Peninsula Care Homes Limited

Cornerways

Inspection report

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Date of inspection visit: 27 May 2015
Date of publication: 08/07/2015

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?	**Good**

Overall summary

This inspection was unannounced and took place on 27 May 2015.

Cornerways is a care home without nursing, which provides care for up to 50 people. People who live at the home are older people, some of whom were living with a dementia or physical disabilities.

There is a registered manager in post. 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.

People were not always protected from risks at the home as some risk assessments had not been completed. These related to supporting people with behaviours that presented challenges to the home or could put the person themselves at risk.

People were not protected from the risks of cross-infection. The laundry area was cluttered and cleaning equipment was not being stored correctly. An audit of the infection control practices at the home had not been carried for nearly a year, and had not been reviewed following the recent outbreak of an infectious illness.

Summary of findings

The amount that people ate and drank was not sufficiently well monitored to ensure they received the food and fluids they needed. Food and fluid balance charts had not always been completed and totals were not being balanced for a 24 hour period. There was no system in place to review the levels of fluid people were taking in over several days or what actions needed to be taken if people were not taking in sufficient fluids to maintain their health.

The systems for managing medicines were safe. People received the correct medicines at the correct time.

There were clear systems in place for managing safeguarding concerns. Staff understood what constituted abuse and what actions they needed to take to raise concerns. There were robust systems in place for recruiting suitable staff. Sufficient staff were on duty to meet people's needs. Staff received the training and support they needed to carry out their role.

People's rights were protected and staff understood the Mental Capacity Act 2005 and about capacity and consent to care. People had access to community healthcare services, such as community nurses and GPs.

Although the premises were not ideal to support people with dementia, work was underway to develop the premises in line with good practice in dementia care.

Staff had developed good and trusting relationships with people living at the home. They engaged appropriately with people and anticipated people's needs, giving information in ways that people could understand. People's privacy and dignity were respected.

People's needs were assessed prior to their admission and care plans identified how to support people with their care needs. Plans were reviewed regularly, and included information on people's interests and life histories. Activities were provided to help meet people's interests, and there was visiting entertainment provided. The home had an activities organiser five days a week.

Complaints and concerns were managed well, with clear systems and policies in place.

People spoke highly of the registered manager. Changes were being made by her to the ethos and philosophy of the home to reflect best practice in dementia care. Staff, people living at the home and relatives was all being involved in the developments.

People were consulted about the operation of the home and how improvements could be made. Quality assurance systems were in place and learning took place from incidents to improve safety and quality.

Records were well maintained and kept up to date. Improvements were being made to the records to make them more personalised and reflective of people's experience of care.

We found a number of breaches of regulations and you can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 home was not always safe.

People were not protected or risks reduced as risk assessments had not always been completed.

People were not protected from the risks of cross-infection. The laundry area was cluttered and cleaning equipment was not being stored correctly.

The systems for managing medicines were safe.

There were robust systems in place for managing safeguarding concerns and recruiting suitable staff. Sufficient staff were on duty to meet people's needs.

Is the service effective?

Requires improvement

The home was not always effective.

People did not always receive clear monitoring to ensure they received the food and fluids they needed.

Staff received the training and support they needed to carry out their role.

People's rights were protected and staff understood the Mental Capacity Act 2005 and about capacity and consent to care.

People had access to community services to meet their healthcare needs.

Although the premises were not ideal to support people with dementia, work was underway to develop the premises in line with good practice in dementia care.

Is the service caring?

Good

The home was caring.

Staff had developed good and trusting relationships with people living at the home.

People's privacy was respected and staff understood and anticipated people's needs well.

Is the service responsive?

Good

The home was responsive.

People's needs were assessed prior to their admission and care plans identified how to support people with their care needs. Plans were reviewed regularly.

Information was gathered on people's interests and life histories and activities were provided to help meet these.

Summary of findings

Complaints and concerns were managed well, with clear systems and policies in place.

Is the service well-led?

Good

The home was well led.

People spoke highly of the registered manager. Changes were being made to the ethos and philosophy of the home to reflect best practice in dementia care.

People were consulted about the operation of the home and how improvements could be made. Quality assurance systems were in place and learning took place from incidents to improve safety and quality.

Records were well maintained and kept up to date. Improvements were being made where identified and in line with best practice.

Cornerways

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 carried out by an adult social care 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. On this day the expert by experience had experience of supporting people with dementia.

