Cornford House Limited

Cornford House

Inspection report

Cornford Lane
Pembury
Tunbridge Wells
Kent
TN2 4QS

Tel: 01892820100
Website: www.cornfordhouse.co.uk

Date of inspection visit:
13 July 2017
14 July 2017

Date of publication:
14 September 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on 13 and 14 July 2017 and was unannounced.

Cornford House is a purpose-built modern building that provides accommodation and nursing and personal care for up to 70 people, in a range of studio or one bedroom suites, all with en-suite shower rooms. People living in Cornford House are either owner occupiers or tenants. Nursing and personal care is provided by staff on site although people are able to choose another care provider if they wish, although no one received care from another provider at the time of our inspection. If people choose to have their care provided by Cornford House Limited, they will have two agreements with the provider, one for their tenancy and a separate one for their care. At the time of our inspection, there were 70 tenants living in the service. The service provides nursing care on the lower ground floor, ground floor, first floor and the second floor. The second floor supports people living with dementia or mental health needs, some of whom also require nursing care.

At our last inspection on 12 December 2016 we found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in regard to staffing levels, individual risk and mental capacity assessments, protocols relating to some medicines administration, internal systems to prevent harm or abuse, people's dining experience, social isolation, continence needs and effectiveness of the monitoring systems.

The registered provider sent us an action plan detailing the improvements they would make and confirmed they would be meeting the requirements of the regulations by June 2017. They kept us informed of their progress.

This inspection was carried out to follow up on compliance with these notices. At this inspection we found that the registered provider had met the requirements detailed in the warning and requirement notices and had made improvements to the culture of the service and the care people received. A new management team had been introduced to implement and monitor improvements in the service. However, new monitoring systems that had been introduced need to be embedded and improvements need to be sustained over time.

There was a new general manager in post since 27 March 2017, whose application to the Care Quality Commission for registration was in progress at the time of our inspection. Their registration was confirmed shortly after our visit. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to

reduce identified risks and guidance for staff to follow or make sure people were protected from harm.

Accidents and incidents were appropriately recorded and monitored to identify how the risks of recurrence could be reduced.

There was a sufficient number of staff deployed to consistently meet people's needs and respond to call bells in a timely manner. Staffing levels had been increased and calculated taking into account people's specific needs and dependency levels. These improvements needed to be sustained over time to ensure people remained safe in the service. Thorough recruitment procedures were in place which ensured staff were suitable to work in the service.

Medicines were stored, administered, recorded and disposed of safely. Staff were trained in the safe administration of medicines and kept relevant records that were accurate. A new system of medicines management had been introduced that was effective and that minimised risks of errors.

Staff knew each person well and understood how to meet their support and communication needs. Staff communicated effectively with people and treated them with kindness and respect.

Staff had received essential training to enable them to meet people's needs, and were scheduled for refresher courses. All members of staff received regular one to one supervision sessions. Staff reported feeling well supported in their roles by the new management team.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff sought and obtained people's consent before they helped them. People's mental capacity was assessed when necessary about particular decisions; meetings with appropriate parties were held and recorded to make decisions in people's best interest, as per the requirements of the Mental Capacity Act 2005.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options had been considered.

The staff provided meals that were in sufficient quantity and met people's needs and choices. People told us the quality of meals had improved and that they enjoyed the food provided. Staff knew about and provided for people's dietary preferences and restrictions.

People's individual assessments and care plans were reviewed monthly or when their needs changed. Clear information about the service, the facilities, and how to complain was provided to people and visitors. Complaints were appropriately addressed.

People were promptly referred to health care professionals when needed. Their recommendations were acted on. Personal records included people's individual plans of care, life history, likes and dislikes and preferred activities.

People were involved in the planning of activities that responded to their individual needs. People and their relatives' feedback was sought at dedicated meetings, and through satisfaction surveys.

Staff told us they felt valued by the new registered manager; that they had confidence in their leadership and in the new management team. The registered manager was open and transparent in their approach

and led by example. They had driven a significant amount of improvements in the service and placed emphasis on continuous enhancement of people's experience in the service.

There was a system of monitoring checks and audits to identify the improvements that needed to be made. The registered manager, the assistant manager, and the lead registered nurse acted on the results of these checks to improve the quality of the service and care. Although many improvements had been implemented, the new management team had only been a place since March 2017. Improvements need to be firmly embedded in the service and sustained to ensure standards of quality and safety are maintained. We have recommended that the registered provider and registered manager continue to closely monitor the service to ensure the improved standards of governance are sustained.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe although new monitoring systems that had been introduced needed to be embedded and improvements sustained over time.

There was a sufficient number of staff deployed to ensure that people's needs were consistently met to keep them safe.

Medicines were administered, stored and disposed of safely.

Staff were trained to protect people from abuse and knew the action to take if they had any concerns.

Risk assessments were centred on individual needs and there were effective measures in place to reduce risks to people.

Safe recruitment procedures were followed in practice.

Is the service effective?

Good

The service was effective.

Staff received appropriate essential training and additional specific training to enable them to carry out their role effectively

Staff had a good knowledge of each person's plan of care and of how to meet their specific support needs.

