Cornford House Limited

Cornford House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out on 13 and 14 September 2018 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, 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; 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 53 tenants living in the service. The service provides nursing care across all floors. The second floor supports people living with dementia or mental health needs, some of whom also require nursing care. People had varying care and support needs. Some people were living with dementia, whilst others had diabetes, Parkinson's disease and physical disabilities.

There was a registered manager employed at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection on 13 and 14 July 2017, we found that the registered provider 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 needed to be embedded and improvements needed to be sustained over time. At this inspection we found that new systems were embedded and sustained and the service that people received had improved.

People were kept safe and staff were knowledgeable about reporting any incidents of harm. Staff received training in safeguarding people from abuse. Staff demonstrated that they understood the signs of abuse and how to report any concerns in line with the registered provider's procedures. People's needs were met by sufficient number of staff who had undergone safe recruitment checks.

Risk assessments were in place and reviewed regularly to minimise the potential risk of harm to people during the delivery of their care. People's care records were held securely and these records were reviewed and any changes to people's care and support needs had been recorded.

Medicines were administered to people in a safe way. Records for the administration of medicines were maintained and medicines were stored safely.

Before people moved into the service they had their needs assessed to ensure the service could meet them. Once people moved into the service, detailed person centred care plans were prepared, with important

information recorded to assist and guide staff to meet people's needs.

People had access to nutritious food and refreshments. Support was offered to maintain dignity and respect to those who could not fully manage themselves. This included, for example, help with meals, personal care and mobility.

People had access to healthcare professionals and their healthcare needs had been met. Care records seen confirmed visits from healthcare professionals had been recorded.

Systems involving digital technology were used and these enabled the service to provide care and support tailored to people's requirements and preferences. It also helped the service move forward. People participated in activities they enjoyed and were encouraged and supported to socialise. People were supported to maintain relationships which mattered to them.

Staff understood people's needs and treated them with respect, kindness and dignity. Staff communicated with people in the manner they understood. Staff supported people to express their views. People and their relatives were involved in their care planning and their views respected.

Staff had the necessary guidance when they required it and were appropriately trained for their role. Staff supported people to make decisions for themselves as legally required by the Mental Capacity Act 2005 (MCA).

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. Mental capacity assessments had been conducted and Deprivation of Liberty Safeguards had been submitted to the local authority.

People knew how to raise a concern or make a complaint and were confident that if they did, the management would respond to them appropriately. Effective systems were implemented to manage any complaints that the service received.

The environment was safe, clean and hygienic. Staff wore protective clothing such as gloves and aprons when needed. This reduced the risk of cross infection. Suitable checks were made on the premises and equipment to ensure they were safe. Emergency contingency plans were in place in case of emergencies.

Systems were in place for monitoring the quality of service provided and the management team was open, transparent and visible during the inspection process. Action plans had been developed, lessons were learned when things went wrong and when improvements needed to be made. This helped to ensure the people that lived at Cornford House received a good quality service.

The provider had submitted statutory notifications and had displayed its inspection rating in the service and on its website as legally required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected by the safeguarding practices in the service and staff were confident in reporting any suspected incidents of abuse.

People had sufficient risk assessments in place which ensured they were provided with safe care.

People's medicines were managed safely.

There were sufficient numbers of staff to meet people's needs. Robust recruitment procedures were followed to employ suitable staff at the service.

Is the service effective?

Good

The service was effective.

Staff were supported through regular supervision, annual appraisals and training.

We observed a positive lunchtime dining experience where people were supported by staff with their meals when this was required.

People had access to healthcare professionals when they needed it.

The service monitored people's ability to make decisions for themselves and provided support to people when they were unable to do so as required by the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

People and their relatives were positive and complimentary regarding the caring nature of staff at the service.

We observed kind and caring interactions between staff and those who lived at the service. Staff spent time talking and socialising with people

People and staff were treated equally. Staff were aware of people's religious and cultural preferences. Records confirmed people had been involved in decisions about their care.