On the inspection we spoke with or spent time with 16 of the 42 people who lived at the home, six visitors and eight members of staff. Some of the people who lived at the home were not able to share their experiences in depth with us verbally as they were living with dementia. We spent time during the inspection carrying out a SOFI observation. SOFI is a specific way of observing care to help us understand the experience of people who could not communicate verbally with us. We also observed people enjoying a meal and being given medication. We spoke with staff about their role and the people they were supporting. We contacted the local commissioning and quality team prior to the inspection to gather their views about the service and also spoke with a community psychiatric nurse from the older person's mental health team.

We looked at the care plans, records and daily notes for six people with a range of needs. We looked at other policies and procedures in relation to the operation of the home

Requires improvement

Is the service safe?

Our findings

The service was not always safe. We identified concerns over the assessment of risks and the management of infection control risks.

People were not always protected from risks. For example, one person presented behaviours that could be challenging, and had been involved in an incident in the days prior to the inspection. Their risk assessment had not been updated as a result of the incident, and there was not detailed guidance available for staff on how to manage the individual's behaviour. A referral had been made to the local Older Person's Mental health Team who visited the person during the inspection. They were satisfied that the home's staff were managing the situation well. However failure to assess the risks or provide detailed guidance for staff meant risks might not be mitigated or the person may not receive consistent care and support should the situation re-occur.

Another person presented significant risks with regard to their leaving the building in an unsafe way. There had been an incident where this risk had been demonstrated in practice. No risk assessment was in place to manage this risk in the person's care plan, and an assessment had not been undertaken of the premises to review risks from the environment in relation to this risk, in particular with regard to the security of windows and doors.

This was a breach of regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks to people's health and well-being had been assessed. People's files contained copies of assessments in relation to swallowing, nutritional status, pressure area care, mobility and falls. Risks from falls were monitored and action taken to reduce risks where possible. For example, one person had fallen three times in two days. The person's risk assessment for falls and their moving and handling plan had been reviewed and updated. The falls were included on the home's accident trend analysis system to see if there were factors that could mitigate the risks, and appropriate referrals had been made to the GP to identify if there was any physical cause for their falls.

Risks of abuse to people were minimised because staff had received and understood training in recognising and reporting abuse. Staff we spoke with were clear about what to do to keep people safe and about how to raise any concerns. The home had clear policies and procedures in relation to safeguarding people and protecting their rights, and information was available on the notice board for reference. Where concerns had been highlighted the registered manager had taken swift action to protect people. The registered manager had attended an advanced course on safeguarding, and was confident about the procedures to follow in case of concerns.

People were supported by sufficient numbers of staff on duty. Staff we spoke with on both day and night shifts told us that they had enough time to support people in the way they wanted. People who lived at the home or their relatives told us that overall they felt they received the support they needed, although at times staffing could be challenged by people falling ill or needing additional support. One person told us "There are enough staff – one friendly face is always welcome – and they seem to keep cheerful despite the hard work they do". Some relatives who felt that staffing was not always enough told us "Staff are pushed to the limit sometimes – spread very thinly" and another person told us that "If all the staff are upstairs helping people to get up or go to bed then there is no-one in the lounge if something happens there". The registered manager told us she had undertaken an assessment of staffing needs and was recruiting for additional staff to ensure that people's needs could be met consistently when numbers of people living at the home increased.

People were protected because the home followed a full recruitment procedure for new staff. Staff files for four people showed that a full process had been followed, including application and interview forms, references and disclosure and barring service checks. Systems were in place to address poor performance in staff.

People were protected against the risks associated with medicines. Staff understood how the systems for the safe administration, storage and recording of medicines worked and had received appropriate training and assessments of their competency. They could show us where they would get information about medicines in use. People we spoke with told us they received their medicines on time. Where the use of medicines required regular health monitoring there were effective systems in place to ensure, for example that regular blood tests were carried out. Where errors had been identified action plans were put in place to prevent a re-occurrence.

Requires improvement

Is the service safe?

People received their medicines at the correct time. We saw that medicines to be given outside of a medicine round, for example medicines to be given an hour before food or for people with individual medicine regimes were given at the correct time. Administration instructions and protocols were in place to ensure that staff understood how medicines on an "as required" basis were to be used. Medicines were stored in a locked clinical room, with a lockable medicine refrigerator in the office. The temperatures of this refrigerator had been recorded, but not every day.