A system ensured people were supported to make decisions and were asked to consent to their care and treatment. Where people were unable to make their own decisions, the principles of the Mental capacity Act were followed to protect their rights.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink.

People were referred to healthcare professionals promptly when needed. Their recommendations were implemented in practice.

Is the service caring?

Good

The service remained: Good.

The staff approach was caring and compassionate. They communicated effectively with people and treated them with respect and kindness.

Staff promoted people's independence and respected their dignity and privacy. Staff were mindful of people's need for companionship and spent time with people.

People and visitors were provided with clear information about the service.

Is the service responsive?

Good

The service was responsive to people's individual needs.

People, and their families when appropriate, were involved with the planning and review of their care.

The delivery of care was in line with people's care plans and risk assessments.

People's care was personalised to reflect their wishes and what was important to them. Care plans were in the process of being updated to become more person centred.

There was a daily activities programme that was inclusive, flexible and suitable for people who lived with dementia.

Is the service well-led?

Requires Improvement

The service was well-led.

The new registered manager promoted a culture that was person-centred and placed people at the heart of the service.

People, staff and relatives welcomed the registered manager's approach, and told us they appreciated her style of leadership and support. Their comments were very positive.

There was an appropriate system in place for the monitoring and management of accidents and incidents.

Emphasis was placed on continuous improvement of the service. A significant amount of improvements had been made to ensure compliance with regulations and enhance people's experiences of the service. However these improvements need to be

embedded and sustained over time.

Cornford House

Detailed findings

Background to this inspection

This inspection was carried out on 13 and 14 July 2017 and was unannounced. The inspection team consisted of two inspectors, an advanced nurse practitioner and one expert by experience.

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 carried out to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to check whether their action plan had been effectively implemented, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The registered manager had completed a Provider Information Return (PIR) in May 2017. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. Before the inspection we looked at the PIR, reviewed our previous inspection reports and the provider's action plan. We noted the records that were sent to us by the registered provider and the local authority to inform us of significant changes and events.

We looked at ten people's sets of records which included those related to care and medicines. This included assessments of needs, risks, mental capacity and records of the care given. We path-tracked six care plans to check that people's care and treatment was delivered consistently with these records. We reviewed documentation that related to staff management and four staff recruitment files. We made observations of staffing levels, staff practice, and staff interaction with people, the premises and equipment. We checked how medicines were administered, recorded and monitored. We looked at records concerning the monitoring, safety and quality of the service, the menus, the activities programme and policies and procedures. We also looked at staff rotas, the dependency tool used by the service, and the call bell response monitoring system.

We spoke with 16 people who lived in the service, 10 of their relatives and five visitors to gather their feedback. We spoke with the provider, the registered manager, the group quality coordinator (responsible for quality assurance), the assistant manager (who is also the deputy manager), the lead registered nurse (who is the clinical lead), two nurses, six care workers, and three social assistants who provided activities in the home. We also spoke with housekeeping, catering, maintenance and administration staff. We contacted

the local GP surgery and three local authority case managers who oversaw people's wellbeing in the service, to gather their impressions of the service.

At our last inspection on 12 December 2016 we found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and rated the service 'Inadequate' overall, with the key questions 'Is the service safe?' and 'Is the service well-led?' rated as inadequate. The service was placed into Special Measures.

Requires Improvement

Is the service safe?

Our findings

People told us, "Everyone is very helpful, I cannot think of anyone who would do any of us any harm", "I feel safe, even when I leave my room door open", "It feels very safe here" and, "I trust the staff; I have been able to bring some of my personal belongings; nothing has been touched." Relatives told us, "It feels safe and secure here; It has taken a lot of worry off me and my brother's minds to know a nurse is always on call" and, "There seems to be a lot more staff around and available, which is very reassuring."

At our inspection in December 2016 we found that the registered provider was in breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. This was because the registered provider had not taken appropriate action in regard to the deployment and visibility of staff and their response to call bells. At this inspection we found that action had been taken and that the required improvements had been made. However, these improvements had been implemented by a new management team who had been in place since March 2017 and needed to be sustained over time.

At he time of this inspection, there were sufficient care staff and nursing staff on duty to meet people's needs. The general manager had implemented changes about staffing levels, staff allocation and about how each floor was managed, to ensure staff visibility was improved and more one to one time was provided for people who may be at risk of isolation. The general manager and lead nurse carried out assessments of people's dependency levels to ensure that there were sufficient staff deployed to meet individual needs. As a result of these assessments, staffing levels had been increased and call bells were responded to quickly. Two people told us, "I always see staff walking up and down the corridor. They always say hello and stick their head in and ask how I am" and, "I always see staff about; lots of staff changes, for the better." The deputy manager told us how some agency staff had been used until permanent staff could be successfully recruited. Staff rota for the week of our inspection showed that no agency staff had needed to be used and the registered manager told us, "Our expectation is to continue with no agency use." Additional care staff were deployed when necessary, for example escorting a person to a medical appointment. These improvements needed to be sustained, monitored and evaluated to demonstrate that outcomes for people have improved over time and become embedded.