People were respected, their dignity was maintained and where possible independence was encouraged.

Is the service responsive?

Good

The service was responsive.

The care plans we saw were well written and person centred documents. They included people's likes, dislikes and preferences.

Technology was used in the service to provide tailored support to meet people's needs, keep them engaged positively and reduce social isolation.

There was a system in place to manage and record complaints and compliments.

The service supported people at the end of their life to have a comfortable, dignified pain free death.

Is the service well-led?

Good

The service was well-led.

People who used the service, relatives, key professionals and staff were all positive about the management team and the changes they had made since commencing their roles.

Regular quality assurance checks were carried out to identify any improvements required and actions were taken in good time as necessary.

People, relatives and staff had ways to feedback to the provider through surveys and meetings.

The registered manager submitted statutory notifications to the Care Quality Commission when these were required.

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

This inspection took place on 13 and 14 September 2018 and was unannounced on the first day.

The inspection was carried out by two inspectors, two experts by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. A specialist advisor is a person who specialises in a particular area of health and social care.

Before the inspection we reviewed information we held about the service. This included statutory notifications. A notification is information about important events which the service is required to send to us by law. We also looked at a Provider Information Return (PIR). The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with 16 people who used the service and seven family members/visitors.

We spoke with the provider, registered manager, assistant manager, practice development manager, clinical lead, three registered nurses, one senior carer, two carers, one cook, the activity coordinator, one social assistant and a member of the domestic staff. We observed staff interaction with people and looked at a range of records which included the care records for eleven people.

We also looked at other documentation, which included medicine records, four staff files, training information, minutes of meetings, surveys, audits of the service and other quality monitoring systems.

Following our inspection, we contacted key professionals involved with the service to obtain their feedback.

Good

Is the service safe?

Our findings

People told us they felt safe. One person told us, "I feel perfectly safe." Another person said, "I feel safe because no one can get in at night." Relatives also felt their loved ones were safe living at Cornford House. Comments from relatives included, "My family member receives safe care", and "there is always someone around."

A social care representative involved with the service commented, "We have no reason or evidence to report that the service is not safe. The management team ensures that returning information as part of their improvement cycle is in place. They also follow up on any quality concerns that they raise themselves within the service."

Policies and procedures were in place for whistleblowing and safeguarding adults from abuse. Staff understood their responsibilities to protect people from potential harm and abuse. Staff told us they would ensure that people were safe and would approach the management team for guidance if they suspected any abuse was taking place. The registered manager understood their responsibilities to protect people from abuse including raising an alert, investigating concerns and reporting to CQC. The service had a system in place to record relevant information on reported safeguarding concerns, including any external social and healthcare professionals involved. This helped the registered manager to monitor the actions taken to protect people. Safeguarding procedures were discussed at staff meetings and management meetings so staff were up to date with what actions to take if they had concerns.

Risks to people were identified and assessed. People and their relatives were involved in assessing risks identified. There were risk assessments in place for falls, moving and handling, nutrition, skin care and infection prevention. Risks were identified and the action needed to minimise these risks were recorded. Staff told us that the assessments provided them with the information they required to keep people safe, reduce the impact of risk, and provide appropriate support to people. Risk assessments had been reviewed regularly and updated when people's needs changed.

People received their medicines as prescribed and these were managed in a safe way. Only qualified nurses and care workers trained and assessed as competent could administer medicines to people. The service used an electronic barcoded system to manage medicines. Medicines were scanned using an electronic pad. Each person's details, including their photos, were recorded on the system, with all their prescribed medicines. Each nurse had their own personal identification number stored on the system so it recognised and recorded who administered the medicine and at what time. One nurse told us the system made medicine administration very easy and reduced errors as it would not allow staff to give the wrong medicine and dosage if these were not due.

