

Barchester Healthcare Homes Limited

Corrina Lodge

Inspection report

79 The Avenue
Camberley
Surrey
GU15 3NQ

Tel: 01276686202
Website: www.barchester.com

Date of inspection visit:
15 March 2018

Date of publication:
06 June 2018

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

The inspection took place on 15 March 2018 and was unannounced. At our last inspection on 2 August 2017 we rated the service 'Requires Improvement' and identified two breaches of regulation in relation to staffing and governance.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe, Effective and Well-led to at least good. At this inspection, we found that despite some improvements having been made the provider had not met the legal requirements. We found further breaches of regulation in relation to risk management, medicines and consent.

Corrina Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Corrina Lodge accommodates up to 58 people in one adapted building. At the time of our inspection there were 57 people living at the service. People were living with a range of complex health care needs. This included people who have had a stroke, diabetes and Parkinson's disease. Some people had a degree of memory loss associated with their age and physical health conditions. Most people required a variety of help and support from staff in relation to their health, mobility and personal care needs. Accommodation was provided over two floors with a passenger lift that provided level access to all parts of the home.

There was a registered manager in post who was present during the inspection. 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.

Staff were not always effectively deployed to ensure people's needs were met in a timely manner. We observed people waiting for care and some people told us they felt isolated and lonely. There was a lack of leadership and direction on individual shifts and nurses and care staff worked in isolation.

Risks to people's health and well-being were not always effectively monitored. Records did not always contain clear and consistent information to evidence the action taken to keep people safe. Where accidents and incidents occurred, robust action was not always taken to ensure that lessons had been learned and reduce the risk of them happening again. Some areas of medicines management were not safe. Protocols for PRN (as and when required) medicines lacked detail and topical creams were not labelled when opened and were not appropriately stored. Other areas of medicines storage and administration were managed well.

The principles of the Mental Capacity Act 2005 were not always followed which meant there was a risk that

people's legal rights were not being upheld. There was a lack of management oversight of the service. The registered manager was unable to provide information in a timely way and did not demonstrate a clear understanding of the provider's systems. Quality assurance process were not always effective in identifying and addressing areas of the service which required improvement. There was a lack of guidance for staff which had led to the service not moving forward in their development.

Although improvements had been noted to the training and supervision of staff, this was not always appropriately monitored. The registered manager was not able to demonstrate how clinical staff developed their professional skills. We have made a recommendation regarding this. Safe recruitment processes were in place to ensure staff safe to work at the service were employed. Staff told us they felt supported by the management team and regular staff meetings took place.

Staff were aware of their responsibilities to safeguard people from the risk of abuse. Systems were in place to ensure the local authority safeguarding team were made aware of any potential risks. People had access to healthcare professionals and were supported to attend medical appointments.

Staff interactions with people were positive and people were treated with kindness. People's dignity and privacy was respected and staff were aware of people's individual needs and interests. Staff supported people to maintain their independence and people's religious and cultural needs were respected. Visitors told us they felt welcome and that there were no restrictions on the times they could visit. People's nutritional needs were met and people told us they enjoyed the choice of foods provided.

People's needs were assessed prior to them moving into the service to ensure they could be met. Care plans were detailed and contained information about the person's life history and interests for staff to follow. There was a dedicated activities team in place who provided a varied activities programme. A group of volunteers also visited the service on a regular basis to provide support to the team and to spend time with people in their rooms.

People and their relatives were provided with the opportunity to give feedback regarding the quality of the service provided. Regular residents meetings were held and an annual survey was sent. The provider had a complaints policy in place which was made readily available.

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.

Sufficient staff were not always effectively deployed.

Risks to people's safety, health and well-being were not always adequately monitored.

Lessons were not always learnt following incidents to minimise risks.

People's medicines were not always stored and managed safely.

Staff had received safeguarding training and were aware of reporting procedures should they have concerns.

Safe recruitment processes were in place to ensure staff employed were of good character.

Is the service effective?

Requires Improvement ●

The service was not always effective.

People's legal rights were not protected as the requirements of the Mental Capacity Act were not being met.

Staff received training and supervision to support them in their role. However, this was not always effectively monitored.

Assessments were completed prior to people moving into the service

People were complimentary about the food and choices available and their nutritional needs were met.