Domestic staff were deployed to ensure two cleaners were in situ on the ground floor and one each to other floors. The service was very clean throughout the premises, pleasantly fragrant and welcoming. The registered manager told us that they were awaiting quotes for the replacement of carpets and furniture that could not be cleaned properly due to their fabric. A relative told us, "The place is always that spotless." The laundry was staffed by two laundry assistants daily. One person told us, "I get all my clothes neatly cleaned and returned to me the same day."

At our inspection in December 2016 we found that the registered provider was in breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. This was because the risk of people being unable to use the call bell system had not been assessed and mitigated; pain management records, protocols for 'as required' medicines and assessments for people who self-medicated were not in place; regular checks of emergency equipment such as suctioning machine were not carried out. At this

inspection we found that action had been taken and that the required improvements had been made.

The registered manager had ensured that each person living in the service had been assessed in regard to their ability to operate the call bell system. When people were not able to us the system, staff carried out regular checks on their wellbeing that were documented. The registered manager told us how the increase in staffing had positively impacted on response times, especially with having a staff team based solely on the lower ground floor. The registered manager had included an audit of response times to call bells in her monthly monitoring programme. The rate of calls answered within five minutes had increased from 93% to 97% over a month. Recorded instances of non-compliance had been investigated.

Pain management records that were person-centred were incorporated in people's medicine records and end of life care plans, including protocols that described how staff could identify individual signs of discomfort or distress. One person was self-medicating at the time of our inspection, taking medicines 'as required (PRN). Appropriate and relevant assessments to ensure this was safely managed were in place. Protocols were in place for each resident on PRN medication, indicating what the medicine was for, how much and how often it could be given and the reason it had been administered. The application of topical creams was appropriately recorded.

A new improved system to help staff manage medicines had been introduced in September 2016, and the medicines policy had been updated in December 2016. Controlled drugs were kept securely and were subject to nightly checks by two nurses, or 1 nurse and the duty manager. They were destroyed appropriately in line with legal requirements. The service used a new system that audited medicines administration records (MARs) daily. It informed staff when medicine stocks were low and ordered these electronically to the GP, who re-authorised the prescriptions and forwarded the requests to the local pharmacy. If a new urgent prescription was issued, such as antibiotics, this was collected from the nearest pharmacy and entered manually into the system.

When stocks were delivered, these were entered automatically onto the system by scanning and were automatically input under each person's individual medicines records. This ensured staff were made aware of any changes in medicines. Medicines were scanned during administration and if an incorrect drug was selected an alarm was triggered, ensuring that only the correct drugs could be given. A nurse told us, "This system is fabulous, no room for errors." Since this new system has been introduced, the medicines audit confirmed there had been no errors concerning medicines.

Four care workers had been trained to administer medicines and the clinical lead carried out comprehensive checks of their competency every six months. The care workers wore red tabards whilst administering medicines to ensure they were not interrupted and fully focussed on their task. Staff took time to talk with people and explain what medicines were for when appropriate.

There were appropriate systems in place for the checking, servicing and maintenance of equipment. An annual health and safety assessment of the premises had been carried out in May 2017. There were external, in-date risk assessments for fire, health and safety and legionella which was regularly checked. An annual service register which was kept as a live document showed when all equipment and facilities were last serviced and were next due for servicing. This showed that most safety checks and routine maintenance were carried out promptly. However, there were no records indicating that portable appliances had been checked as being safe to use. We raised this to the attention of the registered manager who took action to address this. Following our inspection, the registered manager provided evidence to show that the checking of each portable appliance in the service was underway and that checks had been included in health and safety audits to ensure completion.

The person responsible for the maintenance of the premises had been in post since March 2017 and worked through a programme of improvements in the service. They were installing new corridor lighting throughout the premises and this was almost completed, with an improved quality of lighting to help people move around safely.

At our inspection in December 2016 we found that the registered provider was in breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. This was because internal systems to prevent harm and / or abuse were not consistently robust; personal evacuations plans were not appropriately detailed to reflect people's needs. At this inspection we found that action had been taken and that the required improvements had been made.

The registered manager had ensured that staff had received enhanced face to face training in the safeguarding of adults, to promote a clearer understanding of how to keep people safe from harm or abuse, and of the processes to follow. Each member of staff we spoke with was able to identify different forms of abuse and understood the procedures for reporting any concerns. They told us they would not hesitate to report any suspected abuse or malpractice, and expressed confidence that any concerns would be addressed. There was a safeguarding policy in place that reflected local authority guidance and the whistleblowing procedure. The procedures included clear information about how to report any concerns and flowcharts were displayed in corridors and on the staff notice board. The registered manager had contacted the local authority and the Care Quality Commission appropriately when safeguarding concerns had arisen.

The registered manager had ensured that staff had received the training to respond to an emergency. Each person living in the service had a personal evacuation plan, available to staff and emergency services that showed the level of support that they required with their mobility in the event of an evacuation. The support addressed only people's mobility and we discussed this with the general manager who ensured the plans were updated with any relevant psychological or sensory needs that may also impact on their evacuation. The head of care showed us that this update had been carried out during our inspection. Staff had received fire training and knew what to do and where to locate and how to use vital information and equipment. The clinical lead had commenced a checking regime of newly acquired specialist equipment.