Medicines were stored in locked trolleys in the treatment room. These were secured to the wall and were accessed by authorised staff only. The room and fridge temperatures were monitored and recorded daily to ensure the potency of medicines was kept at a safe level. There were systems in place for checking medicines received and for returning unused medicines. Senior staff and qualified nurses carried out

medicine audits and checks to further reduce the risk of mismanagement.

During our inspection we observed staffing levels were meeting the needs of people and there was always someone available to provide support when people needed this. When we asked people and their relatives about staffing levels in the service, most told us there were enough staff to meet their needs. However, a minority felt more staff would be beneficial. One person told us, "Sometimes no, particularly at the weekends, people's needs have changed but they haven't increased the number of staff." Another person said, "I regularly use my call bell, if they can't come immediately they pop their head around the door and tell me how long they will be." A relative told us, "There does seem to be plenty of staff and [relative] has a call bell in their room which I have observed being responded to promptly."

We discussed staffing levels with the registered manager who informed us and evidenced that staffing levels had been increased since our previous inspection. They were also in the process of recruiting more care staff to ensure sufficient cover was available when staff were on leave or attending training.

The service had a robust staff recruitment system in place. The provider obtained applicant's full employment history including explanations for any period of unemployment. Satisfactory references, criminal record checks, proof of address, identity and the right to work in the UK were also checked. Records showed that registered nurses had up to date registration with the Nursing and Midwifery Council (NMC). The NMC is the regulator for nursing and midwifery professions in the UK. This process assured the provider that employees were of good character and had the qualifications, skills and experience to support people living at the service.

Staff and the registered manager understood their responsibilities to record and investigate any accidents, incidents and near misses that may occur. Where incidents had occurred within the service, these were reviewed by the management team and actions were taken as necessary. Any concerns were regularly shared with the staff team through handovers, team meetings and staff supervision to enable learning and to improve practice. Records were updated to reflect any changes in people's needs to enable staff to support people in a safe way.

The service ensured that the environment, premises and equipment were safe for people. Environmental risk assessments were carried out. Health and safety equipment was checked and serviced regularly by external contractors. The maintenance staff also conducted regular health and safety checks of the environment including testing of the fire safety system. Staff knew what actions to take in the event of a fire to keep people safe. There were clear evacuation procedures displayed around the service on how to evacuate the building safely. Records showed that the fire safety procedure was practiced regularly through fire drills to ensure staff felt confident to apply it in emergency situations.

There were emergency plans and a business continuity plan in place. This helped to ensure staff were aware of the correct procedures to follow in the event of an environmental emergency, such as fire, flood, utility disruption or adverse weather conditions.

The service had procedures in place to reduce the risk of infection. We saw that all areas of the service were clean and tidy, and that regular cleaning took place. Relatives commented, "We can't talk highly enough of the cleaner" and "the service is always tidy and clean." Staff had received training in infection control and food hygiene. They used personal protective equipment (PPE) where required, such as gloves and other items of clothing that protected people from the spread of infection. Each person had their personal sling used for hoist transfers. This also reduced the risk of infection. There were hand-washing facilities, paper towels, and hand sanitisers in the toilets and at various points in the service.

Good

Is the service effective?

Our findings

People and their relatives told us they felt the staff were trained, experienced and competent in their roles. One person told us, "The day staff are excellent, especially the nurses, you cannot fault them." A relative said, "They are very well trained, they know exactly what they are doing and the hoisting is excellent."

An external health professional commented, "The staff do receive regular training, and certainly interact well with residents and families."

Newly recruited staff were given an induction and staff told us this was useful and relevant to their job role. The induction programme was in line with the Care Certificate. The Care Certificate sets out the learning competencies and standards of behaviour expected of care workers new to care. New staff worked alongside more experienced staff until they were ready to work with people.

