North Corner Residential Home

North Corner

Inspection report

1 Prince Edwards Road
Lewes
East Sussex
BN7 1BJ

Tel: 01273474642

Date of inspection visit:
18 April 2016
19 April 2016

Date of publication:
15 July 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 18 and 19 April 2016. It was unannounced. There were 13 people living at North Corner when we inspected. People cared for were all older people. They were living with a range of care needs, including diabetes, arthritis and heart conditions. Some people were also living with dementia. Many people needed support with their personal care, eating and drinking and mobility needs. The registered manager reported they provided end of life care at times. No one was receiving end of life care when we inspected.

North Corner was a large domestic-style house which had been extended to one side. It was set in its own grounds on a residential street in Lewes. Accommodation was provided over two floors in the older part of the building and on the ground floor only in the newer extension. A chair lift was available for part of the way to the second floor rooms. A lounge and separate dining room were provided on the ground floor.

North Corner had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also the owner of North Corner, in partnership with another person.

The last inspection was on 30 June and 1 July 2015. At that inspection, we found a number of breaches in the HSCA Regulations 2014. We rated the home as 'Inadequate' and warned the provider they must make improvements. The provider sent us an action plan following the inspection in which they stated how they would make improvements and that all areas would be addressed by 30 October 2015. In February 2016, they sent us their Provider Information Return (PIR) in which they outlined how they were currently meeting the needs of people living at North Corner and areas they wished to further develop.

We found, while the provider had addressed some areas, they had not taken effective action to meet all of the breaches in regulation identified at the last report. We also found further additional areas where they needed to take action.

At the last inspection, we found risks to the health and safety of people were not assessed and all actions had not taken place to mitigate such risks. We also found the proper and safe management of medicines was not ensured. At this inspection, the provider continued to not ensure accurate assessments took place, for example for people who were at risk of pressure damage. The provider continued not to take appropriate action to reduce people's risk, for example where people were at risk of dehydration. Staff were not always following guidelines on administration and recording of medicines, including 'as required' (PRN) medicines. The provider had taken action to ensure all people were assisted to move in a safe way. They had also set up clear systems in some areas relating to medicines, for example administration and recording of prescribed skin creams. They had also ensured they contacted external healthcare professionals about people's healthcare needs in a timely way.

At the last inspection the care of people was not always appropriate, did not meet their needs, and reflect their preferences. At this inspection, we found people's needs were not consistently assessed, for example where they had continence needs. Also care was not designed to meet people's needs, including for people who were living with dementia. Care was not always provided in a way which reflected people's preferences, including their recreational needs. The provider had taken action in some areas. They had developed a programme of activities from external providers, which took place during the afternoons. Some people's care plans were very individual and set out clearly the person's likes and preferences.

The provider continued not to ensure the quality and safety of services people received was assessed, monitored and improved Risks relating to the health, safety and welfare of
people and others were not mitigated. Also each person's documentation about their care continued not to be accurate, complete and contemporaneous. The provider had audited some areas, for example the safety of the building and staff training needs. However the action plans they reported on were not always in writing. Progress where issues had been identified, such as tripping risks to people, were not always evident. Some records remained inaccurate. The provider continued not to ensure relevant records were completed to assist in assessment of people's needs, for example where people showed behaviours which may challenge themselves or others.

The provider had not identified the risks to people of having only one member of waking staff on duty at night. There were no protocols to ensure the safety of people in the event of a fire could be met at night, by only one waking member of staff.

The provider had taken full action to meet the breach identified at the last inspection where people were unable to give consent when they lacked mental capacity to do so. People had clear assessments and plans relating to how they were to be supported in consenting to care. Staff were fully aware of their responsibilities under the Mental Capacity Act (2005).

People said staff were both kind and gentle when supporting them. People said they were happy living at North Corner and felt safe there. They said they could raise issues of concern if they wanted to. People commented positively on the meals provided. The chef was keen to work with people and ensure they could have the meals they liked and enjoyed.

Staff were positive about the service provided at North Corner. They said they felt supported both by managers and by their training. All of the staff we spoke with were fully aware of how to support people who may be at risk of abuse. Staff spoke positively about the homely atmosphere of North Corner.

The overall rating for this provider remains 'Inadequate'. This means that it remains in 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found five breaches of the HSCA 2014 Regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Assessments of people's risks were not consistent and care plans were not always in place, or followed, to ensure people's risks were reduced.

Guidelines on safe administration of medicines were not always followed.

The safety of people at night was not fully ensured by the number of staff deployed. Some documentation relating to the recruitment of staff was not completed.

There were systems to ensure people were safeguarded from risk of abuse.

The home was now clean and hygienic.

Is the service effective?