People were given their medicines with an explanation of what they were being given and time to absorb the information and take the medicine. Where people repeatedly refused medicines staff told us they would be referred to the GP for advice.

People were protected because there was information available for staff as to what to do in emergencies in a "What if" pack in the office. This covered information such as contact numbers for plumbers and lift maintenance people. The home had first aid kits and evacuation equipment available in case of fire. Evacuation points were clearly marked and staff had received training in evacuation procedures in an emergency.

People were not protected against the risks of cross infection. The laundry was cluttered with non laundry related items and could not be kept clean. There was no separation between clean and dirty linens, although potentially contaminated laundry could be taken straight to the machine in dispersible bags. Mop heads had been left in liquid in mop buckets so had not been cleaned or allowed to dry out following use. The home had a recent outbreak of an infectious illness, which had spread amongst the group of people living and working at the home. The home's infection control audit had last been completed in June 2014, so had not been reviewed since the outbreak. We saw staff wore aprons and gloves when supporting people with personal care. People told us they were happy with the cleanliness of the home. **We recommend the registered person seeks advice and guidance from a reputable person on improving the infection control practices at the home.**

Requires improvement

Is the service effective?

Our findings

The home was not always effective.

The amount that people ate and drank was not sufficiently well monitored to ensure they had received the food and fluids they needed. Risk assessments highlighted people at highest risk of poor nutrition and hydration. However fluid balance charts and food charts were not completed in sufficient detail to ensure that people received the fluid and nutrition they needed. For example, one person was identified in their care plan as needing their dietary intake recorded. They were not deemed to be at significant risk as their weight was stable, but their care plan indicated that they had a small appetite and they had a long term health condition which meant that fluid balance would be important to their health and well-being. Their food and fluid charts showed long periods of time where there was no recording over a 24 hour period. On other occasions the person had refused food or fluids, and this had been marked on their chart. On one day it was recorded that the person had only taken in 130 mls of fluid. However there was no way to identify if this was a failure of recording or the person had only taken in that amount of fluid. There was no system for totalling the charts over a 24 hour period, and for this person there was no record in their care notes that they had taken in so little fluid. There was no indication for staff about what the desired fluid total was for this person over a 24 hour period and no instructions for staff as to what actions to take if the person consistently failed to drink. Failure to complete the charts had previously been raised by the manager as an issue with staff in a staff meeting in December 2014.

This was a breach of Regulation14 (4) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed people over a mealtime and saw people being supported to eat by staff in a relaxed and comfortable manner. Meals including soft diets were presented well, and people were able to exercise choice over what they ate. The main meal on offer on the day of the inspection was roast pork, stuffing, roast potatoes, cabbage, swede or a leek, cheese and potato bake. Dessert was fresh fruit salad, rice pudding with jam or crème caramel. People told us they enjoyed their meals, and people who wanted them had 'seconds'. Drinks were offered throughout the day of the inspection and people enjoyed ice-creams in the afternoon. A relative told us they visited the home to see their relation every day and were very impressed with the food.

People received care and support from staff who had the skills and knowledge to meet their needs. Staff files demonstrated the induction training staff received when starting at the home. The registered manager was aware of the new care certificate for induction of care staff; staff that had commenced work prior to this being in place had completed an older induction programme which could be seen in their files. Staff worked alongside more senior staff until their competence was confirmed, and they felt confident to carry out the role. The registered manager told us "It doesn't matter how long this takes – we want our staff to be confident in supporting people and have the right skills". Where agency staff were used the registered manager confirmed that the agency supplied a profile of the staff member and confirmed that they had undertaken training in moving and positioning people and safeguarding.

Staff told us they felt the home supported them to gain the knowledge and skills they needed. One staff member told us about how they had been trained to help people with their eating. Another person who had started working at the home on the day of the inspection was working alongside another member of staff. They confirmed to us they had an induction programme they were working through and a job description so that they were clear about the role they were to fulfil. Staff received regular supervision and appraisal, some of which included observed practice to ensure on-going competence with their work. Bespoke training was undertaken when related to individual people, for example training in care of colostomies.

Staff communicated well with people. Staff could tell us in detail how people communicated their wishes in relation to care, where this could not be discussed verbally. For example one staff member showed us physically how the person would push them away if they did not want care delivered at that time. Staff told us they would try to persuade the person and then leave them alone, returning later to see if they had changed their mind.