Staff received regular training and were supported and supervised. One staff member told us, "I have access to training whenever I need this. They are a mixture of e-learning and classroom based." Training records showed staff had completed courses the provider considered mandatory and essential to supporting people appropriately such as safeguarding, medicine management, equality and diversity, infection control, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff also completed training in Dementia awareness, Parkinson's, end of life, epilepsy, catheter care, oral health care and posture care. This helped the service to meet people's specialist needs. Training needs were discussed with staff during supervision and appraisal meetings. Staff had regular supervision meetings where they were able to have discussions about people, health and safety concerns and other matters relating to service. Actions from previous supervision meetings were reviewed. Appraisals were conducted annually where staff received feedback on their work performance.

Handover discussions took place at the end of each shift and staff change, where staff passed on important information about each person care needs and support provided. This ensured that all staff had this information before starting their shift. The handovers gave staff an overview of how people were and if there were any appointments or other arrangements they needed to know about or things they needed to do for people.

Care plans contained detailed information about people's care needs and the information was captured in an assessment form that had been completed prior to them joining the service. People's needs were assessed and delivered in line with current standards, for example each person's initial assessment included information such as their life history, communication, sexuality, religious beliefs, health needs, mental health needs, social and physical needs, personal safety and end of life.

The registered manager and staff were aware of their responsibilities and followed correct procedures regarding the Mental Capacity Act 2005 (MCA). People were encouraged to make decisions about their care and their day-to-day routines and preferences. 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA.) The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA 2005, and whether any applications had been made to deprive a person of their liberty. Eight people were subject to a DoLS which had been applied for and authorised (or awaiting approval) via the local authority. The service had a system in place to record, monitor and keep track of all the applications made.

Staff understood the importance of allowing people choice and gaining their consent. Where consent was not possible due to a lack of capacity, best interest decisions had been made with people's family, GP's, pharmacist, staff and other healthcare professionals involved. For example, one person received covert medicines which had been recorded in their care records. The registered manager ensured that any decisions made in people's best interests were fully recorded.

People had support to meet their nutritional needs as required. The service was working with a well-known food expert organisation to help them develop the service's menu and to provide guidance to the catering staff on how to improve their skills in presenting the food they prepared. People told us they liked the meals provided. Picture and written menus were both available to people. One person said, "The food is wonderful, it's varied and colourful." A relative told us, "[Person] does not eat as well as I'd like but she's getting a good enough diet." One person told us they preferred to purchase their own food from their preferred high street shop. Their family also brought home prepared meals for them, which were kept in their fridge and staff supported the person to reheat these when required. The person said, "The food they serve here is adequate, but I like my [shop] meals."

Care records reflected people's dietary needs and staff knew people's individual needs in relation to food, for example, if a person had swallowing difficulties and required their meals to be liquidised. We observed staff interacting appropriately with people during lunch time and they showed respect to people who required assistance to eat their meals.

The service used the Malnutrition Universal Screening Tool (MUST). MUST is a five-step best practice screening tool to identify adults who were at risk of malnutrition or who were obese. Where staff had identified weight loss in people, they had provided appropriate intervention, including fortifying foods and drinks. GP's and dieticians had been kept informed of the weight loss and the actions staff were implementing.

People's health care needs were documented in their care plans and the service supported people to access healthcare professionals as needed. Care records showed that risks related to people's health conditions were identified and managed as required. The service made referrals to healthcare professionals in good time to ensure people's good health. Records showed that people received input from dietician, GPs, occupational therapists, speech and language therapists, hospice and optician. Recommendations made by the healthcare professionals were incorporated into people's care plans for staff to follow as necessary.

Staff maintained charts with records of people's food and fluid intake, pressure care and hygiene needs. These were detailed, for example, the daily amounts of fluid taken had been calculated, to ensure early recognition of inadequate fluid intake and the pressure care charts for people were in accordance with the

positional change instructions within their care plans.