Requires Improvement

The service was not always effective.

There were not effective systems to prevent people's risk of dehydration.

The service was not always effective.

There were not effective systems to prevent people's risk of dehydration.

Full training plans to ensure staff could provide effective care to meet people' s needs were not in place.

Systems were in place to ensure the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were met.

Referrals were made to relevant healthcare professionals to ensure people were appropriately supported.

People spoke positively about the meals provided. These took

place in a supportive, domestic environment.

Is the service caring?

Requires Improvement

The service was not always caring.

Where people had needs such as those relating to continence or dementia, the provider's systems did not ensure people were responded to in a caring way.

People commented on the caring nature of staff. Staff showed an understanding of supporting people in the way they preferred and respected their choices.

Is the service responsive?

Inadequate

The provider's systems for care planning did not consistently ensure people's needs were assessed effectively and plans put in place to respond to people's needs.

There was a lack of focussed activities relating to some people's individual needs.

People said they could raise issues of concern with the managers. There had been no complaints received during the past year.

Is the service well-led?

Inadequate

The service was not always well led.

The provider's systems did not ensure relevant action was taken in certain areas where issues had been identified in relation to people's health, safety and welfare. They also did not always ensure improvements were made in the quality of care provided.

Some relevant documentation continued not to be completed.

The provider was open to developing new ideas about improving service provision.

Staff were aware of the provider's philosophy of care to provide a homely environment for people.

North Corner

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 took place on 18 and 19 April 2016. It was unannounced. The inspection was undertaken by one inspector 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 our inspection we reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

The provider had submitted a Provider Information Return (PIR) in February 2016. This outlined baseline information about the care provided at North Corner and also the provider's own assessments of how they provided a safe, effective, caring, responsive and well-led service. We reviewed this information to plan and inform our inspection.

We met with all of the 13 people who lived at North Corner and observed how they were cared for and supported, including during the lunchtime meal. We spoke with two people's relatives. As some people had difficulties in verbal communication, 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 inspected the home, including some people's bedrooms, bathrooms and the laundry. We spoke with six of the care workers, a domestic worker, the chef, the handyman, the administrator/senior care worker and the registered manager.

We 'pathway tracked' six of the people living at the home. This is when we looked at people's care

documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed a range of records. These included staff training, staff recruitment, medicines and accident and incident records. We also reviewed risk assessments, quality audits and policies and procedures. The provider also sent us further information after the inspection, including documents relating to audits of service provision.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at North Corner. One person said they felt "Absolutely safe," and another "Perfectly safe." A person's relative told us "I do feel my mum/dad has been safe." However we found a range of areas where people's safety was not ensured.

At the last inspection, on 30 June and 1 July 2015 we found people's care and treatment was not provided in a safe way because risks to their health and safety were not assessed and all relevant actions to reduce people's risk had not been taken. In their PIR, the provider stated that all people 'have comprehensive assessments of risks to their personal safety and plans, which are regularly reviewed, to manage any risks.' They stated this included, among other areas, prevention of risk of pressure damage. We found they were not doing this.

We talked with staff about certain people's risk of pressure damage. Several staff told us they did not think these people were at risk of pressure damage. This was despite these people's assessments showing this was the case. Several people's pressure damage risk assessments had not been completed correctly. This included, among a range of other areas, assessments which stated their mobility was not a risk factor in pressure damage, when other assessments showed it was a factor for them. This meant as well as not all staff knowing about people's risk of pressure damage, people were assessed as being at a lower risk than they should have been.

We asked staff about the actions they took to reduce people's risk of pressure damage. Staff gave us different answers. Because some staff said certain people were not at risk, staff said these people did not need any support to prevent pressure damage. However they had been assessed as being at risk. Other staff only knew about the skin creams they used for people, not other interventions. A person was assessed as being at risk of pressure damage. Staff gave us differing information about what equipment they used to reduce their risk. People did not receive the support they needed to reduce their risk of pressure damage. People remained sitting in their chairs for extended periods of time throughout both inspection days. They were not supported to move around regularly, to prevent pressure damage risk. Only one of the people assessed as being at risk of pressure damage had a record to show how often their positon was changed. This showed they did not have their position changed at night. This was contrary to their care plan from their district nurse, which stated they were to have their position changed at night as well as during the day. A senior member of staff told us why the person did not have their position changed at night. This was not documented in their care plan. People's care plans were automatically generated following a computerised assessment. These care plans were not person-centred and did not document, for example how often each person needed to have their position changed or the types of equipment they were using to reduce their risk.