Precautions had been taken to ensure the premises were safe from fire hazards, including internal risk assessments and inspections by external consultants. Action had been taken promptly to address any issues identified. Fire drills were carried out regularly and a lead for fire safety oversaw fire training as part of the inductions. An appropriate business contingency plan addressed a range of possible emergencies.

Safe recruitment practices were used to ensure staff were suitable to work with people. Appropriate checks had been carried out to ensure that staff recruited to work in the service were suitable and of fit character. Checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable to work there. Staff members had provided proof of their identity and the right to work and reside in the United Kingdom prior to starting to work at the service. References had been checked before staff were appointed and where possible references had been taken up with previous employers. Gaps in staff employment history were explained and appropriately documented.

Individual risk assessments were centred on the needs of the individual. There were specific risk assessments in place for people who were at risk of falls, who were unable to activate their call bells, for a person who had difficulties waking up in the mornings, and for other people who may be at risk of malnutrition or skin damage. Each risk assessment included clear precautionary measures instructing staff

about how to keep people as safe as possible, taking in account people's individual circumstances and preferences. For example, one person had a bacterial infection that can be resistant to treatment with common antibiotics and a specific comprehensive risk assessment instructed staff about how to reduce risks of contamination. Air mattresses settings were checked daily and adjusted correctly according to people's weight. Staff were aware of the risks and control measures that related to each person.

Good

Is the service effective?

Our findings

People said staff cared for them effectively. They told us, "I had a chest infection and they called the doctor who came that afternoon, I got treatment straight away", " I am monitored very well here, blood pressure and temperature regularly checked" and, "The home will always arrange for an escort to come with me to the hospital or to the doctor. They usually wait in the waiting room but I'm sure if I asked they would come in with me." A relative told us, "Mum fell over, the doctor was immediately called who sent the paramedics. We are happy with the speed of response."

At our inspection in December 2016 we found that the registered provider was in breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. This was because people were not offered alternative meals; their preferences were not consistently sought; specific nutrition needs were not consistently met. At this inspection we found that action had been taken and that the required improvements had been made.

People told us the quality of the food was improving. We observed lunch being served in the dining areas. Meals included options of two main dishes and two deserts, and alternatives were prepared and served for people who chose to digress from the menus. People told us they were offered alternatives at each meal, saying, "They know I don't like fish so they always ask what I would like instead" and, "There is plenty of choice." One of the options at lunchtime was meat-free to accommodate people who were vegetarian.

The lunch was freshly cooked, hot, well balanced and in sufficient amount. People were supported by staff with eating and drinking when they needed encouragement and there were enough staff to provide one to one support for people when they need it. People told us they were satisfied with the standards of meals. They told us, "Food has improved. The curry today was very tasty", "Very nice home-cooking" and, "The variety of food has improved." A person who attended the resident committee told us how they had represented other people's views and had discussed menu options with the chef. They said, "We suggested mushrooms on toast and crumpets and we have tried this on the menu, it went down well." The registered manager told us a new butcher had been sourced to improve the quality of meat provided. Two chefs had introduced more international dishes and reported that these were popular. The catering staff were aware of people's specific diets, allergies and dietary requirements which were displayed in the kitchen.

There were two sittings, with people having pureed meals eating first and at their own pace. A new chef who had started their post in May 2017 told us they were mindful of people's eating experience in the home and placed importance on food presentation. They told us, "If it doesn't look appealing the person will already not like it", stating that puree foods need to have colour and clear differentiation on the plate. However, we observed the pureed food was bland, grey in colour, and that no attention had been paid to its presentation. We discussed this with the registered manager who had identified the need to improve the appearance of pureed food and who had previously ordered moulds and coloured plates to make it more appealing. Following our inspection, the registered manager provided evidence that these were used in practice.

At our inspection in December 2016 we found that the registered provider was in breach of Regulation11 of

the Health and Social care Act 2008 (Regulated Activities) regulations 2014. This was because people's mental capacity had not been appropriately assessed regarding their ability to use call bells; to have bed rails in place; to be restrained by lap belts in their wheelchairs. At this inspection we found that action had been taken and that the required improvements had been made.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People's mental capacity regarding resuscitation, using their call bells, using bed rails while remaining in bed, using lap belts while in their wheelchair and wishing to come and live in the service had been carried out and appropriately documented. When people had been assessed as not having the relevant mental capacity, meetings had been held with appropriate parties to reach a decision in their best interest considering the least restrictive options. One person was receiving their medicine covertly. A relevant mental capacity assessment had been carried out followed by a meeting and discussions with their legal representative, the GP and the pharmacist to decide the best way forward. We observed staff seeking consent from people before they helped them move around, before they helped them with personal care and with eating. People's wishes and refusals were respected

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. The registered manager had considered the least restrictive options to keep these people safe. Staff had received training in the principles of the MCA and the DoLS and staff we spoke with understood the five main principles of the MCA and how these related to their role.

People were appropriately referred to health care professionals when they needed it, for example to a GP, or to a speech and language therapy team. Staff were aware of the healthcare professionals' recommendations, such as a implementing special diet and followed these in practice. The registered manager had referred each person on the lower floor to a physiotherapist requesting individual assessments of their mobility to establish if and how they could benefit from additional equipment. The service was visited regularly by a Parkinson's nurse, a chiropodist, an optician and a dental service.

