Care Quality Commission

Cornford House Limited

Cornford House

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Cornford House provides accommodation for people with nursing care needs and offers a choice of either studio or one bedroom care suites, or nursing home bedrooms. The service has 70 beds registered with CQC but can accommodate 81 people overall for people who choose a tenancy care agreement. The concept of a tenancy agreement is nursing care within your own home

Cornford House is registered to provide both personal and nursing care to the people of the suites. The in-house team of registered nurses and carers is available 24 hours a day to respond to the persons' care needs when required. With registered nurses available on-site, the suites offer a permanent home where people do not need to worry about moving when their care needs increase.

At present there are 42 people who have a tenancy care agreement and 33 people with a nursing care agreement living at Cornford House. There is no difference in the care provided and the care is delivered by the staff of Cornford House.

The accommodation provides nursing care and support for physically frail older people who live with health problems such as diabetes, strokes, Parkinson's disease and end of life care. There is also a specialist unit for up to 18 older people whom live with a dementia type illness. Peoples' spouses can also be accommodated, so that couples can stay together even when one develops the need for on-going care.

This inspection took place on the 28 January and 01 February 2016 and was unannounced. There were 75 people living in Cornford House.

People commented positively about the care and support received and their experience at Cornford House. However, the inspection highlighted shortfalls that had the potential to compromise the safety of people in the service.

Care plans did not all reflect people's assessed level of care needs and care delivery was not always person specific or holistic. We found that people with specific health problems such as end of life care and diabetes did not have sufficient guidance in place for staff to deliver safe care. This had resulted in potential risks to their safety and well-being. Staffing deployment and levels had impacted on people receiving the support required to keep people safe. Whilst accidents and incidents had been recorded, strategies to eliminate risk and manage risk such as recurrent falls in the evening and at night were not in place.

Auditing had not been totally effective in highlighting shortfalls in the quality and safety of the service. Feedback had been sought about the quality of the service, but had not been acted upon.

Staff meetings were not as regular as staff wanted. They felt that meetings should be held so that they the staff could contribute to the running of the home.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission (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.'

The home had an activity programme and staff who were part of an activity team. We observed that the activities were specific to each unit for small groups, guided by their specific social needs. There were also larger group activities for all units to join if they should choose to.

The principles of the Mental Capacity Act 2005 (MCA) had not been properly followed in regard to enabling people to choose to walk independently and therefore promoting people's independence. The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider, manager and staff had an understanding of their responsibilities and applications were in progress.

Essential training and updates were provided for all staff, including safeguarding people, moving and handling, management of challenging behaviour, pressure area care, falls prevention and dementia care. Staff said the training was very good and helped them to understand people's needs. However specific training for people's health needs such as diabetes, strokes and Parkinson's disease had yet to be progressed for all staff delivering care.

People were protected, as far as possible, by a safe recruitment system. Nurses employed by the provider of Cornford House and bank nurses all had registration with the Nursing Midwifery Council (NMC) which were up to date.

All staff had attended safeguarding training. They demonstrated a clear understanding of abuse and said they would talk to the management or external bodies immediately if they had any concerns, and they had a clear understanding of making referrals to the local authority and CQC. People said they were comfortable and relatives felt people were safe.

Visits from healthcare professionals were recorded in the care plans, with information about any changes and guidance for staff to ensure people's needs were met. There were systems in place for the management of medicines and we observed staff completing records as they administered medicines.

Staff had a good understanding of people's needs and treated them with respect and protected their dignity when supporting them.

Staff said the management was fair and approachable, handover meetings were held every morning to discuss people's current needs and to direct staff in meeting these.

Maintenance records for equipment and the environment were up to date, such as fire safety equipment and hoists. Policies and procedures had been reviewed and updated and were available for staff to refer to as required. Relatives told us they could visit at any time and they were always made to feel welcome and involved in the care provided.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not always enough suitably qualified and experienced staff to meet people's needs. People's needs were not taken into account when determining staffing levels.

The management, administration and storage of medicines were safe.

Staff had received training in how to safeguard people from abuse and were clear about how to respond to allegations of abuse. Staff recruitment practices were safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had not always been followed in practice.

Meal times were not an efficient service with food being served to people without the support they required. We also saw that people received food that was not hot and appetising.

People had access to health care professionals for regular check-ups as needed.

Is the service caring?

Good

The service was caring.

Staff ensured that people's equality and diversity needs were respected.

Staff communicated clearly with people in a caring and supportive manner. Staff knew people well and had good relationships with them. People were treated with respect and dignity.

People were encouraged to maintain relationships with relatives

and friends.

Relatives were able to visit at any time and were made to feel very welcome.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's support was not always personalised. Care plans did not all contain the guidance required for individual health problems such as diabetes.

