listen to any ideas I had", "I feel very comfortable to go to the manager or head of care if I had any concerns, they will always listen and act" and "The management are really hands on, they will always support us [care staff] and will work on the floor".

The registered manager was aware of, and kept under review, the day to day culture in the service, including the attitudes of the staff and standard of care provided. This was done through observations of care provision, working alongside staff and regular staff supervision. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. Additionally, the registered manager and head of care completed unannounced spot checks of the service. This was to ensure that they had insight into the quality and effectiveness of the service over a 24 hour period. There was a duty of candour policy in place, this required staff to be open with people and relatives when accidents or incidents occurred. The registered manager was able to demonstrate where incidents or accidents had occurred these were both discussed with people and their families where appropriate and put in writing.

The registered manager had an open door policy for the people, families and staff to enable and encourage open communication. Family members told us they were given the opportunity to provide feedback about

the culture and development of the home and all said they were happy with the service provided. The provider had suitable arrangements in place to support the registered manager, for example regular meetings, which also formed part of their quality assurance process. The registered manager told us that support was available to them from the provider through one to one supervision sessions and regular visits to the home. The registered manager also explained that they receive additional support from the staff team at Cornelia Manor and shared ideas with other home managers and professionals to learn from best practice to aid continuous improvements in the service.

The provider was fully engaged in running the service and their vision and values were built around, "Delivering person centred care, treating people with dignity and respect and encouraging choice and fulfilment". Regular staff meetings provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision. The registered manager said, "We want to enhance peoples quality of life and feel at home, comfortable and happy". Staff members understood the values of the service and many described Cornelia Manor as having a "Homely atmosphere" and, "A home from home". These comments were echoed by family members and people. A staff member said, "I want to make sure people are happy and help them live their lives how they want to". Another staff member told us, "It is a good home, the people always come first, if they didn't I wouldn't work here".

Quality assurance systems were in place to monitor both the safety of the environment and the quality of the clinical care provided. Routine checks and audits were regularly carried out for a range of areas to enable the registered manager to monitor the operation of the service and to identify any issues requiring attention. However, these checks had not identified the concerns in relation to the fire exits and medicine fridge temperatures. The registered manager, head of care and the provider carried out regular audits which included infection control, the cleanliness of the home, resident involvement and care plans. They also carried out an informal inspection of the home during a daily walk round. Where issues or concerns were identified an action plan was created and managed through the regular meeting processes. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, equipment and fire safety. Weekly medicine audits were completed which covered all areas of medicines management. A recent medicine audit had identified that not all early morning medicines were being administered correctly by night staff. The registered manager had held supervision with staff and records now showed these were being administered safely.

Other formal quality assurance systems were in place, including seeking the views of people, their relatives, staff and health professionals about the service they received via quality assurance questionnaires. During a staff meeting care staff members had highlighted to the registered manager that they felt unable to spend enough time with people providing social support. This had resulted in the registered manager reviewing the paperwork staff are expected to complete with a view to condensing this to allow more social time to the people. At the time of the inspection this was still being reviewed.

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, care staff told us they could approach the local authority or the Care Quality Commission (CQC) if they felt it was necessary.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the reception area and on the provider's website.