People lived in an environment which was clean and safe infection control processes were in place.

Is the service caring?

Good ●

The service was caring.

Individual staff interactions were caring and positive.

Staff understood people's communication needs.

People's independence was encouraged.

Visitors were made to feel welcome.

Is the service responsive?

Good ●

The service was responsive.

There was a varied activities programme available which reflected people's interests.

Care plans contained details regarding people's needs and we found these were followed by staff.

Care plans were in place regarding the care people wanted when reaching the end of their life.

There was a complaints policy in place and people were aware of how to make a complaint

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

There was a lack of management oversight of the service.

There was a delay in receiving information from the service when requested.

Quality assurance systems were not always effective in developing and improving the service provided.

People had the opportunity to give feedback through regular meetings and an annual survey.

Staff told us they felt supported by the registered manager.

Corrina Lodge

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.

The inspection was prompted in part by concerns received by the Care Quality Commission (CQC) relating to the care provided and the management of risks. There is currently an on-going safeguarding investigation and a complaint which remains unresolved. These concerns have not been directly reported on within the report as they have not yet reached a conclusion.

The inspection took place on 15 March 2018 and was unannounced. The inspection was carried out by two inspectors, a nurse specialist advisor and an expert by experience. The nurse advisor specialised 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.

Before the inspection, we reviewed records held by the Care Quality Commission which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we did not ask the provider complete a Provider Information Return (PIR) as we inspected the service sooner than we planned. 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.

As part of our inspection we spoke with eleven people who lived at Corrina Lodge and observed the care and support provided to them. We spoke with six relatives, seven staff members and the registered manager. Following the inspection we spoke with the regional manager and regional compliance manager.

We reviewed a variety of documents which included the care records for seven people, five staff files, medicines records, complaints and compliments, quality audits and various other documentation relevant to the management of the service.

Is the service safe?

Our findings

At our last inspection in August 2017 we found that there were not sufficient staff deployed to meet people's needs in a timely way. At this inspection we found that although staffing numbers had increased they were not always appropriately deployed. This meant staff did not always use their time to spend with people and on occasions people had to wait for their care.

People and their relatives told us that although they felt the service was safe there were occasions when they did not feel their care was provided by sufficient staff. One person told, "You have to wait for them when they're with other patients. They're always busy and they can't be everywhere at once." Another person told us, "There's not enough staff, definitely not. Sometimes when you ring they come quick. When they're with someone else you have to wait though. Makes me feel like a nuisance sometimes." One relative told us, "I come to help at lunchtime or (family member) would be waiting for lunch."

Staff were not always appropriately deployed to ensure people's needs were met in a timely manner and that staff had time to spend with people. During the morning of our inspection we spent time in the upstairs communal lounge where eight people were sitting in their wheelchairs. Although the television was on people did not appear interested and the atmosphere was subdued. The majority of people had their eyes closed. For a forty minute period we observed no staff were based in the lounge area although staff did come periodically come in and leave again. One person called for assistance on five occasions but as no staff were present they were not responded to. The persons calling out caused another person to become anxious. A third person was slumped forward in their wheelchair. On four occasions staff entered the room and supported the person to sit upright. However, immediately they left the room the person again slumped forward and looked uncomfortable. We asked staff if the person required assistance and they supported them to return to their room where they could be made more comfortable. The person's care plan stated they were unable to support their own posture. In contrast, when the activity co-ordinator came into the room and spent time with people the atmosphere was more upbeat with people chatting, listening to poetry and laughing. When people required support the activity co-ordinator was able to summon the support of staff to assist them.

People told us that although staff treated people with kindness they did not have enough time to spend with them. This meant that some people living at Corrina Lodge felt isolated and that some relatives felt they needed to visit more frequently. One person told us, "They're nice when they're here but they're always rushing out again." Another person told us, "They're just doling out pills and leaving." A third person told us, "Staff are excellent and they look after you. I get very lonely and don't always speak to anyone between lunch and tea. I am not sure you would call that caring." A relative told us, "If I didn't come in everyday to help I don't think standards would be met."