People decided how they spent their time, and a range of activities were
provided depending on people's preferences. Improvements were on-going as the activity co-ordinators received training.

People and visitors were given information about how to raise concerns or to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Feedback had been sought about the quality of the service, but had not been acted upon.

Audits had not always been effective in identifying shortfalls in the safety or quality of the service.

There was however clear leadership and support from the manager and provider.

There was a culture in the home that was open and transparent.

CareQuality Commission

Cornford House

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 28 January and 01 February 2016 and was unannounced. The inspection was carried out by four inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had personal experience of caring for people living with dementia.

Before the inspection we looked at information provided by the local authority, contracts and purchasing (quality monitoring team). We also looked at information we hold about the service including previous reports, notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

As part of the inspection we spoke with 25 of the people living in the home, eight relatives, ten staff, and the manager. We observed staff supporting people and reviewed documents; we looked at 18 care plans, all medication records, six staff files, training information and some policies and procedures in relation to the running of the home.

Some people who lived in the home were unable to verbally share with us their experience of life at the home, because they were living with dementia. Therefore we spent a large amount of time observing the interaction between people and staff, and watched how people were cared for by staff in communal areas.

Following our inspection we spoke with seven health professionals who visited the service, this included GP's, Speech and Language therapists, specialist nurses and the hospice team.

Requires Improvement

Is the service safe?

Our findings

People said, "Yes" when asked if they felt safe and nodded when asked if the staff looked after them. Relatives said, "The staff are very good, they make sure people are safe, even when they want to walk around." Another relative told us their family member was safe and settled and they did not worry about their safety.

People and staff told us that they felt staffing levels in the home were enough to keep people safe and meet their needs. However as detailed on the staff rota, staffing levels decrease in the afternoons by two staff and by five staff at night time. From our analysis of recorded accidents and incidents there were a number of people who experienced a higher number of falls and there was a clear correlation between the highest number of falls occurring at times of the day when staffing levels had been reduced, for example between 2pm and 10 pm when the numbers of accidents were more than double those at other times. There was also a high number of falls during the night between 10pm and 7 am. In January 2016 there were 17 accidents unwitnessed between the hours of 2pm and 07 am. Four resulting in admissions to the local NHS hospital.

People told us that that they had to wait for up to ten minutes for staff to answer the call bell. We asked to see the call bell system printout but this data only collected the number of calls made from each room within the time period 10pm to 7am, and not how long staff took to respond to calls made. During our inspection we identified that some call bells were unanswered for up to 15 minutes. This was discussed with the manager who told us that she would investigate. One visitor we spoke told us, "The staff are kind but not enough of them, my wife has had three falls since coming here, and used to be able to walk, but staff don't have time to support her or give her exercises." We were also told "I have to wait sometimes when I ring, it's not the staff's fault, because other people need help as well." When we discussed with the manager how staffing levels were determined, we were told that they used an organisation dependency tool which gave the hours of care each person required and how many staff were required to deliver that care. It did not give a reason however as why staffing levels decreased in the afternoon as the hours of care required did not change. It also did not take into consideration the time required to assist each person with their meals and drinks.

At lunchtime we observed that there were not enough staff available to provide the assistance some people needed to eat their meals. Although people who ate in their rooms were given their meals first, some people were asleep when meals were put in front of them, or unable without prompting, to eat more than one or two spoonful's as staff were busy elsewhere.

There were people who remained in their rooms and were on continuous bed rest. During our inspection it was identified that apart from specific tasks, such as personal care and being offered drinks and food, they did not receive interaction from staff. One person on the dementia unit remained in their room and was seen just sitting in a chair dozing for the majority of our visit. The activity person acknowledged that as ten people from the dementia unit had attended the activity downstairs, a staff member had had to go with them. This meant the staffing levels were reduced on the dementia unit for the people who did not attend. Staff said "It just isn't possible to be everywhere as people in the communal areas need us as well." We

found that the deployment of staff had not ensured people's needs were met.

The failure to ensure there are enough staff employed and deployed to meet people's needs is a Breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at personnel files for seven staff. All seven included relevant checks on prospective staff suitability, including completed application forms, two references, Disclosure and Barring System (DBS) check and evidence of their residence in the UK. This meant the provider had undertaken appropriate recruitment checks to ensure as far as possible only suitable staff were employed.