The National Institute for Health and Care Excellence (NICE) has produced guidelines on the prevention of pressure wounds. These state that pressure wounds, once developed can take an extended period to time to heal, can be very painful and may present a risk of infection. The emphasis must always be on their prevention, before they occur. They emphasise the importance of accurate assessment of risk and a

coordinated approach to care planning to reduce risk as much as possible. The service continued not to follow these guidelines.

The service was also not acting in other areas to reduce people's risk. Several of the people were assessed as being at risk of falling and some had a history of falling. This included people who spent much of their day in the sitting room. There were extended periods of time in the sitting room when there were no members of staff available to support people or take action should people get into difficulties when walking about. For example during one twenty minute period, no staff were available to support people in the sitting room. During this period, we observed a person get up and walk out of the room and return a few minutes later. When they did this they were unsteady on their feet and were clutching at the furniture and the wall by the door to get in and out of the room. The person did not receive support or supervision when they did this, although they were unsteady.. We asked a senior member of staff about this. They said a member of staff was always allocated to support people in the sitting room but would not always be available in the room all of the time.

The provider was not ensuring people's care was provided in a safe way. This was because they were not accurately assessing people's risks and doing all that was reasonably practicable to mitigate such risks. This is a continued breach of Regulation 12 of the HSCA Regulation 2014.

We saw staff supporting people in a safe way in other areas, including following relevant guidelines about safely moving people. Staff consistently always gave people time to understand how they were going to support them before they started helping them to move. They gave clear directions on what the person needed to do to stand up safely, using relevant equipment correctly when needed. When staff walked with people, they were mindful of possible hazards. For example a care worker advised a person to "Mind the step" in a gentle, kindly manner as they supported them in walking out of the sitting room. A person told us they needed a frame to walk about safely. They said they were pleased that staff had enabled them to have two frames, one in their room (which was upstairs) and one on the ground floor, which they could use once they got off the chair lift.

At the last inspection on 30 June and 1 July 2015 we found the service did not have proper and safe systems for the management of medicines. The service had addressed some areas but other areas remained.

A member of staff told us that a person had difficulties with constipation and to help them, they had been given a certain medicine. We looked at the person's medicines administration record (MAR). This showed they were not prescribed the medicine the member of staff told us about. Their MAR did not record they had been given this medicine as a 'homely medicine'. 'Homely medicines' are medicines which are purchased from pharmacists which can be given to people, after agreement from their GP. The person's daily records documented they had been given this medicine, which they were not prescribed by their GP. Current information on the medicine they were given showed it needed to be given regularly for it to be effective and a single dose was not an effective way of supporting a person's needs. Managers for the home were not aware of this matter, although it had been documented in the person's daily record. NICE guidelines state medicines must only be given under the direction of a person's GP, and records of any individual medicines given need to be recorded on their MAR, including the reason for this. This is to ensure the safety of people. The staff were not following these or their own guidelines and policies in this instance.

Several people were prescribed 'as required' (PRN) medicines. People had protocols about actions to take in relation to these medicines. Included in the protocol was a direction that their GP should be contacted if such medicines were requested too often. This was not being followed. Several of the people were being given PRN medicines regularly. This included two people who were being given PRN medicines every

morning to help their breathing. There was no evidence these people's GPs had been contacted about this. Staff reported one of the people who was given the medicine every morning showed anxiety at times. Current information on side-effects for the medicine for breathing stated it can cause anxiety. The service was not following their own medicines policies and ensuring the safety of people.

The provider was not ensuring the proper and safe management of medicines. This was a continued breach of Regulation 12 of the HSCA Regulations 2014.

People said staff supported them to take their medicine in a safe way. One person told us about their tablets, "I take so many I wouldn't remember," so they were pleased staff supported them. Staff gave people their medicines in a safe way, checking their MAR before giving them their medicines and making sure they had fully swallowed their medicines before signing for them. The provider now had clear systems for supporting people in applying their prescribed skin creams. This included a full record to show which skin cream was to be applied to which part of the person's body. All these records were signed to show people had these prescribed medicines applied.

In their PIR, the provider stated 'our staff rotas show that our staffing levels are adequate to meet the needs of our service users at all times.' People gave us mixed comments about staffing levels. One person told us "I'd feel safe here if there were more staff." A person told us if they rang their bell at night, "They come after a while." Such comments were not echoed by other people. One person told us "Mostly there are enough staff, including evenings and weekends." A person's relative told us "Generally there are enough staff." A member of staff told us staffing levels were "Not too bad."

We looked at the staff roster and saw only one member of staff was rostered on duty at night to care for 13 people, several of whom were frail and many of whom were living with dementia. We looked at people's records. One person's record showed they had remained restless and unable to sleep for most of the night. Another person, who was also assessed as being at high risk of falling and who was living with dementia, had records showing the night member of staff had found them on occasion out of bed on their own. There were also no records to show if the people who were assessed as being at risk of pressure damage, had been supported to change their position regularly at night to reduce their risk. The service's fire risk assessment showed eight people would need assistance to be evacuated from the premises at night either by physical support or because of their dementia care needs.