Staff told us that although staffing levels had improved there were still times when people had to wait for their care. One staff member told us, "We now have more carers so we aren't rushing all the time. In the mornings it's still quite hectic. When the bells ring we have to explain to people they will need to wait as we are with someone else. Some people aren't happy about it." Another staff member told us, "I'm not one to

moan but sometimes we do struggle." They told us that they were unable to spend time talking with people due to their workload. We observed clinical staff throughout the inspection and found they spent the majority of their day administering medicines. One staff member told us, "I have very little time to do anything apart from medication. With administering ordering and chasing this takes all my time."

The registered manager told us they were aware that shifts needed to be managed better and had been working with clinical staff to ensure this happened. However, there was little communication between clinical and care staff. Both had their allocated duties which were performed in isolation. There was no sense the shift was being led or any difficulties being communicated. This meant that although staffing numbers had increased the deployment of staff was not effective in ensuring staff worked together as a team to provide person centred support.

The provider had failed to ensure that staff were appropriately deployed to ensure people received their care in a timely manner. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health were not always safely and effectively monitored. We viewed records for one person who had a long standing pressure sore. Although a treatment plan was in place it was difficult to track the action which had been taken. Notes contained different descriptions of which area the pressure sore was situated and this was difficult to confirm from the photographs available. Records did not provide a clear chronology of actions taken and treatment provided. One entry indicated the pressure sore had deteriorated but did not record the action taken. Another entry stated that a referral to the Tissue Viability Nurse was required but this had been left for another staff member to complete as they had run out of referral forms. The registered manager was able to demonstrate that the relevant professionals had been involved in the persons care and treatment although this information was not easily accessible. This meant there was a risk that staff and visiting professionals may not have an up to date picture in order to provide safe and effective care. Another person had a urinary catheter in place and had medical conditions which pre-disposed them to problems with fluid intake and output. Their care plan stated, 'input and output monitored day and night by staff'. However, there were no fluid charts in place and no records evidencing the times between the catheter being emptied or the appearance of the urine. This meant that risks associated with the person's medical condition and catheter care may not be identified in a timely manner. In other areas we found that risks were managed safely. Risk assessments and management plans were in place with regards to mobility, falls, skin integrity and nutrition. Where required risk management plans were implemented in order to reduce the risks to people's safety.

When mistakes were identified robust action was not always taken to reduce the risk of them happening again. Prior to the inspection we were informed of a number of errors and near misses in the administration of medicines. Although these errors had all occurred during the same administration round it had taken 24 hours for them all to be identified. The registered manager had spoken to clinical staff regarding this issue and had taken appropriate action regarding the individual staff member. However, they had not ensured that systems and medicines checks were reviewed to minimise the risk of this happening again. Following the inspection we received reassurances from the regional manager that medicines systems and staff competency had been reviewed. We will check the effectiveness of this during our next inspection. In other areas we found that accidents and incidents were monitored and action taken to minimise the risk of reoccurrence.

Robust medicines practices were not always implemented. During our inspection a relative approached us with two inhalers which had been left in their family member's possession. Although the person's name was clear on one of the inhalers neither contained complete labels as they had been torn or damaged. The

person's relative told us that due to her family member's health concerns it had been decided that the inhalers now needed to be administered by staff. A review of the person's records showed this was recorded in part of their care plan but in another area it stated the person was administering their own medicines. Protocols for the administration of PRN (as and when required medicines) were in place. However, we found there was a lack of detail in some records regarding when the medicines should be administered. Topical creams were not always safely stored. We found prescribed topical creams were stored in people's rooms. No creams were dated when opened to guide staff on when the creams remained suitable for use. Many of the containers did not have the lids replaced correctly, containers were sticky, and labels were unreadable due to the cream smeared on them.

The lack of effective risk management systems and medicines practices was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that other areas of medicines management were managed safely. Each person had a medicines administration record (MAR) which contained an up to date photo, information regarding their GP contact and any known allergies. MAR charts showed that all prescribed medicines had been administered in line with prescription guidelines and no gaps were present. Systems were in place to ensure that medicines were securely stored, ordered in a timely manner and any unused medicines were disposed of safely.