A number of people living in the home were looked after in bed and not able to walk. Some were on 1st and 2nd floors. The manager was asked about personal emergency evacuation plans for these people who could not evacuate independently in the event of a fire. The manager showed a fire list which detailed the names of all the residents, red signified being looked after in bed, blue was a wheelchair user and green signified mobile. The list showed that 10 people living in the home were looked after in bed, however from our observations the actual figure was much higher than this and there were inconsistencies in this list. For example there are people on the list marked in blue but these people were also considered to be End of Life and looked after in bed. It is a recommendation that the fire evacuation procedures were reviewed with the fire authority to ensure the evacuation procedure is fit for purpose and ensures the safety of all the people in Cornfield House.

Care plans were generated on a computer system and then printed off for staff to refer to. A further copy was also held by the registered manager for her to access as required. Risk assessments were specific to each person. Their needs had been identified and reviewed and updated as people's needs changed and there was guidance to ensure staff provided appropriate care and support. These included waterlow scores to protect people from pressure sores, nutrition, risk of falls and moving and handling. For those who had falls we saw that a follow up plan was put in place. We also saw recorded preventative actions such as 'check foot wear', alarm mats to alert staff the person was on the move and check room for trip hazards. We observed equipment, such as hoists, walking frames and pressure relieving devices were used to protect people, and risk assessments in the care plans identified the mobility aid people or staff used to support each person. Where risks were identified there were measures in place to reduce the risks as far as possible. For example low beds were in place for those that may fall out of bed and pressure mattresses and cushions were in place for those that were susceptible to skin damage and pressure ulcers. All risk assessments had been reviewed at least once a month or more often if changes were noted. The care plans highlighted health risks such as diabetes and epilepsy however these were lacking in directives for staff to follow.

Information from the completed risk assessments were transferred to the main care plan summary. All relevant areas of the care plan had been updated when risks had changed. This meant staff were given clear and up-to-date information about how to reduce risks. Peoples weights were monitored regularly and records were seen for the past seven months. It identified the weight loss or gain and stated the action taken on identifying weight loss, for example refer to dietician or GP. Staff had recorded weight loss into individual care plans and an action plan had been put in to place, such as fortified drinks and puddings. For example, one person had lost weight and once identified, staff took action to ensure food was fortified and offered regularly. We also saw that staff weighed certain people who were identified at risk weekly and two weekly and updated the GP regularly. The latest review for one person had recorded that the risk had reduced, and staff continued to make sure the person was offered snacks and fortified foods. This was monitored closely by staff.

We saw people on all floors being safely supported during moves from wheelchair to armchair with the

support of appropriate equipment. We observed that staff were mindful of the person's safety and well-being whilst being moved. Staff offered support and reassurance to the person being moved, with an explanation such as "We are going to move you now so it will feel a bit strange as it starts to lift you." People told us they felt safe whilst being moved by staff. One person said, "I can't do much myself but staff move me safely." Another person said "I am getting used to it, staff are very kind."

Staff supported people who lived with behaviours that challenged others in a competent and safe manner. Management strategies for staff to manage people's behaviour safely had been introduced and training was being organised. We saw throughout the inspection that people were calm and staff were attentive to people's mood changes. We saw that one person became restless and staff immediately responded and engaged this person in an activity. This was done in a gentle and professional way.

Staff had an understanding of abuse and what action they would take if they had any concerns. They identified the correct safeguarding and whistleblowing procedures should they suspect abuse had taken place, in line with the provider's policy. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, anonymously if necessary. One staff member told us, "I would always tell my manager if I thought someone I was looking after was at risk. I'm sure they would do something but if they didn't, I'd let the local authority know." Another staff member said, "I just wouldn't tolerate anything like that. I'd report anything like that. I'd report it straight away." Staff confirmed the manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence. The manager said all concerns were reported to the local authority, they waited for a response before they took any action and records were in place to support this. This meant people were protected as far as possible from abuse.

There were systems in place to manage medicines safely. Medicine administration record (MAR) charts clearly stated the medicines people had been prescribed and when they should be taken. MAR charts included people's photographs, and any allergies they had. The MAR charts were up to date, completed fully and signed by staff. We observed staff when they gave people their medicines. We saw medicines were given to people individually, the trolley was closed and locked each time medicines were removed, and staff signed the MAR only when people had taken the medicine. Staff followed the medicine policy with regard to medicines given 'as required' (PRN), such as paracetamol and records had been completed with details of why they had been given. Medicines were kept in locked trolley, which was secured in a locked room.

Risk assessments had been completed for each person with regard to medicines; the assessments identified that people may not remember to take medicines, therefore they were at risk and staff were responsible for their medicines. The provider had devised a medicine competency framework to look at staff capability around the administration, storage and disposal of medicines. Two staff members accurately described their role in the management of medicines and displayed a working knowledge of the provider's policies in this area. Audits were in place to check that there were no gaps in the MAR, that PRN records were appropriate, and medicines were administered safely.