People's rights were protected because staff had a clear understanding of the Mental Capacity Act 2005 (MCA). This is legislation that helps ensure that people who do not

Requires improvement

Is the service effective?

have the mental capacity to make decisions for themselves have their legal rights protected. Staff had received training in the principles and application of the MCA. Some people who lived in the home were able to make day to day decisions about what care or treatment they received. People were asked for their consent before staff assisted them with any tasks. This was also kept under review. For example one person had been assessed as being unable to consent to their medication, which was considered essential for their health. A best interest's decision had been made with the GP, family members and the home in relation to administering the medication covertly. However staff we spoke with confirmed that on the day of the inspection they had asked the person if they wanted their medication and they had agreed to take it. This told us that staff still persevered to give people choice.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Applications had been made for deprivation of liberty safeguards authorisations where people were considered to be deprived of their liberty.

People told us and we saw from their files that they had access to healthcare services in the community. This included dentists, podiatrists, speech and language therapists, psychiatric nurses and GPs. On the day of the inspection one person was being assessed for a new chair by an occupational therapist and another person saw a community psychiatric nurse. Contact had also been made with a GP. People's care files showed evidence of specialist hospital appointments, and district nurses visited the home to take blood and support the home with pressure area care.

Cornerways is a large home over three floors, with a number of staircases and mezzanine floors. There are two large ground floor lounges and a dining room. The home is not ideally constructed to provide care for people with dementia. The provider and manager had recently attended a number of courses in relation to best practice in dementia care and were keen to make adaptations to provide a more suitable and comfortable environment for people. This included orientation aids such as signs and pictures and the use of colour to identify particular areas, such as toilets. Some of this work had already commenced. Some parts of the building were looking tired and in need of redecoration to chipped paintwork or carpets. Work had been undertaken to provide a small secure seaside themed garden to the front of the home with seating which was being very much enjoyed on the day of the inspection.

Good

Is the service caring?

Our findings

The home was caring.

People told us they were supported by kind and caring staff. They said “The staff treat me very well”, “Great caring staff – nice crowd”, “We visitors are always welcomed here. The staff are a good team” and “The manager is one of the best. There are never any problems with the staff. I am very pleased with everything here. It suits me down to the ground”.

Staff knew people well. A staff member told us what they knew about a person’s life before they had moved into the home as well as about their current care needs. They understood the impact that the person’s life history had upon the individual and their behaviour. They told us “I enjoy it here. Everyone gets on well and staff are caring people. The residents are really nice.” The registered manager gave us an example about how a traumatic event in one person’s life had led to them exhibiting a behaviour that presented risks, and the way that the home had worked with the person and their family to help keep the person safe.

People’s privacy was respected and all personal care was provided in private. Staff supported people in public areas in a discreet manner, respecting their dignity and at the person’s own pace. We heard people being offered choices in ways they could understand with simplified information on which to make a decision. Communication was clear and supportive where needed. For example we saw one person who was living with dementia became distressed as they wanted to see a relation, and were insisting staff contact them as they were worried about them. Staff gently distracted the person into another activity. When the person returned to the topic of their relation we saw staff repeatedly and patiently kept distracting the person until they were otherwise engaged and became less distressed.

Where we saw people being offered care and support this was done sensitively and with care. Staff moved people using equipment in ways that supported the individual’s dignity. We saw staff spoke with the person throughout the procedure to help re-assure and support them. Staff joined in activities with people and were proactive in anticipating care needs, such as identifying people’s behaviours as indicating they needed to go to the toilet or were hungry. There was appropriate use of touch to comfort and engage with people.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. Staff knocked on people’s doors before entering. When we heard staff discussing people needs either in the handover or during the day the discussions were respectful and compassionate. Written records were respectful and used appropriate language.

People were offered ways to express their views about their care. Each person had their care needs reviewed on a regular basis which enabled them to make comments on the care they received. There were also residents meetings where changes could be discussed.

Good

Is the service responsive?

Our findings

The home was responsive.

People who lived at the home all had a care plan based on an assessment of their needs. Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. People and their relatives were able to contribute to the assessment and care plan as much as they wished. Some families had completed information about people's life history prior to people coming in to the home which gave staff invaluable information about people's lifestyle choices, and we saw this in people's files. Three visitors told us they had been involved in discussions about care planning, and three visitors we spoke with told us they could not remember having done so. Only one person who lived at the home that we spoke with could remember being involved in developing their care plan or in reviewing it. People did not have a copy of their own plan.