New care staff underwent an in-house induction process with a requirement of completion. This entailed shadowing experienced staff until they could demonstrate their competence in care tasks before being put on the staff rota, for example promotion of personal hygiene, continence and self-care. New staff were provided with a comprehensive staff handbook, a health and safety book, and were required to undertake the provider's e-learning in customer care and practical training in moving and handling. All new staff studied towards the care certificate, which sets out the learning outcomes, competencies and standard of care that care homes are expected to uphold.

Staff were up to date with essential training such as first aid and moving and handling, and were scheduled for refresher courses. The deputy manager planned training availability into the rota, so staffing levels were not diminished due to staff attendance at training. Each member of staff was reminded of their training due with their payslips, in the rota and on staff notice board. Staff received additional specialist training aimed at meeting people's specific needs such as continence, end of life and dementia from the local hospice,

Parkinson's awareness from a specialist nurse, and posture awareness from a physiotherapist. The registered manager had undertaken a 'train the trainer' qualification so she could replace safeguarding training with face to face sessions. They told us, "Face to face is so much better, we aim to replace E-learning as much as possible." Nursing staff were trained in relevant health interventions. Care staff were supported to study and gain qualifications for a diploma at different levels in health and social care.

Staff told us they felt well supported by the management team. They told us, "We get a lot of support and encouragement, they appreciate what we do when we do it well and we get a lot of training here." Supervision for all care and nursing staff was planned every six to eight weeks and implemented. The supervision sessions included reviewing with staff what they had learned from their training and how they applied their knowledge into practice. The registered manager told us they had been holding off annual appraisals to allow time to get to know staff and embed changes in the home. Appraisals were due to start in September 2017. The registered manager selected a monthly topic to share with staff and invited them to answer related questions, through handovers and supervision sessions, such as promotion of dignity, meeting special needs of people who lived with Parkinson's , hydration needs of people with dementia, and assessments and minimisation of risks of falls. This ensured that staff were actively engaged to apply the knowledge they had acquired during their training in practice, and supported people in an effective way.

There was an effective system of communication between staff that ensured continuity of care. Staff handed over information about people's care to the staff on the next shift. Information about new admissions, accidents and incidents, referrals to healthcare professionals, people's outings and appointments, medicines reviews, people's changes in mood, behaviour and appetite was recorded appropriately.

Good

Is the service caring?

Our findings

The service was caring. People told us they were very satisfied with how the staff cared for them. They described the staff approach in positive terms such as, "caring; good; helpful" and, "very attentive". They said, "It is very nice here, the staff are ever so kind; it doesn't feel like an institution here, there is a nice relationship between us all", "I am really happy to be here, everyone is so kind" and, "I just love it here, the staff is lovely; I wake up in the morning and look forward to the day in front of me." Relatives told us, "[X] seems very happy here and has never had need to complain about anything to anyone" and, "The staff are very good at responding and are very patient." Relatives had commented, about their loved one's end of life care, "[X] was given dignity and the highest quality of care that we could have wished for her."

At our inspection in December 2016 we had made a recommendation about recording people's individual concerns or wishes regarding how they would prefer to be supported when they approached the end of their lives. At this inspection we found that action was being taken to address this but had not yet been fully implemented. End of life care plans followed a format in line with the End of Life Care Pathway, set out in the End of Life Care Strategy (Department of Health 2008), that comprised of six steps and was developed to help anyone providing health and social care to people nearing the end of life. The six steps addressed discussion, assessment, coordination of care, delivery of high care service, care in the last days of care and care after death. Some end of life care plans were still in process of being updated to render them more personalised and the registered manager showed us this was a work in progress. Discussions were being held with people and their legal representatives and as a result several care plans had been updated to reflect how people preferred to be cared for when they would approach the end of their lives. The registered manager told us, "This is a sensitive issue that needs to be approached at the right time and we are in the process of recording people's wishes and any decisions they may have taken in advance." The service was well supported by the local hospice that provided training, support and advice if needed. The registered manager had sent four members of staff to the local hospice to attend advance training in dignity, compassion, dementia and end of life care. They aimed to enlist all the staff as vacancies became available on the course, and told us, "Marvellous course. Everyone will be attending."

We spent time in the communal areas and observed how people and staff interacted. Staff had time to spend one to one time with people and support them. There was a homely feel to the service and there were frequent friendly and appropriately humorous interactions between staff and people. Staff treated people with kindness and addressed them respectfully by their preferred names. We observed laughter as well as gentle reassurance with appropriate body language, such as staff leading a person gently when they moved around. Staff anticipated people's needs and asked them what they would like to do next or where they would like to go, and provided the support that was required.

People's care files included clear instructions to staff about best to communicate with people. They included how people preferred to be named, whether they had hearing or visual impairment, or whether they experienced any anxieties that needed specific communication methods. For example, ne person was blind and their care plan included instructions for staff to follow, such as ensuring they introduced themselves gently when they entered the room and again to announce their departure so as not to startle

the person. We observed staff followed these instructions in practice. Staff ensured people had their call bells within reach. We observed how staff communicated with people when they used equipment to help them move from one place to another. The staff talked clearly to the person in a reassuring tone through each stage of the procedure, ensuring the person knew what they were going to do next. The provider had organised English language lessons for staff who came from abroad, to improve their communication with people who lived in the service and other staff.