We asked the registered manager about this. They said there was always a member of staff who slept in during the night. They agreed this was not documented. This meant they could not identify which member of staff had been sleeping in, on any particular night, if they needed to. We asked about the duties of this member of staff, including how long they supported the waking member of staff before going to bed, and when they got up in the morning to support the waking member of staff. We asked about the types of occasions when they would be called on to support the waking member of staff, such as supporting a person who showed signs of restlessness at night or supporting the waking member of staff to change a person's position where they were at risk of pressure damage. The registered manager said they did not have any protocols about the duties of the sleeping in member of staff. The fact that there was only one waking member of staff on duty at night had not been included in the home's fire risk assessment. The registered manager had also not made any assessment to check one waking member of staff at night was enough to meet the needs of 13 older people, some of whom were frail and several of whom were living with dementia.

The provider had not ensured that sufficient numbers of staff were deployed to meet the needs of people living in the home. This is a breach of Regulation 18 of the HSCA Regulations 2014.

In their PIR, the provider stated 'our staffing records show that we recruit staff in line with our aim of keeping service users safe at all times.' We looked at staff records, including the two most recently appointed members of staff. One of the staff showed two gaps in their previous employment records and what was documented on their application form did not match what they had documented on their CV. We asked a senior member of staff about this. They knew the reasons for the member of staff's gaps in employment, but it had not been documented to ensure any future manager could be aware of the issues. A member of staff's interview assessment record stated their suitability was 'good,' despite one of their references reporting on a specific area of their performance which the referee was concerned about. The senior member of staff knew the reasons why a decision had been taken to appoint the member of staff. This was also not documented. We discussed that documentation was an area which required improvement to ensure the provider could fully demonstrate all staff had been recruited in a safe way.

Staff had all other relevant checks completed, including police checks, proof of identity and health status questionnaires. These demonstrated prospective staff had been assessed to ensure they were safe to care for vulnerable people.

In their PIR the provider stated 'we have written policies and procedures on keeping people safe: we ensure that they are kept free from abuse.' They also stated 'every staff member knows what to do in the event of a service user being harmed or is at risk of harm, including how, if necessary to notify the local safeguarding authority.' All of the staff we spoke with knew about their responsibilities for safeguarding people from risk of abuse. One member of staff said informing the local authority safeguarding team if they needed to was "Just one phone call away."

At the last inspection, we identified areas of the home which needed attention to cleanliness. The provider had taken action, and all areas of the home were now clean. This was commented on by people. One person told us "The home is a clean place," and another "They do my room daily". We saw, when we first came into the home during the morning that some areas needed attention, such as sticky bedside tables and a toilet which was not clean. These had all been fully cleaned by the mid-morning.

Requires Improvement

Is the service effective?

Our findings

People said they received effective care. A person told us "I think they do a good job here." A person's relative told us "The staff are taught from the top." A person told us the staff "Seem to be trained." A person also told us "Oh yes, they get the doctor in if I need it." People said they liked the meals. One person told us "The food is excellent," and a person told us "There's more than enough," about the meals provided. Despite these positive comments, we identified areas where the service was not effective.

Some of the people were frail and one of them had been assessed as being at risk of dehydration. We heard a person in the sitting room who called out for a drink. This person had been seen by the speech and language therapist (SALT) who had directed that staff were to 'maintain accurate fluid charts.' Staff confirmed the person needed support with taking in fluids. One member of staff told us the person was able to drink, but only if they had a drink placed within their reach. The person sat in the sitting room on both days of the inspection. They had no drinks placed to hand on either day. Despite the directions from the SALT, they did not have a fluid intake chart. The person did have a food chart where some of their drinks were recorded. When we totalled these, for one day the record indicated they had only drunk 100 mls plus a cup of tea, on another day it indicated they had drunk 300 mls plus a cup of tea. Current guidelines are that a frail person should be drinking in the order of 1500mls a day, to maintain their hydration. There was no evidence this was taking place for this person. Another person's food intake chart indicated on one day they had drunk 200mls, a cup of tea and 'sips.' This person was also frail and could not access drinks without support. No drinks were made available in the sitting room for people to have when they wanted. People did not have assessments or care plans in relation to their risks of dehydration. We discussed risk of dehydration for people with a senior member of staff. They said they felt people were offered adequate fluids.

The provider was not ensuring people's hydration needs were met. This is a breach of Regulation 14 of the HSCA Regulations 2014.