People's needs were met by the adaptation, design and decoration of premises. There was a range of communal areas available for people to spend time in and we saw that people were supported to move freely around the service. People's rooms were comfortable and personalised and any equipment they required to meet their needs was readily available, for example, hoist to support them to transfer safely. The dementia care unit had been tastefully decorated, in accordance with guidance around environments for those who live with dementia. Good signage was evident. This helped with orientation for people to walk around safely. There was accessible garden space with many seating areas and a gazebo for shading, and people had space for privacy when they wanted it.

Good

Is the service caring?

Our findings

People told us they received good care from a kind and caring staff team. They told us staff respected their privacy and dignity and would ask for their consent before carrying out any tasks. Comments from people included, "The staff are all lovely, really lovely. Even the manager comes to see us and has a chat with us" and "They are very very kind and caring; the nurses have a great empathy for people."

Relatives said, "They are all genuinely caring people, even though mum is unable to communicate they do their best" and "I do think staff care, they seem to be doing the best they can."

We observed positive interactions between staff and people. We saw staff providing kind and compassionate support to people throughout the day, and independence was promoted as far as possible. On occasions it was necessary for staff to manage situations which were challenging. This was done in a sensitive and appropriate manner, which reassured people and provided them with the support they needed. During our inspection, we saw staff consistently demonstrating caring skills towards people. The staff team knew people well and had an excellent rapport with them. People were seen to be treated equally and all were offered the same opportunities.

We observed staff taking time to chat with people and cheering them up. One person told us, "There is lots of laughter in here, they always take the time to have a little chat, they really do go the extra mile." We observed staff were relaxed and spent time chatting to people. They responded patiently to people calling out to them.

The service had successfully piloted the use of a digital activity programme and this was going to be enrolled in other sister services. The programme involved the use of a specific tablet where people's information about their lives, likes, life history, family and photographs were stored. The service worked closely with relatives and friends who brought in their loved one's photographs of their younger days and when their families were younger, as well as grandchildren. Films could be uploaded as well as different types of music, for example, church music and music by decades according to people's interests and preferences. This meant that staff could tap in to the activities people enjoy based on their life history through the tablet.

The tablet could be taken to people's rooms when they were cared for in bed, to engage them in activities which suited their interests and reduced social isolation. Staff showed us how the tablet worked by giving a demonstration and showing examples of people's individual profiles. It stimulated conversations. We observed this to be an extremely enjoyable experience for people. Staff also showed us a paper file that was being developed from the information gained from the one to one sessions with people and this information was being used to pass information on to the day to day staff to enable them to get to know the residents more quickly and better. All staff were trained to use the tablet, including domestic staff so any staff could engage people with it.

Feedback from staff following the activity sessions included, '[Activity programme] really calmed [person]

down when they were getting distressed in the afternoon. I was able to distract them and before long they were giggling away to a TV programme they hadn't seen for years' and 'This was the first time I saw this person laugh in around 6 months. It was amazing to see and such a pleasure to be there for this moment.' Relatives were also positive and they said, 'I have observed [programme] being used with mum and it makes a real difference to her day… this has supported her to stay in touch with her memories with staff' and 'I really felt that mum's memory had completely deteriorated but I have been proved wrong! After setting it up we could use it with mum and she can remember some of those early memories really well.'

Staff were aware of people's communication needs and the support they required to feel comfortable. We saw staff getting to people's level when talking to them so the person could hear them better. We observed staff having conversations with people and they used simple language to encourage people to interact and share their memories. One person who was hard of hearing, refused to wear hearing aids and was very good with written communication. In their care records it was clearly documented how to communicate effectively with the person. For example, the care plan stated, 'Staff to use papers or board to communicate' and 'Needs to feel [person] is understood, so staff to listen and spend time to communicate well through writing.'

Staff respected people's wishes in accordance with the protected characteristics of the Equality Act. People were supported to maintain relationships with friends and family. One person told us, "My daughter can come anytime, she's always welcome." Another person said, "My family can drop in whenever they like, and they take me out when I feel like it." People had also developed and formed close friendships with other people living at the service.