Staff ensured people's dignity was respected. People were assisted discreetly with their personal care needs and closed doors when helping people with personal care. People told us staff were respectful, taking care to cover their body when necessary and respecting their pace and wishes. Relatives told us, "If mum has ' an accident' at night they change her straight away and remake the bed, no fuss." People were appropriately dressed, appearing comfortable and were well presented. Some ladies had their lipstick on, and gents were cleanly shaven when they had wished this. A relative said, "My dad is always well groomed, always looks clean; if any food gets spilled they make sure he is clean afterwards and without stains; they know it is important to him."

Staff were mindful of respecting people's privacy. They were attentive to people's needs and regularly checked on their wellbeing. People told us, "I close my door whenever I want to and the staff always knock and ask before entering, they check on me regularly anyway". Staff were careful to speak about people respectfully and maintained people's confidentiality by not speaking about people in front of others.

Cultural and religious requirements of each person were included in their individual care plan. Ministers from a Roman Catholic, a Church of England, two different Baptist churches and members of a Christian Missionary Society visited residents in the service on a weekly basis. A person visited the local Kingdom Hall of Jehovah's Witnesses, supported by their family.

People followed their preferred routine, for example some people chose to have a late breakfast, stay in bed or stay up late. One person liked to have their breakfast in bed before getting up and this was provided. Staff presented options to people so they could make informed decisions, such as what they would like to wear, to eat and to do, so that people could be in control of their day. Some people used the lift by themselves; others went in the gardens independently. A person told us, "I like to go for a walk every day." As staff encouraged people to do as much as possible for themselves, people's independence was supported.

Clear information about the service and its facilities was provided to people and their relatives. In the entrance, the complaints policy and procedures, the last CQC report, information about the duty of candour and minutes of the last relatives and residents meetings were displayed. There were informative boards that displayed activities programmes and forthcoming dates of events. A display showed photographs of residents seemingly enjoying taking part in a 'Rogues gallery'.

A 'Cornford House care suites residents' handbook explained clearly how Cornford House Limited was the landlord of Cornford House care suites and was the registered provider of care services to the suites. It explained what care suites were and gave information for prospective applicants in order to decide whether a care suite was the right choice for them. This handbook included explanations about how people were free to choose whichever care provider they wished, and how, should they choose to have their care provided by Cornford House Limited, they would have two standalone agreements, such as one for their tenancy and an entirely separate one for their care. The registered manager had ensured a brochure that had included outdated information was re-designed by an external company and updated appropriately, this was in progress at the time of our visit. The provider had maintained an informative up to date website that was easy to navigate and included a video presentation of the new registered manager and the sales

coordinator. It provided details of the services to include 'help with moving in' as well as nursing, medical, social and pastoral care. Visitors could download a wide range of documents including the provider's statement of purpose, the previous CQC report, the care suites brochure and the residents' handbook.

People were involved in their day to day care when they were able to and when they wished to be. People and when applicable their legal representatives were involved in decisions about their care and in agreeing their care plans. People's care plans were in the process of being updated to render them more personalised and staff had been provided with comprehensive guidance regarding how to update documentation relevant to care, risk, preferences and wishes. Care plans were forwarded to people and their families quarterly when they had consented to this. This provided an opportunity for any comments and suggestions to be added. A relative told us, "They reviewed all the information they had with my mum and I and we went into it in great detail, now everything is recorded and the staff are very much aware of what she likes; as a family we feel very involved and kept in the loop."

Good

Is the service responsive?

Our findings

People gave us positive feedback about how the service and the staff responded to their needs. They told us, "It is very flexible here; I could have a cooked breakfast if I wanted it", "The staff know me well; I prefer to get up early so I have my shower at 6am", "There is a lot more staff around than before, so if we need anything there are more people to come and help us" and, "At night you only have to ring the buzzer. Everyone's got a smile on their face." A social assistant told us, "I am able to see everyone on the floor I am in, to give one to one attention every day I'm on duty. It's a poor day if I haven't managed that."

At our inspection in December 2016 we found that the registered provider was in breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. This was because person centred care planning had not been consistently applied throughout the service; the risks of social isolation had not been consistently assessed and mitigated. At this inspection we found that action had been taken and that the required improvements were in progress.

People's needs had been assessed before they moved into the service to check whether the service could accommodate these needs. Care plans were documented and developed taking into account people's lifestyle preferences and expectations. The registered manager ensured that people's care plans were improved and personalised to reflect people's individuality and wishes. The registered manager told us, "This is a work in progress. We have commissioned external consultants who work with care and nursing staff to make our documentation more person-centred. It may take a little time but we want to do this right, our residents are the ones to decide about their care. We are in the process of sitting with each person and their family if they wish, and build their life stories and capture exactly not only what they need but also what they want, and what is important to them." Following our inspection, the registered confirmed that 100% of care plans personalisation had been attained. Eight dedicated staff had sat with people and families to obtained vital information about people's life history, background, significant memories, and had added this information in care plans for staff to consider when they delivered individual care and support.