People's nutritional needs were met. A person told us "Our chef is pretty good" and that they "Know I'm a diabetic." A person described the "Nicely prepared food." We observed a lunchtime meal. Lunch was provided in a comfortable, domestic-style dining room. The meal smelt good and people were clearly enjoying what they ate. The chef showed a flexible approach, confirming they would do "Spot meals" if a person decided at the time of the meal that they did not want either of the choices on offer.

A person who had difficulty in swallowing had been seen by the SALT. They had a clear care plan about the thickening of their fluids and consistency of their meals. All of the staff we spoke with knew about this care plan. We saw staff gave the person their meals in the way directed by the SALT.

Our discussions with staff and review of training records indicated some staff had not received relevant training in meeting the needs of people living in the home. We spoke with staff about their training, such as supporting people with continence, prevention of pressure damage and nutrition and hydration. Some staff said they had been trained in these areas, others said they had not. What some staff told us showed they did not know about current guidelines on preventing risk of pressure damage to people, such as the high risks

associated with diabetes. One member of staff said they felt because of the needs of people living in the home, they had needed to know more about continence management, so had looked it up on line in their own time. Staff records reflected what staff told us about the variance between different staff in training in the specific needs of people living at the home.

We asked a senior member of staff who was involved in planning training whether there was a training plan for staff. They reported they used a responsive approach to staff training, which was based on the needs of people living in the home, also depending on what training was available locally. For example courses offered by the local authority and on-line courses, giving an example of some recent free on-line training in hand hygiene. They reported the provider did not do an overview of staff training needs, but they did do a month by month plan, which was based on currently available training. They did not complete this plan in writing. This meant the provider did not have a training plan to demonstrate how they would ensure all staff were appropriately supported by training to provide effective care to meet the current needs of people living at the service.

The provider was not ensuring they had sufficient numbers of suitably qualified, competent and skilled staff to ensure they provided effective care to people. This was because they were not ensuring all staff received such appropriate support, training and professional development to enable them to carry out the duties they are employed to perform. This is a breach of Regulation 18 of the HSCA Regulations 2014

The provider was ensuring staff were supported in other areas. One of the new members of staff said they had previous experience in their role and their induction to the home had suited their individual needs. They had shadowed a permanent member of staff for the first two shifts to enable them to get to know the home and the people living there. All staff said they had been trained in fire safety and all were aware of the fire muster point. Staff confirmed they had been trained in other areas like how to help people to move in a safe way and prevention of spread of infection. Staff said they felt supported in their role by receiving one to one supervision. A newly employed member of staff said they had received one to one supervision at the end of their probationary period. A permanent member of staff said they could bring up "Anything and everything" during their one to one meetings. In their PIR sent in, in February 2016, the provider stated they had identified staff needed training in supporting people who were living with dementia and stated 'Our staff will be undertaking Dementia Training as an area of focus over the next 6 months.' They outlined the ways they were planning to do this in the future.

At the last inspection on 30 June and 1 July 2015 we found where people were unable to give consent because they lacked the mental capacity to do so, the provider was not acting in accordance with the Mental Capacity Act 2005. In their PIR the provider stated they had identified the people who required an application for authorisation under the Deprivation of Liberty Safeguards. They said, following the last inspection they had learned a great deal about the issues, procedures and processes involved.

We met with a person who had been assessed as not having mental capacity. They had a very clear mental capacity assessment which documented how they were to be supported in giving consent. Staff actively supported the person in consenting on a day to day basis. At lunchtime, the person said they were not hungry, and did not want a meal. The member of staff tried to encourage them to eat and offered to get them an alternative meal of their choice. The person continued to say they did not want anything to eat. The member of staff accepted the person's right to choose not to eat at that time. A newly employed member of staff confirmed they had been trained in the Mental Capacity Act and showed an understanding of how they supported people on a day to day basis. All of the staff we spoke with showed a good understanding of their responsibilities under the Deprivation of Liberty Safeguards.

At the last inspection, we found the provider was not ensuring timely care planning with other healthcare professionals, to ensure the health, safety and welfare of people. In their PIR the provider stated 'We consult with the other professionals such as GP's, district nurses, local authority and DoLS team and work together with them." Staff confirmed this was taking place. A member of staff described the advice given to them about a person's swallowing difficulty as "Very useful." People's records showed evidence of consultation with external professionals, including district nurses, therapists and SALTs. A person who had dementia care needs had been referred to a community psychiatric nurse and staff were awaiting an appointment for them.

Requires Improvement

Is the service caring?