People's care plans covered their physical and psychological needs, including the support people needed with dressing, personal hygiene, social care and mobility. They included instructions to staff about how people wanted their care to be delivered where this was known and included information on retaining people's skills and independence. For example one care plan we saw stated that the person needed assistance from a carer when dressing for their "socks and bra" only, and that they could manage other areas independently with some monitoring. A staff member we spoke with told us about a person they had got up that morning. They told us the person could wash their own face and front of their body which they had encouraged as it "was important people do what they still can, to remain independent".

The registered manager told us she was working on developing the care plans to make them more individualised, and better reflective of the individual person. We saw a newer care plan that was being implemented, which contained more information about the individual and their experience of life, their care needs and how their care should be provided.

Care plans and assessments were being reviewed regularly. We found that staff understood people's needs. For example, we discussed one person who had a medical condition with a staff member. They understood the person's condition and what signs they might see that would indicate the person was becoming unwell. This information was also on display in the medicines cupboard and prominently in their care plan.

People were able to take part in activities, and the home had an activities provider at the home five days a week. They provided a variety of both group and individual activities of people's choice, ranging from keep fit and quizzes to reminiscence and craft sessions. Visiting entertainers also come to the home, and the home had fund raising events for local charities. On the day of the inspection people took part in a skittles game in the morning and an individual tasting session in the afternoon. People were given copies of the activities programme, and one person had taken up knitting again since being at the home.

The complaints procedure was given to people and their relatives at the point of admission and was on display in the home. Complaints were acted upon promptly and a response sent to the person with an apology or an indication of actions to be taken to prevent a re-occurrence. People we spoke with told us they would feel free to raise any concerns with the management or would tell their families if they were unhappy about anything. One person we spoke with told us that they had raised a complaint and had been satisfied with the response.

Good

Is the service well-led?

Our findings

The home was well led.

People knew the registered manager and could identify her even if they could not remember her name. The registered manager of the home had been in post for nearly 12 months, and told us that they had been on a "steep learning curve" since their appointment, but now they felt things were moving in the direction they wanted. People expressed confidence in her. They said "She is one of the best", "The manager is a lovely person and a real 'hands on' person who will work an extra shift if staff fail to turn up", "She is good to everyone" and "The manager is always around and available". Staff told us she was accessible and supportive.

Staff teams were well organised and had individual allocated duties for the shift along with a group of people whose care they were responsible for. Staff handovers were comprehensive and included a review of the days work to ensure that things did not get missed. For example in the morning handover we saw that the previous day a GP had requested a urine sample be obtained from one of the people at the home. Staff were delegated to ensure the sample was taken and sent off.

The manager had begun training in dementia care management and best practice and was starting to share the ethos and philosophy she was learning with her staff and people who lived at the home. The registered manager told us for example that when selecting new staff they were focussing on how well potential new staff related to and were empathetic with people who were living with dementia rather than just on their skills and past experiences. A recent staff meeting had been held to focus on culture change. Staff were being consulted on a proposal to stop staff wearing uniforms in order to make the home feel more homely. Discussions were being held with people who lived at the home about alterations to the accommodation, for example choice of colours and floorings. Support was planned to help relatives and visitors understand the changes in ethos and practice the home was planning to implement. The home had joined a local initiative in developing good dementia care in care homes and the manager attended regular meetings.

People benefitted from good standards of care because the service monitored the quality of the care delivered through quality assurance systems. A programme of audits and checks were in place to monitor safety, falls, risks and quality of care issues. The provider organisation had a calendar for these audits to be completed by, and some of these were due. The manager agreed to discuss the schedule with the provider as some audits were only being carried out on an annual basis.

Questionnaires were sent to relatives, visiting professionals and people who lived at the home to formally gather their views about the home and any improvements people felt would be of benefit. This was last done in November 2014. Following the return of the questionnaires the results were analysed and an action plan drawn up. The action plan showed that suggestions made in previous questionnaires had been acted upon.

Records that we saw were well maintained and up to date overall. Concerns were identified over the risk assessments and fluid balance charts that were not completed fully. New care plans were being implemented that would better reflect people's experience of care. Policies and procedures were being updated to reflect new legislation. Care plans were available to staff in the home's office, which was locked when staff were not in it. Confidential information such as fees and funding arrangements was not kept in these files.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used services and others were not protected against risks as the provider had not done all that was reasonable practicable to mitigate risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Clear and effective systems were not in place to ensure people received the food and fluids they needed.