People's privacy and dignity was respected by staff. We saw that staff knocked on people's doors before entering, and that care plans outlined how people should receive care in a dignified manner. People had access to privacy screens which could be used in the event of an emergency in communal areas. Staff told us this would be used to ensure people's privacy and dignity was protected and maintained at all times. We observed staff were respectful in their interactions with people. People's confidential information was protected and kept securely.

The registered manager and staff were aware of the need to support people to access advocacy services when required and advocacy information was available to people. An advocate is an independent person who can help people to understand their rights and choices and assist them to speak up about the service they receive.

Good

Is the service responsive?

Our findings

People felt that staff knew their care and support needs well. One person told us, "The staff have made the effort to get to know me, I can't speak highly enough about them."

Care plans were personalised and contained information about people's care needs and preferences. People's care plans covered areas related to moving and handling, life style, communication, mental well-being and skin care. Records showed that people's complex health needs were identified and support plans were put in place in response to their needs. Care plans were managed electronically. With people's consent, relatives could access the electronic care planning system; they could log in and see the care given to their relatives throughout the day.

People had a life story and interest folder. These were well set out and contained a personal details sheet with the person's photograph, their last address, medical history and life story. The areas of particular interest within the life story were highlighted so staff could easily see what to focus on. For example, [Person] likes knitting, crochet and reading, had holidays on the isle of Wight, and likes all types of music. A paper copy of the information held on the digital activity programme was also kept in the file. The folder was used to enable a quick and easy reference for staff, particularly new staff to pick up and use.

Staff we spoke with confirmed relatives and friends were very supportive and involved in the care of their loved ones. It was evident from the records we saw that care plans had been regularly reviewed and any changes in need had been recorded. External healthcare professionals had been involved in the care and treatment of those who lived at the service. This helped to ensure that people's health and social care needs were being appropriately met.

The activity coordinator and social assistants were visible and were seen to be positively attempting to encourage people to join in activities, although choices were always respected if people preferred not to participate. A range of activities were available for people. Activities schedules and information about activities were clearly displayed around the service. Staff involved people in tasks to encourage them to maintain their independence in the areas they could. One person told us, "I am the postmistress for the building; I sort the post in the morning and distribute it to people's rooms." We saw people participating in a crossword activity followed by flower arranging for the local church flower festival. On the days of the inspection, there was nice relaxing music playing at a low level throughout the morning, with no television on. People were reading newspapers and magazines. Staff were available in the lounge throughout the morning. Staff took people down to have their hair done at the on-site hair salon.

The service had started to use a specialist methodology for one to one activities which was specifically designed for people with memory loss and dementia. Although in the early stages of development staff have found this to work well with some people. There were baskets set out in a bookcase in the lounge with activities such as matching the colour, sorting the cutlery and folding items. Each basket was clearly labelled with the task to complete, for example, yellow card with black writing, as staff had learned through workshops that words stand out clearer for people and so they are more able to read. There were other

notices in the lounge which were displayed in the same way such as 'read a magazine'. This provided opportunities for people to be able to self-initiate activities by providing repetition of tasks based on people's past interest and strengths.

The service had a 'Commonwealth Day' at the end of June. A tea party was held and relatives were invited. A large cut out board of the queen was on display and banners of Commonwealth flags were hung around the lounge, giving the communal area a party atmosphere. Many photos were taken and copies given to relatives where requested. People were able to have their photo taken with 'the queen'.

The service had a complaints procedure in place which included timescales for responding to any complaints received and details of who people could contact if they were not satisfied with the response from the service. People told us, "If I had a problem I would go to the manager she is often around" and "I'd be happy to talk to the manager." A relative said, "I can make a complaint to the manager if I had to."