Our findings

People gave us mixed comments about the way staff cared for them. One person told us "Sometimes they are slow at getting me to the toilet" and another "In general the response to a call is not so good." This was not echoed by other people. One person said "The staff are very nice," another said "They're very good the girls are," and another described the staff as "Friendly." People's relatives also gave us positive comments. A person's relatives told us "The staff are very kind, patient and helpful," and another "The people who work here are nice." A member of staff said "Everyone's cared for."

In their PIR, the provider stated 'We already consider that we are providing a caring service and this is supported by the feedback that we get from residents, their relatives and other Professionals.' However we found the home did not always show a caring attitude towards all people.

People's dignity in relation to their continence needs was not always ensured. Many of the people living at the home had continence needs. We observed several people were not offered the opportunity to visit the toilet or freshen up either before or after their lunchtime meal. This was despite several people having care plans which stated they should be helped to go to the toilet before or after their meals to support their continence needs. Other people had care plans which stated they should be prompted to go to the toilet regularly to support them in maintaining their continence. We asked staff about how they supported different people with their continence. Staff gave us differing responses about different people's degree of continence needs and how they supported them. Monitoring records were not used to support assessment of people's individual continence needs. This did not support people's dignity.

People did not always receive support when they asked for it. Although a member of staff was reported to be allocated to support the people who stayed in the sitting room, our observations showed people who requested assistance remained unsupported for periods of time. On the first day of the inspection, a person in the sitting room sounded distressed and called out "Help." They were reassured by another person, but no member of staff came to support them. The person continued to sound distressed and again called for help three minutes later and five minutes after that. Throughout this period no member of staff came to support them and find out how they could help them. The person's records showed they were frail, unable to move without assistance and were living with dementia. This did not show a caring approach to a person who showed distress and felt they needed assistance.

We met with a person who spent most of the time during both inspection days on their own in their room. The person's care plan stated they were to sit in the sitting room every day, beside a family member, who also lived in the home. We asked staff why the person's care plan was not being followed. One member of staff said they did not know why the person remained in their room and said the first day was "An exception" to what they usually did. We asked another member of staff who said the person did not like the noise in communal areas and preferred to sit quietly. This was not documented in the person's records and no review of the person's care plan had taken place to ensure their preferred way of spending their day continued to meet their current preferences and needs.

The provider did not ensure that people's care was appropriate, met their needs, and reflected their preferences. This is a continued breach of Regulation 9 of the HSCA Regulations 2014

In other areas the service ensured people's privacy, dignity and respected their preferences. A person told us "I have breakfast in my room, I like that," Another person told us they sometimes had their dinner downstairs in the dining room and sometimes in their own room "It depends how I feel." A person told us they could meet their family where they wanted to, including in their room, the sitting room or the dining room. A person told us they appreciated the way they were "Free to move around using my walking frame."

Staff treated people as individuals, encouraging them to make choices. A member of staff asked a person if they wanted gravy with their meal and where they wanted it putting on their plate. A member of staff supported a person who needed assistance to eat, first explaining how they were going help them and asking their permission to sit them up in bed so they could eat more easily. The member of staff sat down with the person, engaging them in conversation during the meal. The registered manager came up to a person who was in the sitting room, asked if they were ready for lunch, chatting comfortably with them about how they were going to support them and what they were going to do next.

One person who had difficulty in communicating had a detailed pen picture of their past life in their records, which described them as an individual and what their likes and preferences were. The information would give any member of staff who was unfamiliar with them the information they needed to support them in caring for the person as an individual.

People's visitors said they were free to come and go as they wanted to. We asked the registered manager about the sign on the front door which detailed the visiting times for the home. They said this was a guide only and people's visitors were not expected to keep to it, if it did not suit them or the person they were visiting. A member of staff said "We have visitors all the time."

In their PIR, the provider stated people were 'encouraged to bring in their own furniture and belongings,' if they wanted to. This was reflected in people's rooms which were individual in tone, reflecting their likes and preferences.

Inadequate

Is the service responsive?

Our findings

We asked people if the service was responsive to them. They gave us mixed replies. One person told us "There isn't much going on," another "There's not much to do," and a person told us they were a bit concerned about the people who didn't get many visitors because of the lack of activities at the home. One person was more positive, saying "They make sure we get some entertainment." A person told us "I do need looking after and I usually am," another "If I needed anything, I would get it" and another "I do think I get the care I should." Despite these more positive comments, we found the service did not always respond to people in the way they needed.

At the last inspection on 30 June and 1 July 2015 we found people's care was not appropriate, did not meet their needs, and reflect their preferences. In their action plan following the last inspection, the provider stated they would have addressed this by 31 October 2015. In their PIR the provider described their care plans which they reported were 'based on a comprehensive assessment' people's needs and also stated 'We see our job as one of meeting the individual needs as stated in the care plan.'