The home was clean and well maintained. There were records to show relevant checks had been completed, including lighting, hot water, call bells and electrical equipment. The fire alarms system was checked weekly and fire training was provided for all staff and the records showed they had all attended. External contractors maintained the lift, electricity supply and kitchen equipment, and if there were any problems staff were able to access their contact details. The floors were clear of obstruction and people were able to move safely around the home with walking aids. The staff on the dementia unit ensured that the corridors were kept clear as there were people who enjoyed to walk around the unit. There were sensory areas with chairs for people to sit if they became tired.

Requires Improvement

Is the service effective?

Our findings

People told us they liked the food. One person said, "Have you tasted it, it's very good. It might not look much but it tastes alright." Relatives told us choices were available and they met people's specific needs, like diabetes. Staff told us they had a good understanding of people's dietary needs and had the time to support people when they were ready to eat their meals. One staff member said, "We have a good idea what people like and dislike and they can change their mind and we give them something else. However our observations during the inspection did not support these comments.

The lunchtime meal was prepared and presented in relation to individual needs, with mashed, pureed and cut up food provided as required, and if people did not like what was available staff said they could have something else. However we received a range of negative comments about the quality of food. One person said "Not so good – grey potatoes and veg looked like it had been boiled for hours," and "It can be good but also awful." A visitor said, "Meal times seem to be a problem, disorganised especially supper time, and there is a lack of staff to help people like my mother, so I try and visit so at least I know she is eating something." We saw that the pureed food was of a consistency that was problematic in that the mashed potato was hard and the vegetables grainy. One staff member said, "Really difficult when it starts to cool as it it's hard. Not really suitable for people who have swallowing problems." Three people on the dementia unit were unable to eat the meal in full. No alternative was offered.

There were people that needed assistance or prompting with meals. As identified previously in the report under the safe question, not all people were assisted with their meal in a timely way. We saw on all units that some people were left with a cooling meal in front of them. Staff tried to support people but it was rushed and therefore people were unsupported. For example, one person sat looking at their meal without eating and by the time staff tried to assist the food was cold and unappetising. We found that this was not an isolated incident. We also saw meals wheeled out on trollies that were not heated, meals were therefore left on some trollies for some while whilst a staff member assisted a person with their meal. We observed a meal sitting on a trolley outside a room for 20 minutes before a staff member came out of the room having assisted someone, and moved the trolley onto the next person, by this time the meal was tepid possibly cold.

We saw that special equipment to support people to eat independently was not always available or offered. For example one person was given a knife and fork that they struggled to use due to poor hand co-ordination. The person after attempting to eat gave up and did not eat their meal. We alerted staff to this and they gave the person a spoon. On discussion with staff they acknowledged the person could not use a knife and fork. Another person was struggling to eat their pudding with a fork, a staff member went and gave them the spoon that they had used to eat their main meal. We also noted that plate guards were not used to assist people to eat independently.

Therefore we were not assured that people's nutritional needs were met and is a breach of Regulation of 14 1(a) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also observed some staff (activity person and registered nurse) assisting people on a one to one basis and this was provided in a calm and unhurried manner. Staff chatted and checked in between mouthfuls if people were ready for more and drinks were offered throughout the meal.

.The staff were aware of people's preferences and the chef had a good understanding of people's needs and their likes and dislikes. We were told that if people had nutritional cultural preferences and requirements this would be provided. Vegetarian meals were provided and the menus displayed a varied diet.

Tea and coffee was available throughout the day when people wanted it. The chef and staff said snacks and drinks were available at any time and if people did not want their meal at the usual time, for example if they had had a late breakfast, their meal was kept and they can have it when they are ready. Staff said they would notice if people were not eating and drinking as much as usual and would report this to the nurse or the manager and they were confident GPs would be contacted if there were concerns. Food and fluid records were kept for some people, particularly people who had lost weight or who appeared disinterested in food. They had been completed daily and reflected the meals and drinks we observed during the inspection.

Staff had completed training and had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This had included the nature and type of consent, people's rights to take risks and the necessity to act in people's best interests when required. They described the purpose of the MCA Act and its potential impact on people they were supporting. They understood there was a need to assess people's ability to make decisions for themselves but this was not something they were actively involved in and was primarily the responsibility of senior staff. There was a concern that people were encouraged not to walk about due to risk of falls and had been instructed or told not to do so by staff. This is a subtle restriction that masks the fact that there are insufficient staff to spend time observing and monitoring people as they walk about, hence some people mobility has suffered and they no longer walk but use a wheelchair. Two people and their families expressed their concerns regarding this. It is a recommendation that further training and support be offered to staff in supporting people to take risks within a risk assessment framework.