People were protected against the risks of potential abuse. Staff told us they had received safeguarding training and were able to describe signs of abuse they may encounter and reporting procedures. One staff member told us, "I'd go straight to a manager or if not then head office, police or social services." Policies regarding safeguarding and whistle-blowing were in place for staff to follow. People had information regarding how to report concerns within the service user guide in their rooms. Where concerns had been identified we saw evidence that these had been appropriately reported to the local authority safeguarding team. We spoke with the local authority safeguarding team who confirmed that although they were notified of incidents they did not always receive additional information requested in a timely manner.

Robust recruitment processes were in place to ensure only suitable staff were employed. Staff files contained a checklist to confirm that relevant documentation had been received prior to staff starting work. Staff were required to complete an application form and attend a face to face interview and records were kept to evidence this. Staff files contained references from previous employers, proof of identification and a completed Disclosure and Barring Service (DBS) checks. DBS checks identify if prospective staff have a criminal record or are barred from working with adults at risk.

People lived in a clean environment and effective infection control practices were followed. We spoke to housekeeping staff who told us they had recently started at the service and completed all relevant training, including infection control. Cleaning schedules were in place and we saw that these were completed on a daily basis. We observed that staff wore gloves and aprons when supporting people with their personal care and they told us these were always readily available to them. The laundry room was organised with separate areas for dirty or soiled clothes and linen. There was a red bag system in place for soiled laundry and a sluice machine available.

At the time of our inspection there were extensive refurbishment works taking place on one floor of the service. Relevant risk assessments were in place to keep people safe during this time. Regular maintenance checks of the environment were completed to ensure the building remained safe. A contingency plan was in place which detailed the action staff should take should the building not be fit for use. This ensured people would continue to receive their care in the event of an emergency.

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The principles of the MCA were not consistently followed to ensure people's legal rights were upheld. Care records showed capacity assessments were not always fully completed and were not decisions specific. We viewed three people's files where capacity checklists had been completed. The record gave a space for the decision being assessed to be completed but this was left blank. The three checklists all determined that the people concerned were unable to understand, retain or weigh up information to make a decision and therefore lacked capacity. However, there was no record of how these decisions had been reached and no indication of what this meant to the person's care. We observed that restrictions to people's liberties were in place including bedrails and wheelchair straps, although no decision specific capacity assessments had been completed with regards to this. Where DoLS applications had been completed these did not include details of these restrictions. The registered manager was unable to provide accurate information about the DoLS applications made.

Failing to ensure that the principles of the MCA were consistently followed is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in August 2017 we found that staff did not always receive regular supervision and that training was not always updated in line with the provider's policy. At this inspection we found that although improvements had been made, systems were not wholly embedded into practice.

At the time of our inspection records showed that training was up to date. Training provided included areas such as; safeguarding, moving and handling, infection control and health and safety. However, audits showed that refresher training had not always been completed within the timescales provided. Care staff told us they felt they received the training they required for their role. One staff member said, "We get a lot of training. We are learning every day and have regular refreshers." We asked the registered manager to provide evidence of the clinical training provided to nursing staff. This information was not made available for several weeks following the inspection and the registered manager told us they did not monitor the dates of clinical training provided to staff. This meant there was a risk that clinical staff would not be regularly updated in their clinical practice. One nurse told us that they had been waiting for several months to complete elements of their clinical training such as phlebotomy, syringe driver training and wound care. Although they were working with other clinical staff who were competent in these areas they felt they were

unable to fully complete their role. The registered manager was unaware when the staff member would receive this training.

Staff told us they received regular supervisions to support them in their role. One staff member said, "We get to talk to the manager. We are also reminded and supervised in doing things every week. They sign it off so they know we've been shown how to do it properly." Another staff member told us, "I have supervision and I do supervision. We have themes like this time I've been talking about dignity with staff." Records were available to show that staff had received supervision. However, the registered manager was unable to provide a clear record of when supervisions had taken place and how this was monitored.

We recommend that all staff training and supervision is regularly monitored to ensure that all staff receive the support and training they require.

With the exception of the concerns identified within the safe domain we found people had regular access to health care professionals. People told us the GP visited the service regularly and additional appointments could be requested. One person said, "They will get the doctor if I need them. Same for any of us." Care records contained evidence of people receiving recent optician and dental checks. People were supported to attend consultant appointments and follow-up appointments were arranged. Following a specialist appointment it had been recommended an assessment from the Occupational Therapy Team was arranged. This had been completed and the person now had a more suitable and comfortable wheelchair.