We found the provider had not taken relevant action since the last inspection to ensure they were responsive in meeting people's individual needs. On the first day of the inspection, throughout the morning and much of the afternoon, we heard a person who repeatedly called out in a distressed-sounding way, shouting words like "No," "Don't" and that they felt they were falling. This happened when the person was on their own, as well as when staff were with them. We asked staff about this. Different staff gave us different reasons as to how often the person called out, why the person did so and about different actions they would take to respond to the person when they did this. The person's dementia care plan reported on behaviours they might show, such as those observed during the inspection, but did not set out actions staff were to take to support the person when they called out. We looked at both the handover sheet and the person's daily records on the second day of the inspection. A record had not been made in ether record about the person's calling out behaviours or interventions from staff. There was no ongoing monitoring record to record matters such as how often the person experienced these calling out behaviours, their duration or any triggers. The lack of a monitoring record meant effective assessment of the person's dementia care needs could not be made. The lack of assessment meant a responsive care plan could not be developed to meet the person's dementia care needs.

Staff were not meeting other people's dementia care needs or following their care plans. We met with a person who had recently come to live in the home. Their records stated they were living with dementia. They had a clear care plan about their behaviours which may challenge others, which outlined the actions staff were to take if they showed these behaviours. Five of the staff had signed this person's care plan to show they had read it. On the first day of the inspection, the person showed these behaviours, as described in their care plan. None of the staff followed what the care plan stated they were to do when they showed such behaviours.

Staff were also not following other people's care plans. Two very frail people had care plans which stated they needed to lie on their bed for a period after lunch both to give them a rest and to support them in

straightening their lower limbs. This did not take place on either day of the inspection, for either person. We asked a member of staff why this was. They told us one of the people did not want to leave their friends in the lounge and preferred not to go to their room after lunch. Other staff we spoke with did not know why these people had not been supported in lying on their beds after lunch. A review of one person's daily records showed they had been supported in lying down some days and not on others but gave no reasons for this. Neither people's care plan had been reviewed to ensure all staff supported these people in a consistent way to meet their individual needs and preferences.

A person had a care plan which reported on the importance of a variety of activities for them to engage with. The person was not provided with a variety of activities on either day and they spent most of the time sitting in their chair either asleep or not engaged with anything, apart from occasional support from staff who checked to see if they wanted anything. These contacts were brief and mainly related to functional matters.

In the PIR the provider reported on actions they had taken to develop the provision of activities in the home. We found the provision of activities was limited and brief. A person told us that "Someone comes once a week to do painting and drawing and keep fit," they also said there were "Occasional other activities."

During both mornings, people sat in the sitting room, there was music playing, no other activities were provided. Although we were told a member of staff was allocated to support people in the sitting room, most of the time people sat on their own with no activities provided. Most of the people were living with dementia and needed support from staff to enable engagement. Published guidelines state that activities are an important part of ensuring people's well-being and that being involved in an activity may reduce people's feeling of isolation and give purpose to their days. The provider continued not to follow these guidelines.

Records showed an activity was provided every afternoon, and we saw these taking place. On one day an external provider brought in some new-born lambs for people to engage with. On another day, an art group took place, organised by an external person. Both these activities lasted for approximately an hour and did not involve the people who remained in their rooms.

The provider was not ensuring that people's care was appropriate, met their needs and reflected their preferences. This is a continued breach of Regulation 9 of the HSCA Regulations 2015.

One person who was living with dementia had been provided with a rummage box. They spent much of the day on both days in the dining room examining and organising the objects in the box. They were fully engaged with what they were doing.

In their PIR the provider stated 'We have a clear complaints procedure, which service users and their relatives know how to use if they wish to make a complaint about our service. And a complaints book which is kept in the hallway.' They also stated 'The feedback we receive….has always been very positive.' People confirmed they understood the complaints procedure but had not needed to bring up any issue of concern to themselves. One person said "I've no real complaints," another "I don't grumble much" and "If I did I'm sure they would sort it out," and another "I've not needed to complain about anything serious." A person's relative told us "I've never had to worry or complain about anything." We looked in the complaints record and saw no complaints had been raised about the service.

Inadequate

Is the service well-led?

Our findings

People said they thought the home was well led and they liked living there. A person told us "The management is pretty approachable" and another "The management is well-meaning." A person said the home was "Run very smoothly," and another "I think they run this place well." A person's relative told us "As managers, they are very good" and another "We are very pleased they are here." Despite these positive comments, we found the provider had not taken relevant action to address issues identified at past inspections.

At the last inspection on 30 June and 1 July 2015, we found systems and processes were not established and operated effectively to ensure the quality and safety of services people received was assessed, monitored and improved, and risks relating to the health, safety and welfare of people and others were mitigated. Each person did not have an accurate, complete or contemporaneous record. In their PIR submitted to us in February 2016, the provider reported on their systems, including 'We maintain a safe living environment, e.g. by being compliant with all health and safety.' We found the provider had not taken full action to ensure the safety of people.