The improved care plans reflected accurately the specific way people liked their care delivered, their preferred routine, food, and activities. For example, one person with a complex condition became breathless on frequent occasions. Their care plan explained how to encourage the person to practice their breathing exercises. Another person who had a contracture needed to have their fingers gently cleaned, dried and to be provided with a palm roll. Daily notes confirmed these actions were taken.

The registered manager had ensured that all care plans were appropriately completed and updated regularly to reflect people's change of needs. A person told us, "We had a meeting in my room, with my daughter, and the manager, and we went through all the paperwork and they checked whether I was still happy with everything or if anything needed to be changed." Updates were recorded in people's main care files as well as in summarised care plans. The care plan system was computerised and staff referred to the system and updated it throughout the day.

Steps had been taken to reduce people's isolation and the activities programme was being enhanced to

meet people's social needs. Five social assistants were assigned throughout the service five days a week. When people remained in their bedrooms, they were provided with one to one activities such as loud reading, hand massage, sorting out the content of their wardrobes, and going through photographs. Additionally, the registered manager had introduced a 'care buddy' on the ground floor and was monitoring people's response to see if this was popular and could be extended to other floors. The 'care buddy' offered one to one attention and companionship, sitting with people, going through their history book, listening to what people had to say, talking about daily news events taking part in discussions or simply sharing a pot of tea. This service was provided seven days a week. The registered manager told us, "This is being tested at the moment and we will get feedback at the next relatives and residents meeting." Following our inspection, this service had been increased to eight care buddies (two on each floor). The registered manager also had requested a physiotherapist to assess people's mobility, with their consent, starting on the lower floor where people remained in their bedroom. They told us, "Depending on the results of the assessments, we are looking at purchasing specialist chairs to get people out of the lower ground floor and access other floors including the gardens, so they will feel more included in what is going on."

The weekly programme of activities ran seven days a week and was displayed prominently on each floor. There were varied sessions to reflect different interests, for example word games, visit from 'PAT dogs', live entertainment, keep fit, art and crafts, and relaxation therapy. There were coffee mornings and tea afternoons where people were encouraged to get together, to promote social interaction and inclusion. Information was displayed about how certain activities could benefit people with dementia. A social assistant told us how they sought and used information from people and their families, for example one person's interest in tennis had been developed into a 'strawberries and Pimms' day for all the residents across the four floors." We saw staff manned several decorated trolleys with a Wimbledon theme using the lift to reach everyone in the service. Staff recognised the importance of activities and stimulation but also that some people liked to watch from the side, or just prefer to do one to one activities. Social assistants were involved in helping people decide if and how they wished to use memory boxes and picture frames on their bedroom doors and in decorating the corridors. They made frequent use of the gardens so people could get 'fresh air and relax under the sun' when the weather was clement.

At our inspection in December 2016 we found that the registered provider was in breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. This was because people's continence needs had not been adequately assessed and the risk of skin breakdown had not been appropriately mitigated. At this inspection we found that action had been taken and that the required improvements had been made.

People's care plans included guidance for staff regarding individual continence needs, such as catheter care, frequency of toileting and repositioning, history of infections, and application of barrier cream when necessary. Each person had been assessed about their continence needs. Assessments addressed how many continence pads would be required if necessary and the requests were sent to the local Community Health team. As a result, two months supplies were delivered and stocks were kept in each person's room accordingly to what they needed to use. Staff told us there were no shortages of pad supplies. People were regularly assisted to attend the toilet facilities throughout the day. Staff told us, "It doesn't matter if a resident wears a pad or not, it is important for them to go to the toilet and get a fresh pad whenever they want or need it."

People were aware of how to make a complaint. The complaint procedure was displayed in evidence in the foyer. This was available in a format suitable for people with visual impairment. One complaint had been received since the registered manager had been in post, regarding a heating problem in a bedroom. As a result, swift remedial action had been taken.

People's views were sought and acted on. Every two months, relatives and residents meetings were held to which all were invited. The registered manager had held two meeting, one of which was to introduce herself, the assistant manager, and the lead registered nurse, and answer any queries and questions. Additionally, they held individual meetings with relatives and addressed any concerns. At the last relatives and residents meeting, feedback and comments were obtained on the recent changes implemented by the new management, including staffing levels, staff uniforms, and the care buddy scheme. Action taken as a result of feedback included updating a database of relatives that people wished to be informed about changes in care, and involving people and relatives in menu planning. In addition, the provider had organised a visit from a Master chef to suggest new recipes and create new menus in partnership with the committee.

A resident satisfaction survey was in progress, and nine people had completed the survey, which addressed every aspect of the service. Seven people had stated being 'satisfied' with the service and two were 'very satisfied.'

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff told us the service was very well led by the new registered manager. All were complimentary about the registered manager's approach and style of leadership, as well as about the new management team. A GP who visited the service told us, "I have no concerns about the service. Staff seems to be caring and [the manager] is an excellent manager." Three local authority case managers who oversaw people's wellbeing in the service told us, "The residents are very happy there, it seems to be better managed, the new manager, the assistant manager and the lead nurse form a very good team, they have made so many improvements", "There is a different feeling in the place, staff seem happier since the new management" and, "The new care plans are very comprehensive, the staff are very helpful, and the manager is very pro-active." A person from the residents committee told us, "The manager is a good listener and gets things done. We invited her to talk about the food, the menus, the CQC report, she delivers."