We noted on one care plan that a best interest discussion had been undertaken as to whether the person should have a flu injection, and contained discussions about end of life care with relatives.

A mental capacity assessment had been completed for each person with information about their individual capacity to make decisions and understand the support and care provided. Most people were unable to tell staff verbally about their wishes and needs and staff said as they got to know people they were able to interpret people's responses. One member of staff said, "Some people are unable to speak, but we know if they want to get up or have something to eat, they let us know by turning away or they use a particular facial expression and body language."

Staff were aware that the locked front door and key pads to the dementia floor, which prevents people entering and leaving, were a form of restraint and applications had been made to the local authority under DoLS about this. Staff told us people should be encouraged to make choices and felt they were able to make decisions about the day to day support provided. We saw people decided where they sat and how they spent their time, some sat in the lounge or the dining area and others were supported to return to their room after lunch.

All new staff underwent a formal induction training period. Staff records showed this process was structured around allowing staff to familiarise themselves with policies, protocols and working practices and was based on the Skills for Life Care Certificate. The Care Certificate familiarises staff with an identified set of

standards that health and social care workers adhere to when they provide support and care. Staff 'shadowed' more experienced staff until such time as they were confident to work alone. Staff felt they were working in a safe environment during this time and were well supported. One staff member told us, "I'd never done this type of work before so I did a lot of shadowing. If I still felt unsure I know that the manager would have let me do it for longer." Another staff member said, "Yes, that was fine. I never felt that I was on my own. There was always someone around to ask."

The training plan and staff files showed that staff had access to relevant training which they felt enabled them to provide the care and support people living at Cornford House needed. The training was mostly e-learning and some practical training was provided by external training agencies, such as moving and handling. The provider had made training and updates mandatory, these were dementia awareness, infection control, moving and handling, food hygiene, fire awareness, safeguarding, The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, falls prevention, pressure area care and medication management. Additional training offered to staff included maintaining confidentiality, care planning and documentation, reporting and recording, and risk assessing. Training for person centred care and managing behaviours that challenged were planned. We noted that specific training in diabetes, Parkinson's disease and end of life care had been discussed but not yet progressed and we were told that now all staff had attended essential training other training would be progressed. Staff were satisfied with the training opportunities they had. One staff member said, "I've learned a lot since I've been here. The training is good." Another staff member told us, "It has helped me understand my job better. I realise how important it is now." There were opportunities for staff to develop professionally and one staff member said they had signed up to start a Health and Social Care qualification.

Staff had attended equality and diversity training, and they had a good understanding of the issues and their implications for the people they were supporting. One staff member told us, "I think we need to make sure we understand each person's background to make sure the care suits them. For example, I know that a lot of people living here don't like the television on all day. That's because they were more used to listening to a radio. We have to be mindful of that and not just use the television for company."

Staff told us they had regular one to one supervision with the manager and felt this gave them a chance to sit down and talk about anything, as well as find out if there were areas where they could improve. The supervision records showed staff attended regularly and appraisals had been carried out or were planned. Staff said they could talk to their colleagues, including the manager and provider, at any time, and they were clear about the disciplinary procedures if the registered manager or their colleagues thought they were not providing the care and support people needed. One staff member said, "I do feel well supported anyway but supervision really helps." Another staff member told us, "The manager is always around but it's good to be able to sit down and talk." All of the staff said they felt well supported by the management.

People had access to health care professionals as and when they were required. These included the community mental health team, continence nurse, dentists, opticians and chiropodists. GPs visited the home as required and staff felt they could contact them if they had any concerns. A relative told us, "Yes they'd get the doctor, the chiropodist comes here too and I am going to mention glasses to the manager."

Advice had been sought from the Speech and Language team with regard to people's swallowing difficulties. There was guidance in the care plans for staff to follow with regard to the use of thickener for fluids and meals that were suitable to each person's needs. Staff were aware of each person's needs and demonstrated an understanding of why people had mashed or pureed meals and which people needed thickener in their drinks. We contacted six health professionals following the inspection. One health professional said they had no specific concerns about the support of healthcare needs of people they visited

and was aware that the service had been proactive in making a referral to the Speech and Language team for a person they visited with swallowing difficulties. Another health professional told us that nursing staff within the service always provided a good handover of the needs of people. We were also told that "Staff were professional" and "Welcoming" and that "Staff knew people well and were receptive to advice and support."

Good

Is the service caring?

Our findings

The home had a relaxed atmosphere and people responded well to staff because they approached them in a kind and dignified way. People nodded and smiled when asked if staff were kind and caring. Relatives felt staff offered the care and support people needed and wanted. One relative thought the staff were, "Caring enough" and, "We have a laugh and a joke." One staff member said, "We provide the care people need when they are ready for it, rather than when it suits us, which is how it should be."