The provider had employed an external company to perform a full health and safety audit of the building. This had taken place in October 2015. The report detailed a range of areas which needed addressing. Among other areas, the audit identified a risk in one of the bedrooms, where the floor sloped down into the en-suite and a risk at the entrance to a person's room where the floor sloped down to the corridor. The external company made recommendations about what actions the provider should take to reduce risk to people, including for these two rooms. Their recommended actions had not been acted on six months later, despite people who were assessed as having a risk of falling being cared for in both these rooms. These people's own risk assessments also did not document actions or plans to reduce their risk from these hazards. We asked a senior member of staff about the audit. They said an action plan was in place and timescales for actions were based on the assessed level of risk. We asked for the action plan during the inspection, but it could not be found. We asked the provider to send us a copy of the action plan after the inspection, they did not, although they did send us a copy of the assessment drawn up by the external company in relation to bathrooms and other areas. The provider's systems had not ensured all relevant actions had taken place to reduce identified risk for people.

In their PIR, the provider listed the audits they performed. We asked the provider for these audits. The audits they gave us were not recent and did not consider all relevant areas. The provider gave us a copy of an external quality audit performed by an external company, this was in terms of previous standards and had taken place in February 2015. We asked for their most recent audit of care, the document they gave us was dated over nine months ago. A medicines audit had been completed in February 2016, but it did not review the use of PRN medicines to assess if staff were following their own procedures.

The provider's audits had not identified they were continuing not to correctly complete necessary records. We observed a range of records which were not accurate. For example a person was lying on their right side at 12:40 pm, but their record stated they were sat up. At 2:20 pm a person's record stated they were on their

right side but they were lying on their back with a neck support in place for their comfort when lying on their back. Only one of the people who was assessed as being at risk of pressure damage had records to show their position was being changed regularly. One of the people who did not have such a record was not able to move themselves without support and had a history of past pressure wounds. There were no records to show what setting a person's air mattress should be on, or that it was regularly checked. The settings on the mattress were incorrect for the person's weight on both days of the inspection. An air mattress placed at an incorrect setting for a person's weight may increase their risk of pressure damage. Records of people's fluid intake often did not document the amount a person had drunk, and only used such unspecific terms as 'a cup'. Where people showed behaviours which may challenge themselves or others, no records were made of the duration or frequency of these behaviours. The provider's audits had not identified these and similar issues relating to record keeping and ensured they had taken action to address them.

The provider was not ensuring their systems operated effectively to assess, monitor, mitigate and improve the quality and safety of the services provided. They were also not maintaining an accurate, complete and contemporaneous record in respect of each person. This is a breach of Regulation 17 of the HSCA Regulations 2014.

A survey of people's and visitors' views about care had taken place. Not many survey forms had been completed; the few which had been were all positive about care. The survey format used by the service did not enable people to complete surveys confidentially and they were not available in formats which people living with dementia could understand easily. This meant the provider's survey did not ensure people could fully provide the provider with their opinions about the service. The provider reported they were seeking the views of people about the service in other ways and were developing their residents' meetings so they could receive comments from people on the service, for example provision of activities and meals.

The provider was performing audits in some areas. These included accident and incident audits. We noted as good practice that all relevant matters were included in these audits, such as skin tears and unexplained bruising to people. Where issues were identified, such as unexplained bruising, the information was reviewed and followed up to ensure people's safety. The provider made sure regular maintenance of the home environment took place, for example the chair lift was being serviced during the inspection.

In their PIR, the provider described their plans for the future. This included 'We hope to make our home more Dementia friendly in design and layout both in the interior and exterior.' They also stated 'The management works as a close-knit team, which helps to develop the open and transparent home ethos that we aspire to. We believe in being 'hands on' and constantly visible to service users and staff.' People reported on the ethos of the home, which reflected what the provider reported in their PIR. One person told us the manager "Does pop in and I do see her around." People told us about the home atmosphere, one person said "It's certainly quite nice here," another "l like it here. I'm glad I'm here."

Staff said they found the registered manager approachable. They commented positively on the ethos of the home. One member of staff said they would place one of their relatives in the home because it was "A very nice home." Another member of staff told us North Corner "Seems a nice place, welcoming and friendly all residents like living here."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider was not meeting people's hydration needs by ensuring people received suitable hydration to sustain good health and provide appropriate support for a person to drink. Regulation 14(1)(4)(a)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed. The provider could not evidence that staff received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform, Regulation 18(1)(2)(a)