Comprehensive assessments were completed prior to people moving into the service. This enabled the provider to ensure they were able to meet people's needs. Assessments contained evidence that people and, where appropriate, their family members were involved in the assessment process. The assessment documentation viewed contained details of people's clinical needs as well as information about their preferences and personal background.

People we spoke with were very complimentary about the food provided. One person we spoke with told us, "The food's been very good. I couldn't eat properly before I came here but now I can."

We observed that staff showed people the choices available to enable them to choose which meal they preferred. Where people did not want either option there was a range of alternatives available at each mealtime. Catering staff were aware of people's dietary needs and preferences and had information available should they require it. Where people required their meal to be of a modified consistency such as pureed this was well presented.

People were supported well and in line with their nutritional guidelines. Where people received support to eat this was provided in a timely manner. A number of relatives came to support their family members with their meal. Staff were observed to take time to check people were comfortable and had everything they required. We did observe one staff member standing up to support someone and there was little interaction between them. This did not appear dignified for the person. We informed the registered manager of this who assured us they would address it with the staff member concerned.

Is the service caring?

Our findings

We received positive feedback from people and their relatives regarding staff being caring. One person told us, "They (staff) are caring, they talk to me." One relative told us, "The staff here cannot do enough for my wife. She is well cared for and it's a good place." As previously reported, although people felt individual staff members treated them with kindness there were times they felt isolated due to the staffing concerns.

People were treated with kindness and compassion in their day-to-day care. We observed positive interactions with staff. Whilst speaking with one person a staff member entered the room, they gave each other a high five before and after they spoke. They clearly enjoyed each other's company and the person told us, "(Name) is my favourite member of staff." We saw another person was laughing with a staff member regarding what TV programme they wanted to watch. One relative had brought food for their relative and we observed the catering staff speaking to them to ensure it was heated properly. The relative told us, "These people can't do enough for me, they are very kind." When passing people in communal corridors we observed staff ask how they were.

People's privacy and dignity were respected. We observed that staff knocked on doors prior to entering and ensured that doors were closed when providing personal care. One staff member told us, "We would always check the door was closed and check what gender of staff the person preferred. I ask what personal care people want, they may want different things on different days. We should always check with people they feel relaxed and nothing is disturbing them." When speaking to people we observed staff knelt beside them to be on the same eye level.

People were supported with their communication needs. We observed a number of people had computers in their rooms which enabled them to maintain links with their family and friends. Staff demonstrated a good understanding of people's individual communication styles and needs. Staff told us it was important for staff to let one person with a visual impairment feel their facial features before asking them anything so they were aware of who was there. The person's care records confirmed this. Another person had a specialist computer and adaptation which enabled them to communicate with staff. Staff supporting the person were also able to describe how they closely observed their facial expressions and gestures in order to communicate with them.

People were supported to maintain their independence. We observed staff supporting one person to walk down the corridor to increase her mobility. A second staff member followed behind with the person's wheelchair to ensure they were safe should they become tired. A staff member told us this was something the person liked to do daily, "It's important to (name). If they just need a little assistance, then I will let them do things for themselves." Another person told us, "I sort out the post and whatever I am able to do, they let me do it." It was clear the person valued the opportunity to deliver people's internal mail. We observed people were able to move around the service freely and had access to the aids and adaptations they required.

People's cultural needs were supported. People's religious and cultural needs were discussed during the assessment process to ensure the service were able to meet them. The registered manager told us that

regular church groups were held at the service. Where appropriate people were supported by staff or volunteers to attend the local church. It was important to one family that they were able to continue to provide food for their relative and the service ensured that this was facilitated.

Relatives we spoke with told us they were free to visit the service at any time and there were no restrictions in place. One relative told us, "I'm always here and they always make me feel welcome. I'm like part of the furniture now." We observed there were frequent visitors throughout the day of our inspection. Staff greeted people warmly and knew the names of people's visitors.

Is the service responsive?

Our findings

People told us the service was responsive to their needs. One person told us, "The staff are easy to approach and help when I need it." A relative told us, "They will ring and ask me to come in to talk about things if they're struggling." However, other people and relatives said they did not feel as though staff always responded to their needs.