The service supported people at the end of their life to have a comfortable, dignified pain free death. The service followed the End of Life (EoL) care pathway which lists the six steps to follow as identified by the Department of Health (DoH). This was reflected within people's care plans and people were supported to make choices about their death and the plans they wished to implement before dying. For example, we saw evidence of discussions that took place regarding where a person wanted to spend their end of life, DNAR decisions, assessment, care planning and review, coordination of their care, delivery of high care services; care in the last days of life and care after death. Details of funeral plans were also recorded.

Feedback from relatives included, 'Thank you from all the family for the wonderful care that [person] received while they were at Cornford House, from the beautiful sunny room to the hard work and friendliness of all the care staff, not forgetting the hairdresser, kitchen and laundry and everyone who worked to make her time with you the best it could be' and 'I would like to thank you for the love and care you gave to [person] for the time he was with you and how you also looked out for me.'

Good

Is the service well-led?

Our findings

People and relatives we spoke with, spoke highly of the service and the way it was run. One person told us, "[Registered manager] is very efficient, she has a good senior presence in the service but is approachable and gentle." A relative said, "The manager is easy to talk to, I feel very comfortable with her."

An external social care professional commented, "Absolutely well led, with good support from increased management staff, who ensure quality and continuity."

The service had a registered manager in place. 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 registered manager was supported by a management team, which included an assistant manager, a practice development manager and a clinical lead. The team provided support to the staff team at the service. The registered manager understood their responsibilities in providing effective care service to people and fulfilling the requirements of their CQC registration. The management team had regular meetings where they supported each other, shared information and discussed plans to improve the service.

Staff said they had good support from the management team and the provider. Senior staff were approachable and listened to their feedback about the service. One staff said, "The managers are very good. They involve us and keep us updated on what's happening." The registered manager told us, "Staff have been brilliant in accepting the changes. Everybody here are very good with talking to people, their relatives and supporting them. I am proud of my team and what we have achieved over the last months."

The service had implemented robust quality assurance practices and these were fully embedded in daily practice. The business development manager had oversight of all audits. They completed an in-depth and comprehensive monthly practice development report, with an action plan, which was presented in the monthly senior management and provider meeting. The report looked at various aspects of the service such as resident/relative surveys, care plan reviews, daily care recordings, call bell response rates, complaints and compliments, safeguarding, social programme, food, unplanned hospital transfers, accidents and falls, pressure ulcers, infection, training, care practice, medicines and recruitment. We saw that the service took action where this was required. For example, it was identified that more blue plates were needed as they were chipped and needed replacing. We checked and this had been actioned.

In addition to the above, a daily report for the call bell was produced, which was analysed by the registered manager and the business development manager to identify any trends. Any discrepancies were promptly investigated, for example, they identified a fault in the system and had since started the process to have the call bell system replaced as the current one had become obsolete. Other audits included call bells, infection control and medicines.

The service had a positive and open culture that encouraged people using the service, relatives and staff to influence the development of the service. People, relatives and friends had the opportunity to give their views on the quality of the service provided. There were regular meetings for them to attend. One relative said, "I have attended relative/resident's meetings." The provider regularly sought feedback from people through meetings, feedback forms and surveys. We saw that quality questionnaires were completed by people's relatives, which enabled them to provide their view of the service their relative received. The service sent out surveys to relatives every six months. They were in the process of analysing the results and were planning to feedback to people and their relatives in a forthcoming meeting.

The registered manager worked in partnership with other organisations to make sure they were following current practice and provided a quality and safe service for people. These included social services, district and hospice nurses, GP's and other healthcare professionals. They also maintained links with the local school and children came to visit the people living in the service. One person who was previously in the teaching profession, read a book to the children. The service organised annual fairs to raise funds for local organisations and also raised funds for the Kent Air ambulance service.

The registered manager had submitted notifications to the Care Quality Commission (CQC). A notification is information about important events that the service is required to send us by law. It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating as required.