People were treated with kindness and respect, as individuals, and it was clear from our observations that staff knew people very well. Staff made eye to eye contact as they spoke quietly with people, they used their preferred names and took time to listen to them. Staff knocked on people's bedroom doors before they entered, saying "Hello its me (staff name) are you ready to have a shower ?" and, "Good morning sir." We saw several lovely interactions, staff used affectionate terms of address and gentle physical contact as they supported people, and people responded with smiles. Staff said, "Hello you look at lot better today. I'm here" whilst stroking their arm. "Hello there" while gently wiping the person's mouth and asked, "Is that better" and, "What would you like for breakfast? You hold my hand if you like."

People's preferences were recorded in the care plans and staff had a good understanding of these. There was information about each person's life, with details of people who were important to them. the information included how they spent their time before moving into the home, such as looking after their family or employment, hobbies and interests. Staff said they had read the care plans and told us each person was different, they had their own personality and made their own choices and they enabled people to do this as much as possible. People chose how and where they spent their time. People on the dementia unit who wanted to walk around the home, rather than participate in activities, were able to do so.

People's privacy and dignity was protected when staff helped them with personal care and bedroom doors remained closed as people were assisted to wash and get up. We saw staff encouraged one person to return to their bedroom to change, although they wanted to remain in the lounge, staff spoke quietly with them, encouraged them and they agreed to change their clothes. Staff told us, "We have to remember it's their home. We won't go wrong if we remember that" and, "People need a lot of support with their personal care and we keep in mind at all times that some things are very private. We would not like everyone to know that we had had an accident and our clothes were wet and needed changing. We just need to imagine how we would feel if it was us or a relative." This showed staff understood the importance of privacy and dignity when providing support and care.

Staff people to make choices. Staff talked to people and asked them if they needed assistance, they explained to people what they were going to do before they provided support and waited patiently while people responded. One staff member said, "I am just moving you along a little bit so someone else can sit at the table and join in, is that alright." They leant down to talk to the person face to face so they could see their expression, and waited until the person responded. Comments from staff included, "It is our responsibility to make sure people they make decisions about all aspects of the support we provide, even if we don't agree with them." "I don't interfere if I think someone can do something for themselves" and, "I like

to get people to make their own decisions if they can. For example, if someone doesn't want to do something then it is up to them."

People's equality and diversity needs were respected and staff were aware of what was important to people. One person liked to wear make-up, nail varnish and particular clothing to reflect their lifestyle and staff supported them to do this. Staff said to them, "You look lovely today, would you like a bit of make-up on? The person was assisted to put some make-up on and nail varnish of their choice had previously been applied. Another person liked to look smart and have their handbag with them as they sat in the lounge. Staff ensured their handbag was with them as they were transferred from their room to the lounge and it was positioned so that it could be easily accessed.

Staff said relatives and friends could visit at any time and relatives told us they were always made to feel very welcome. One relative told us, "We ring the bell and wait to be let in, so people here are looked after, and they always make a cup of tea for me and I have a chat with the staff, manager.. They always let me know what is going on and they have got used to me as I visit every day."

Requires Improvement

Is the service responsive?

Our findings

People liked their rooms and had individualised them with colour schemes, memorabilia, photographs and personal possessions with the assistance of relatives and friends. Relatives said they were involved in discussions about and the planning of people's care and felt able to talk to the staff about this at any time. One relative said, "I know there is a care plan and they have recently been updated, they are much easier to look at, but I don't get involved in them." However we found there were areas that required improvement to make sure people's individual needs were responded to.

People's needs had been assessed before they moved into the home and the computerised care plans had been developed from this information. Staff had reviewed this information and updated it with the help of relatives, friends and representatives. The main care plans included all the required information about people's needs, including risk assessments, mental capacity assessments and hospital appointments, The staff also used specific care plans on a daily basis, for example wound care and nutritional needs. These contained important information covering areas of care and support needed on a daily needs. We found however that peoples specific health problems such as diabetes were mentioned but lacked depth and guidance for staff in recognising when their health might be affected. For example a person's individual 'normal' range of blood sugars. There was a lack of guidance for staff to recognise a low blood sugar (hypoglycaemia) such as abnormal shaking, sweating, hunger and tiredness, or high blood sugar (hyperglycaemia) such as increased thirst and excessive urination. This had not assured that their health needs would be responded to appropriately by staff.