People were supported by staff who knew them well. A number of staff working at Corrina Lodge had worked there for many years. They were able to tell us about people's lives, interests and family members. Staff told us they used this information to generate conversation when providing care to people.

There was a varied activity programme in place. One person told us, "They do all sorts here. I like art and the word games. Music and the exercises have been a big help as well." Another person told us, "The activities are very good. The activity staff can't do enough for you." A third person said, "There is always something if you want it. I really like the exercises." The activity programme included a wide range of visiting entertainers, indoor games and quizzes, various music and exercise groups, crafts and poetry. Regular trips were planned to various shopping centres, lunches and places of interest. There was a dedicated group of volunteers who supported the activities team. It was clear from observing their interactions with people and speaking with them that they knew people well and felt part of the team. People's care plans contained guidance on people's interests and this had been built into the programme. One person enjoyed a particular musician, this music had been found for them so they were able to enjoy it being played in their room. Another person enjoyed listening to poetry and we observed the activity co-ordinator reading poetry to them in the communal area. It was clear both the person involved and others in the room enjoyed this.

People had detailed care plans in place covering areas including communication, personal hygiene, tissue viability, nutrition, cultural, spiritual and social values, hopes and concerns for the future. These contained detailed guidance for staff and where individual support needs had been identified separate care plans had been written. Staff we spoke with and observed demonstrated they were knowledgeable about people's needs and routines. One person had an individual way of communicating their choices. Staff were aware of this and we observed them waiting for the person to respond in this manner. Another person's notes contained information regarding how they contacted their family. We observed the person had the equipment they required close to them so they were able to do this. Staff we spoke with were confident in speaking to us about people's needs and how to support them. Regular reviews were completed with people and, where appropriate, their relatives. Whilst people described this as a positive process we did find one person's file had not been updated following their care plan being reviewed.

People received the support they required when nearing the end of their life. Care plans contained basic details of the care and support people would prefer at the end of their life. At our last inspection the deputy manager had told us that this was an area they wanted to improve to ensure they were working to the highest standards. However, at this inspection they told us they had not had the opportunity to develop this work as much as they would like. Proactive Anticipatory Care Plans (PACe) documents were in place for a number of people where appropriate. Staff were able to describe the importance of respecting people's

wishes at this time. One staff member told us, "It's very important they have the family they want there and all the things they like. We will sit with people if they want that."

There was a complaints policy in place and this was made available to people within the service information packs in their individual rooms. People and their relatives told us they would feel comfortable raising concerns with the registered manager and were confident these would be addressed. A complaints file was in place although this did not contain comprehensive information regarding the complaints received. Following the inspection the provider sent information relating to how complaints were logged on the central system for the organisation. This meant that any themes or trends emerging with the complaints received could be identified. Records showed that individual complaints were investigated and responded to. Following the inspection we received information from a relative expressing their dissatisfaction at the response they had received to a complaint. They are continuing to follow up their concerns with the provider.

Is the service well-led?

Our findings

People told us they felt the registered manager was approachable. One person told us, "If I go to them it gets sorted." They gave the example of telling the registered manager they were unable to access their basin due to the vanity unit built around it. They told us the unit was removed the same day which they were happy about. Relatives told us that although the registered manager was kind, issues such as staffing and care plan reviews were not always addressed promptly.

At our last inspection in August 2018 we found that quality assurance systems were not always effective in identifying concerns and that records did not always contain the most up to date information. At this inspection we found a continued lack of management oversight.

The registered manager did not demonstrate an understanding of the systems in place and how these were used to monitor the service provided to people. We asked the registered manager for information relating to accidents and incidents and how these were analysed. During the inspection the registered manager was unable to provide us with this information and was unable to describe the systems in place. Following the inspection we received information which showed that on a day to day basis accidents and incidents were monitored. However, when incidents which were more complex occurred the registered manager had not ensured that prompt action was taken to mitigate the risks. As described earlier in the report, the action taken following medicines errors being identified was not robust and did not ensure that lessons had been learnt.