At our inspection in December 2016 we found that the registered provider was in continuing breach of Regulation17 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. Although the provider had started to make changes since the previous inspection in January 2016, these changes had not yet been fully embedded or actioned in December 2016. There continued to be shortfalls in audits of monitoring charts, and policies relating to safeguarding, abuse and consent had not been updated. At this inspection we found that action had been taken and that improvements had been made to ensure compliance with regulations, monitored through a new system of governance.

The management team completed an appropriate range of checks and audits to identify how to improve the service. These included quarterly medicines audits, backed up by daily and monthly reports, and checks of staff competency by the lead registered nurse; monthly audits of staff training and supervision, call bells response reports; maintenance and repairs; care planning and reviews, infection control and accidents and incidents. Every day, the registered manager approved three to four care plans after having checked how updates had been documented by the nurses. When the registered manager saw any shortfall such as a missing life history, they requested remedial action.

The registered manager brought results of checks, reports and audits to monthly management meetings where any shortfalls were discussed and an action plan was written that was monitored until completion. As a result of an audit in infection control, three deep steam cleaning machines had been purchased. In addition to internal infection control audits, the registered manager had requested a Clinical Commissioning Group Head of IPC (infection prevention and control) to inspect the service in June 2017. As a result of this inspection, a number of issues had been identified and had been remedied promptly.

The provider had recently recruited a group quality coordinator who inspected the service and compiled a comprehensive monthly management report that addressed every aspect of the service at monthly management meeting. They worked in partnership with the registered manager and ensured that action plans were addressed and the quality of standards was maintained.

The service's policies were reviewed and updated to reflect changes in legislation. They were easily

accessible by staff through the service's computerised system. A policy on dealing with violence and aggression had been introduced by the registered manager that reflected legislative requirements; the policy on safeguarding reflected the Care Act 2014 and different types of abuse. Records were well organised, fit for purpose, kept securely and confidentially. Archived records were disposed of safely and appropriately according to legal requirements.

At our inspection in December 2016 we had made a recommendation about the reviewing of accident and incidents analysis system in line with best practice guidelines. This was because relevant documentation failed to record what action would be taken to prevent any future recurrences. At this inspection we found that action had been taken and that the required improvements had been made. Accidents and incidents were logged and reported to the registered manager on the day who analysed the reports to identify whether any trends and patterns were identified. The registered manager told us that there was a falls protocol that people were to be checked intensively following a fall, with consideration given to any equipment that they may need.

A new management team had been introduced from 27 March 2017.The new management team consisted of a registered manager supported by an assistant manager (who is also the deputy manager), and a lead registered nurse (who was the clinical lead). One relative commented that there had been improvements in the environment and in communication between the home and the relatives. However, these changes were recent and had not yet been fully embedded. There were still some areas that had not been fully implemented at the time of this inspection, for example PAT testing and improvements to pureed food. We discussed with the registered manager the need to now ensure that improvements are firmly embedded in the service and sustained to ensure quality and safety are maintained. The provider told us, "There is always room for improvement, we strive to improve continuously." We recommend that the registered provider and registered manager continue to closely monitor the service to ensure the improved standards of governance are sustained.

Emphasis was placed on improving the service and people's experience. The registered manager talked with us about their philosophy of care and values regarding the service, which included involving people in making decisions, and person-centred care. They told us, "My vision is feeling safe, loved, respected, enabled, valued, trusted, supported, cared for, and comforted. Our residents need to feel this is their home."

Relatives and visitors told us that the registered manager, the assistant manager and the lead registered nurse were visible in the service and knew everyone on first name terms. They told us that they had been able to meet the registered manager to discuss any concerns and that she operated an open door policy. Comments included, "This manager wants to know what people think". The registered manager had included people in a satisfaction survey, held a relatives and residents meeting every other month and had created a residents committee ran by four people who liaised with others in the service. A relative had sent a compliment to the manager that read, "We attended the relatives and residents meeting this morning and would like to thank [the manager] for being so open and transparent. We appreciate that you have an uphill struggle to bring the standard of the home up to your expectations and by what we have seen so far you are doing a good job, well done."

The new registered manager was open and transparent. They had notified the Care Quality Commission of any significant events that affected people or the service and were aware of their duty of candour. The rating of our last inspection was prominently displayed in the service as per legal requirements.

The registered manager supported staff and had held regular sessions with staff from each department to

discuss the management's expectations of their role and performance. Staff across the service told us that this had made them feel supported and that the new manager was a "great role model". One member of staff said, "The management change has been great. The manager and deputy come regularly to all the floors. We never felt supported before".

The registered manager had worked with the Clinical Commissioning Group and the local GP practice on a 'Microsystem project' that involved all community health professionals and the mental health team to create better working partnerships. The registered manager had started the project in a sister home previously to them taking their post at Cornford House, and had involved Cornford House in March 2017. This had resulted in a positive impact on medicines management and in a reduction of referral time for people needing treatment and support from other health professionals over the past four months. For example, referrals to mental health teams took ten days instead of six weeks.