People who had been identified as at risk of pressure ulcers were provided with air flow mattresses and their personal care routine ensured that there skin was creamed or protected with medicines like Pro-shield. However one person's care plan under pressure sore risk stated "very high risk" the record also said "X is unable to move if uncomfortable" no turning charts were in operation for this person. We observed three further people who were in bed on their backs from 10.00 until 3.00pm and whilst there was no evidence of pressure sores, there were areas of redness of their skin noted in care plans and no turning chart in place. We also saw that whilst turn charts were in place for some people who needed regular changes of position to mitigate the risk of pressure areas developing, the documented required frequency of changes was not always well maintained. There were gaps in recording for some people that could pose a risk of people not being turned as often and needed. For example one person was required to be turned every two hours, their turn chart for the previous day to inspection said they had been turned at 6 am, 8 am and 10 am but not turned again until 9 pm, for another person who was end of life they had been turned on the day of inspection at 10:30, 11.00, 12:15 then at 16:00 and 16:02. The above examples meant that staff had not been responsive to people's individual needs and ensured their health and well-being and was a breach of Regulation 9 (1) (a) 3 (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each computerised care plan looked at the person's individual communication needs, the outcomes the support the care aimed to achieve and the action staff had taken to achieve this. For example, one person's need was assistance with their hearing, a hearing aid had been provided to assist them. The outcome was for the person to be able to hear what staff were saying and what was going on around them. The action was

for staff to encourage the person to wear the hearing aid, and if they chose not to wear this for staff to talk clearly and loudly, not shouting, so they knew what was happening. This was important not only as it enabled them to be aware of what was happening, but also because the person had become distressed when they were not sure what people were saying or doing and staff were clearly able to address this. Staff spoke clearly with the person when they provided assistance, and when necessary moved closer to ensure they spoke privately about personal care support.

We asked staff how they knew about changes to people's needs. A staff member said, "We have our daily meeting (handover)which is very useful, especially if you have been on days off and someone has been poorly or had an accident. We can talk about things, and get other people's ideas and support and make a decision." The purpose of the daily handover meeting was to review the care and support provided over the previous 24 hours and to share knowledge and developments with a view to maintaining high standards of care. The meeting was conducted in an open and inclusive manner and all staff were invited to share their observations and opinions. The discussions were focused on people's care needs with clear plans of action drawn up following the meeting. For example, people's dietary needs were reviewed and potential issues discussed and action agreed. One person was having antibiotics to treat an infection. The team discussed the care of this person and the need for extra fluids to be taken at this time and for closer observation until the person has recovered, with fluids recorded so they had a record of how much the person had consumed. We looked at a selection of handover records and found they were clearly focused on the care needs of people living at the home. This meant that staff had a good understanding of people's support needs and how to respond to them.

The support and social care provided was personalised and based on people's preferences. An activity programme was displayed on the notice board, for people to think about and choose to attend if they wished. The three units undertook activities within their units and also joined main group activities in the dining area on the ground floor. We saw people enjoy a musical session in the ground floor lounge. Activity staff said they spent time with people who remained in their rooms and we saw them talk to people sitting in the lounge. Conversations were relaxed and friendly, people responded when spoken to and there was a considerable amount of smiling and laughing. We saw that staff enabled families to personalise their loved ones bedrooms with photographs and pictures. It was acknowledged that improvements could still be made on developing meaningful activities for those people who were unable to participate verbally and physically due to the restrictions of the medical condition they lived with. Ideas were being discussed and developed. The staff meeting notes from June 2015 had identified that activity provision could be improved. An activity co-ordinator said, "We have had some really good training recently and we have some really good ideas to go forward with. They had worked hard on the dementia floor to provide sensory areas and an indoor garden at the end of the corridor. Further ideas were discussed in bringing in live herbs and flowers to enhance the sensory experience.

Care staff said they did not have a lot of time to spend with people doing activities, but felt they should be involved in this. One staff member said, "We have some time to sit and talk to people, but often it is when we are supporting them during meals, but it is still chatting about something that is not about the care they need which is important."

A complaints procedure was in place; a copy was displayed on the notice board near the entrance to the home, and given to people and their relatives. Staff told us they rarely had any complaints, and the manager kept a record of complaints and the action taken to investigate them. The complaints folder contained one recent complaint. People told us they did not have anything to complain about, and relatives said they had no concerns and if they did they would talk to the manager, provider or the staff.

Requires Improvement

Is the service well-led?

Our findings

From our discussions with relatives, staff, manager, provider and our observations, we found the culture at the home was open and relaxed. Care and support focused on providing the support people living at Cornford House needed and wanted. Staff said the manager was always available and they could talk to them at any time. Relatives said the management of the home was very good, they could talk to the manager and deputy manager when they needed to and staff were always very helpful. One relative said, "The home is well led, the area manager is always here and keeps any eye on what is going on."