There was a lack of leadership of individual shifts. The registered manager told us that the nurses based on each floor were responsible for leading the shift. They said they felt the staffing levels within the service were now correct but felt any delays in people's care was around how staff were deployed. They had recently conducted a group supervision with nurses to clarify their responsibilities in this area as they had identified the lack of direction to staff as a concern. We reviewed the documentation regarding this supervision and found it was a list of tasks to be completed and did not give guidance on how staff should be supported, communication systems and leadership skills. During the inspection we observed little communication between clinical staff and care staff. Although care staff and nurses said they would communicate any concerns regarding people's needs, we did not see any direction regarding the running of the shift or discussion regarding people's general well-being. This did not demonstrate a positive working culture where staff were working together as a team to ensure the best outcomes for the people they were supporting.

The registered manager did not provide information to statutory agencies in a timely and detailed manner. Following the inspection we spoke with the local authority safeguarding team. They informed us incidents of concern were being raised with them to enable them to ensure people were being kept safe. However, when additional information was requested from the service this was often late being returned and was not always completed in a detailed manner. This had led to the local authority needing to visit the service more frequently to ensure action had been taken and people were being kept safe. Following the inspection we had requested information which the registered manager could not access during our visit. The registered manager had to be prompted to provide the information on several occasions. This resulted in us needing

to contact senior managers to assure ourselves the service was being safely managed.

Quality assurance systems were not always effective in identifying and addressing concerns. As reported, the principles of the MCA were not being followed to ensure that people's legal rights were protected. When this was discussed with the registered manager and senior staff within the service they were unable to demonstrate an understanding of the principles and how they should be applied. This shortfall had not been identified within quality audits and therefore no action had been taken to ensure people's rights were being protected. Quality monitoring systems looked at care records and identified areas where these had not been updated. However, we found that although these individual concerns were rectified, there was no analysis of themes to ensure that the same concerns did not arise again.

Records were not always updated in a timely and accurate manner. We viewed one person's care records which stated the person was able to eat independently. However, we observed at lunchtime staff supported them with their meal. We spoke to the registered manager about this who later told us the person's care needs had changed but records had not been updated. We asked the registered manager about one person's medicine support needs as they had inhalers in the bag. The registered manager initially showed us records that the person was able to self-medicate but later found additional documents stating the person now required support. The registered manager assured us they would update the person's care records and staff to ensure consistency. As described in the safe domain, one person's records regarding wound care lacked clarity and detail.

The lack of management oversight and effective quality assurance systems was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our discussions with senior managers from the organisation we were provided with reassurances that they had identified the service required additional support and had taken steps to ensure senior staff were visiting the service most days. This included senior clinical managers and general managers who were best placed to provide the registered manager with the support they required. Once this support was in place we noted an improvement in the response times for information and in the quality of the information received. They assured us that areas such as the monitoring of clinical training and competence were now being addressed and that supervisions would be recorded in a more transparent way. The registered managers and senior managers had worked alongside the local authority safeguarding team had the information they required and that, where appropriate, learning outcomes were being actioned.

This is the second inspection where we identified breaches of Regulations 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have on this occasion taken the decision to issue the provider with requirement notices in respect of these regulations for a second time. This decision was taken as a result of the robust action taken by the provider to support the service and the reassurances we have now received. We will continue to monitor the service closely.

On the whole staff told us they felt supported by the registered manager. One staff member said, "I like the manager, she has been very good to me. Staff are happy working here and want to help the residents." Another staff member said, "The manager has an open door policy and we know we can always speak with her." However a third staff member told us, "Things aren't always addressed properly. Some days you feel as though you are walking on eggshells with your colleagues." Records showed that regular staff meetings were held and were well attended. Staff had the opportunity to contribute to the meeting and raise any ideas or concerns.

People and their relatives had the opportunity to give feedback regarding how the service was run. The

provider conducted an annual survey of the service provided at Corrina Lodge. The latest survey had been completed in October 2017 although the registered manager told us that results had taken some time to come through. The overall results for the service were generally positive. Where actions were required these had been recognised and the registered manager told us these would form part of the overall action plan for the service.

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 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had to ensure that the principles of the MCA were consistently followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to ensure effective risk management systems and medicines practices were implemented

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to ensure robust management oversight and effective quality assurance systems were in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider had failed to ensure that staff were appropriately deployed to ensure people received their care in a timely manner