Quality monitoring systems had been developed. Despite this the accident records had not identified that a high percentage of falls were in the afternoon and evening. The reduced staffing levels in the afternoon had not been reviewed in line with this potential trend. Call bell audits were randomly undertaken by the manager but not formally reviewed. The manager looked at the room numbers of who called frequently but not at response times or the pattern of calls. Such as a call for first assistance to go to the bathroom and then how long staff took to go back and assist them from the bathroom. From our observations on the day of the inspection we identified that the response to call bells was slow at times. We saw that some were not answered for up to 15 minutes. This was fed back to the manager for investigation. Feedback from people and visitors was that they had to wait for assistance as staff were busy elsewhere.

There were a range of monitoring charts in place to ensure staff were giving the care required to people who were at risk from pressure damage. However we found that there were inconsistencies in the completion of these charts. For example people who were identified as needing two hourly turning or position change were not receiving this care. We saw gaps in charts that indicated people had not had their position changed for up to six hours. The audits undertaken had not identified this as rather than people not being helped to turn but could not assure us that people were in fact receiving two hourly care as required. We also saw that for some people identified as at high risk of pressure damage they did not have a chart in place even though daily records identified skin redness. Senior staff were not sure whose responsibility it was to review the 24 hour monitoring charts that were used to inform care delivery and changes to people's health and welfare needs.

Staff said they had staff meetings but these were not seen as regular or that many staff attended. We looked at the last minutes of the meeting which took place in 22 June 2015 with seven staff in attendance. There had been no further staff meetings. Staff therefore were not able to raise ideas for improvement or for sharing their concerns . One staff member said, "More staff meetings are needed because changes in the organisation are happening but we are not all aware and can't discuss them as a team."

Residents meetings had taken place in May 2015 and in September 2015. At the most recent meeting in September 2015 there were quite a few issues that were raised by residents. There was no action plan evident of how these issues would/might be addressed or any formal feedback to residents to ensure confidence that their concerns and complaints were being listened to. Some complaints referred to the menu choice of dessert at supper time where people didn't want a particular dish on the menu. When we looked at the menu they had been no changes.

There were a number of people living at Cornfield House under a tenancy agreement. During conversations with the registered manager we found there was a lack of clarity of how this worked for people especially those who lived with a dementia type illness. There was no evidence to support this decision and no best interest meeting to discuss how this decision had been made.

The failure to have a system that effectively monitored and assessed the service with the intention of making improvements is a breach of Regulation 17 1 (a) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

A number of audits had been introduced, including for care plans, which had identified that additional training and support was required to ensure care staff updated the care records when people's needs changed. Staff said that they received guidance and support in completing documentation. Medicine audits looked at record keeping and administration of medicines and the manager said action would be taken through the supervision process if issues were identified. The audit systems for medicines were seen as very thorough and undertaken each day by a registered nurse.

The registered manager told us about their philosophy of care and said they had developed a system that was based on meeting the needs of each person, providing the care and support they needed in a way that they wanted it. We did see many examples of warm interaction throughout the inspection when staff assisted people. However despite the registered manager describing how they felt they made sure people got the care they needed we found a number of shortfalls that not everyone got the care they needed safely, effectivly or in response to their personalised needs. There were a number of breaches of the regulations and areas that need to be improved to enable the registered manager to assure everyone that their philosophy of care is in place and achieveing the aims.

Staff were positive they could provide individual care and that people benefitted from the relaxed and inclusive way the home was managed. We observed if people wanted to do an activity they could, there were no specific times for people to get up or going to bed, and meal times to a certain extent were flexible, so that people could have their meal when they wanted to.

Staff said the registered manager had an open door policy and staff and people were able to go to the office at any time. The registered manager was available for people and staff, and involved with the provision of care and support. Staff said they had confidence in the management of the home and they felt well supported. One member of staff said, "I feel supported and listened to. She is a good manager, will listen and give advice." Another one told us, "I think we are well led, we want to improve and I think everyone who works here wants to give good care." Another one said, "More staff meetings and would be really good to have separate meetings for different teams and then one big meeting with everyone from all departments." This was said by a number of staff.

Staff said there were clear lines of accountability. They were aware of their colleague's role on each shift and, they felt they worked very well together as a team. Staff were clear about their own role and responsibilities and felt that there were systems in place to deliver a good service.

The provider had informed CQC of any issues that might affect the safety of people living in the home. Such as safeguarding concerns raised by the local authority. The manager said she used the notification system to inform CQC of any accidents, incidents and issues raised under safeguarding and we were able to check this on our system. We found information had been sent to CQC within an appropriate timescale.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that service users received person centred care that reflected their individual needs and requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured that the nutritional and hydration needs of service users were met. The provider had not ensured that there was sufficient support provided for a service user to eat or drink.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs.