Cornford House Limited

Cornford House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 12 and 13 December 2016 and was unannounced. Cornford House is a purpose-built modern building and provides accommodation and nursing and personal care for up to 70 people. Cornford House is registered with the Care Quality Commission (CQC) to provide accommodation for up to 70 people but a total of 81 can live and receive support within the building. Cornford House also provides personal care and/or nursing care for people who rent or buy their accommodation within Cornford House. There were 73 people living at Cornford House during our inspection; of which 25 people were receiving accommodation and nursing care and 48 people were renting their accommodation and receiving nursing and/or personal care. The service provides nursing care on the lower ground floor, ground floor, first floor and the second floor. The second floor supports people living with dementia or mental health needs, some of whom also require nursing care.

The service has a registered manager, who was present throughout the inspection. 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 and associated Regulations about how the service is run.

Cornford House was last inspected in January 2016 where a number of breaches of the regulations were identified in staffing, nutrition, person-centred care, and governance and it was rated Requires Improvement. The provider sent us an action plan to tell us what actions they were taking to implement those improvements. At this inspection, we found the provider had made improvements to person-centred care and meeting people's nutritional needs but the provider continued to breach the regulations relating to the other areas. Further areas of concern were also identified at this inspection. We also found a new breach of person-centred care.

Staffing levels had been increased since the last inspection. However, people continued to have concerns over response times to call bells. The deployment of staff and visibility of staff on certain floors was not sufficient. This added to people's risk of social isolation.

The management of medicines was not consistently robust. Risk assessments for self-administration of medicines were not in place. Pain assessments had not been completed and protocols for the use of 'as required' medicines were not consistently in place. Checks were not in place for the use of emergency equipment.

The principles of the Mental Capacity Act (MCA 2005) were not embedded into practice. Assessments of capacity had not been considered for decisions such as the use of bed rails, inability to use call bells and consent to care plans. Where people had lap belts done up whilst using wheelchairs, the rationale for this restriction was not consistently recorded.

Where people could not safely use their call bells, robust risk assessments were not in place. The

management of continence required improvement. Person centred care plans and risk assessments were not in place to manage people's continence needs.

The risk of social isolation had not adequately been addressed across all floors. Some people commented they felt lonely. One person told us, "Yes, I am lonely." Improvements were required to make care plans person centred.

End of life care plans were in place. However, these were not consistently personalised. We have identified this as an area of practice that needs improvement and have made a recommendation about the review of end of life care plans.

Fire evacuation procedures were in place. However, people's individual ability to evacuate the building had not been assessed and consideration had not been given to the factors which may prevent a safe evacuation. The provider had identified this as a concern and was in the process of implementing new fire evacuation plans for people.

People's dining experience varied. People had mixed opinions over the quality of the food provided. One person told us, "Food is terrible, I don't like it much." The presentation of pureed food required improvement.

The risk of people experiencing harm and or abuse was increased because staff's knowledge of adult safeguarding varied. During the inspection, a safeguarding concern was raised which was still being investigated at the time of writing this report.

Quality assurance systems failed to consistently drive improvement and identify shortfalls.

People spoke highly of the group activities provided. The provider and staff worked in partnership with the project 'Ladder to the Moon.' People spoke highly of the social coordinators and consideration had been given to making activities meaningful for people living with dementia.

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.

Staff had a good understanding of people's needs and treated them with respect and protected their dignity when supporting them. We saw many positive interactions and people enjoyed talking to the staff. The importance of promoting independence was understood by staff and staff told us how they protected people's privacy and dignity. 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.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate enforcement action, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Cornford House was not safe.

Where people were unable to use their call bells, robust risk assessments were not consistently in place. The management of medicines required improvement. Not all risks had been assessed.

The provider's internal systems to protect people from harm and/or abuse were not consistently robust. The deployment of staff and visibility of staff was poor.

Appropriate checks were undertaken to ensure suitable staff were employed to work at the service. Risks associated with moving and handling were in place and reviewed monthly. A business continuity plan was in place and risks associated with the environment were monitored and reviewed.

Is the service effective?

Requires Improvement

Cornford House was not consistently effective.

The principles of the Mental Capacity Act 2005 were not embedded into practice.

People's meal time experience varied. People were not consistently aware of the meal options available and the presentation of the food required improvement.

Staff received appropriate training and support to enable them to meet people's health care needs effectively. People had access to external healthcare professionals such as the GP and district nurse when they needed it.

Is the service caring?

Good

Cornford House was caring.

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. Staff ensured that people's equality

and diversity needs were respected.

People's privacy and dignity was respected by staff.

Is the service responsive?

Requires Improvement

Cornford House was not consistently responsive.

The risk of social isolation had not been fully mitigated. Some people spent large amounts of time in bed and commented they felt lonely. Care plans were not consistently person centred.

People and their relatives knew about the home's complaints procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

A wide range of group activities took place which people enjoyed.

Is the service well-led?

Inadequate

Cornford House was not well-led.

Although systems were in place to monitor the quality of the service, they continued to remain inadequate in identifying shortfalls. Actions to drive improvement had not been embedded or sustained.

Statutory notifications were submitted to the Care Quality Commission. Staff spoke highly about working at the service and the leadership of the registered manager.

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 12 and 13 December 2016 and was unannounced. The inspection was carried out by two inspectors, an inspection manager, a specialist advisor with nursing expertise 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 13 of the people living in the home, four relatives, six care staff, five registered nurses, a social coordinator, chef, deputy manager and the registered manager. We observed staff supporting people and reviewed documents; we looked at 12 care plans, all medicine records, four staff files, training information and some policies and procedures in relation to the running of the home. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We observed care and support in the communal lounge and dining area and spent time observing the lunchtime experience for people and the administration of medicines.

Cornford House was last inspected on the 28 January and 01 February 2016 where concerns were identified and the service was rated as Requires Improvement.

Inadequate

Is the service safe?

Our findings

People told us the design and layout of the building made them feel safe. One person told us, "I can wander around into other areas freely because I know I am safe." However, people and their relatives felt staffing levels could be improved. One person told us, "No I don't feel safe, no one comes in."

At our last inspection in January 2016, the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because staffing levels were not always adequate to meet the needs of people and the deployment of staff was not sufficient. A recommendation was also made to review the fire evacuation procedures with the local fire brigade. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by May 2016. At this inspection, we found changes had started to take place but further improvements were required to ensure compliance with the regulations and the safety of everyone at the service.

Staffing levels had increased since the last inspection. Staffing levels on the second floor had increased to four care staff in the morning and afternoon. The registered manager told us, "We try and get feedback from staff as well on how they find staffing levels. Following feedback from the night staff, we have increased staffing levels at night to seven care staff and plan to increase this to eight in the New Year." Most staff felt staffing levels were sufficient. One staff member told us, "Yes I would say staffing levels are sufficient. It allows us to spend time with 'residents'." Another staff member told us, "It can be busy, especially depending upon how the 'residents' are. However, overall I would say staffing levels are good." However, some staff felt more improvements could be made. One staff member told us, "There should be more staff. There is not enough to cover breaks, deliver care and complete records." Staffing levels were based on people's individual assessed need and the number of hours care each person required. The registered manager told us how they used an organisational dependency tool which assessed how many hours of care people required each day. From the hours assessed, the number of staff required could be determined.

Throughout the inspection, we identified a large number of people who remained in their room all day. Some people preferred to remain in their room, whereas other people remained in their room due to reduced mobility. We queried with staff if they had time to spend one to one with people in their rooms. Staff members felt staffing levels allowed for this. However, people and their relatives did not echo this view. One person told us, "I don't feel that safe; there is definitely not enough staff. They don't always come at night when I ring my call bell. Sometimes it takes more than five minutes." Another person told us, "They don't sit with me. I spend all day in here." The deployment of staff also contributed to people not feeling safe. During the inspection, we found that on the first and lower ground flood, the visibility of staff was poor. Inspectors commented to the registered manager that they could walk around without seeing any staff. One person was calling out for help (this was there mechanism for summoning assistance) and was unable to access their call bell as it had been tied up and was attached to the wall. Inspectors had to ask a domestic member of staff for help as we were unable to locate any care staff.

People had mixed opinions to the response time of call bells. Some people felt call bells were answered promptly, while others felt they had to wait a significant time. One person told us, "My main problem is that

they don't come when you ring the call bell." At the last inspection in January 2016, we found that people had to wait in excess of 10 minutes before staff responded to their call bell. This was discussed with the registered manager at the time, who confirmed they would investigate. At this inspection, we asked to see copies of call bell audits to ensure that response times to call bells were being monitored and acted upon. The registered manager told us that formal audits were not taking place.

The provider had not fully embedded and implemented their action plan. People (both tenants and non tenants) told us that the poor deployment, visibility of staff and response to call bells made them feel unsafe. The above examples demonstrate a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care and support was provided to a high number of people living with dementia, frailty and old age. Where people were unable to use the call bell to summon assistance, robust systems were not consistently in place to assess that risk and assess how often people should be checked on. Throughout the inspection, we identified that most people had their call bell to hand. However, when we spoke to staff, they confirmed that due to people's care needs, they could be unable to use the call bell. This risk was not consistently assessed and actions were not put in place to mitigate that risk. For example, one person's elimination care plan stated they would not be able to call for assistance. However, within their safe environment care plan it was documented 'ensure call bell to hand at all times.' The care plan was contradictory and failed to identify how to safely manage that risk. This was a consistent theme throughout the home. Throughout the inspection, we heard a large number of people call out for help. Staff told us this was their way of summoning assistance as they were unable to use the call bell. This was not reflected in people's care plans. The layout of Cornford House and deployment of staff posed the risk that people could be in their rooms, calling for assistance for a significant length of time before they were heard. Well-being checks were not consistently recorded which meant it was difficult for us and the provider to be certain that people received regular checks.

The risk of people being unable to use the call bell had not been assessed and actions were not in place to mitigate those risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management of medicines required improvement. Medicines were stored safely and people felt confident with the administration of medicines. Medicine fridges were maintained and kept at a recommended temperature. Extreme temperatures (hot and cold) or excessive moisture causes deterioration of medicines and some are more susceptible than others. Documentation confirmed the temperatures of fridges and clinical rooms were checked on a daily basis and were consistently within the recommended limits. We spent time observing the administration of medicine. Medicines were given safely and correctly. Whilst administering medicines, staff preserved the dignity and privacy of the individual.

For people living with dementia or communication difficulties, they may not be able to verbalise they are in pain or discomfort. For people who were not tenants, pain management risk assessments or care plans were not in place. Therefore, there was no consistent mechanism in place for the measuring, understanding and assessment of people's pain levels. For example, one person was living with dementia and was not always able to verbalise their needs effectively. They were prescribed pain relief on an 'as required basis.' We asked staff if they knew when the person was in pain. One staff member told us, "Their facial expressions and signs of grimace indicate to us they might be in pain." However, this knowledge was not reflected in their care plan. For new staff members, this posed the risk that insufficient documentation would prevent them from recognising when people might be experiencing pain.

A number of people were prescribed as 'required medicines' (PRN). PRN medicines can be prescribed for people with mental health needs, people living with dementia and to help manage pain. PRN medicine should only be offered when symptoms are exhibited. Clear guidance and risk assessments must be available on when PRN medicine should be administered and the steps to take before administering it (this is required for both tenants and non-tenants). We asked to see PRN protocols but the management team advised that PRN protocols were not in place. The absence of PRN protocols meant the provider was unable to embed a consistent approach to the management and administration of PRN medicines. We brought our concerns to the attention of the registered manager who was responsive and agreed to implement protocols immediately.

Guidance produced by the National Institute for Health and Care Excellence advises that it is important for people living in care homes and receiving care in the community to maintain their independence, and that they have as much involvement in taking their medicines as they wish and are safely able to. A number of people at Cornford House were self-administering their medicines. However, risk assessments for the self-administration of medicines had not been completed. Risk assessments are important to determine what support a person may need. Periodic checks were also not in place to determine how the person was getting on with the self-administration of their medicines. Emergency equipment was available for people receiving nursing care in the care home, such as suctioning machine. However, regular checks were not taking place to ensure the equipment was in good working order and safe for use.

Failure to have pain assessments, PRN protocols, self-administration risk assessment and checks of emergency equipment is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in January 2016, a recommendation was made for the provider to review their emergency fire evacuation procedures with the local fire brigade. We confirmed with the registered manager whether this recommendation had been acted on. They confirmed it had not. The registered manager told us, "The fire evacuation list has been updated since the last inspection to ensure it reflects everybody's needs correctly but it has not been reviewed with the local fire brigade." The fire evacuation list detailed the names of all the residents, red signified being looked after in bed, blue was a wheelchair user and green signified mobile. However, for people who received care on the first floor and second floor and required a wheelchair to evacuate, in the event of a fire and the lifts not working, no information was available on the support required to safely evacuate. The registered manager confirmed that in that situation, the evacuation chairs would be utilised. However, this information was not recorded. The management team showed us copies of new personal evacuation plans they intended to roll out which considered each person's ability to evacuate and what may prevent a safe evacuation.

The risk of people experiencing harm and/or abuse was increased because the systems for identifying and reporting were not consistently robust. During the inspection, a safeguarding concern was raised by the registered manager. The concerns related to allegations of physical and psychological abuse which when first identified were not reported to the local authority. A month after the concerns were identified, they had been referred to the local authority and was being investigated at the time of writing this report. The registered manager told us, "In hind-sight, I did not handle this safeguarding concern appropriately and I'm kicking myself about that. I've already booked myself onto refresher safeguarding training." This demonstrated that the registered manager was aware of how improvements could be made and that recognised refresher training was an appropriate response to their continued professional development. Documentation confirmed that staff had received adult safeguarding training. However, staff's knowledge of adult safeguarding varied. When asked about safeguarding. One staff member told us, "It's about ensuring the equipment is safe to use." Another staff member told us they were yet to complete safeguarding training.

We posed an abusive scenario to staff who all recognised that situation was abuse. However, in light of the safeguarding concern above we raised concerns that staff had not potentially reported poor care to the management team and subsequently people had experienced care and treatment which did not uphold their rights. When talking to people, we asked them whether they felt safe living at Cornford House and if there was anything that made them feel uncomfortable or not safe. People told us that some staff made them feel uncomfortable. Terms were used such as, "One carer is a bully," and "I don't trust some of them." We brought these concerns to the attention of the management team to address as part of their safeguarding investigation. Supervision documentation also reflected that staff had raised concerns over the conduct of other staff which had not been reported as potential safeguarding matters in line with the local authorities safeguarding procedures. .

A safeguarding investigation was on-going; however, the provider's internal systems to prevent harm and/or abuse were not consistently robust. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment practices were robust. Staff records showed that before new members of staff were allowed to start work, checks were made on their previous employment. Files had copies of documents which verified people's identity and checks were made with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care and support. The registered manager checked the details of all the nurses who were on the Nursing and Midwifery Council (NMC) register to ensure they were safe to practice and held a valid registration.

Risk assessments were in place which considered areas such as falls, moving and handling, skin breakdown and epilepsy. These were reviewed monthly. Where people required the assistance of two staff members to move and transfer along with a mobility aid (hoist), risk assessments considered the equipment required, handling constraints and other factors which may prevent a safe transfer. For people requiring the support of an air mattress (inflatable mattress which could protect people from the risk of pressure damage), it is important that the setting of the air mattress matches the person's weight. Otherwise, it may increase the risk of a person sustaining skin breakdown. Mattress settings were recorded daily which reduced the risk of people received care on a mattress which was not set at the correct setting.

The management of diabetes was safe. At the last inspection in January 2016, diabetic risk assessments were not in place and guidelines were not available on the symptoms of high and low blood sugars. Improvements had been made. Robust risk assessments were now in place which considered the action in the event of a person experiencing high or low blood sugars. Clear guidelines were available for staff to follow. People's individual blood sugars were recorded and monitored on a regular basis. This allowed for staff to monitor people's blood sugars and take action appropriately.

Staff supported people who lived with behaviours that challenged others in a competent and safe manner. Risk assessments were in place which provided guidance for staff to follow and staff demonstrated a clear awareness of any potential triggers. We saw throughout the inspection that people were calm and staff were attentive to people's mood changes. For example, where people had become agitated, staff responded in a kind and gentle manner. During the inspection, we observed one person who called out frequently. Staff responded by offering reassurance and being responsive to their needs.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded. Health and safety checks had been undertaken to ensure safe management of electrics, food hygiene, hazardous substances, moving and handling

equipment, staff safety and welfare. There was a business continuity plan. This instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power. In the event of the building needing to be evacuated, a place of safety had been nominated.

Requires Improvement

Is the service effective?

Our findings

People told us they felt staff gave them effective support with their individual healthcare needs. One person told us, "The staff are well trained and know how to use the equipment correctly." Staff commented they felt valued and supported as employees. One staff member told us, "I enjoy working here. I've been supported to obtain NVQ level two and three and the manager is very approachable." Despite these positive comments, we found Cornford House was not consistently effective.

At our last inspection in January 2016, the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because people did not receive support to meet their nutritional needs. Adapted cutlery had not been sourced to promote independence with eating and people did not receive support in a timely manner. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by June 2016. At this inspection, we found changes had been made and the provider had met their action plan. People received adequate nutrition and hydration to sustain good health. However, we found a new breach of Regulation 9 as people's individual choices and preferences around nutrition were not being met.

Improvements had been made since the last inspection in January 2016. Staff told us how adapted cutlery and plate guards were available and used to promote independence with eating and drinking. This was observed in practice. A new hot trolley had been purchased since the last inspection which enabled meals to remain hot whilst staff waited to serve the meals. However, people and their relatives had mixed opinions about the quality of food. One relative told us, "The food has got a little better recently, the soup used to be horrible but its ok now." One person told us, "I don't care for the food there is no flavour." Another relative told us, "The food is not so good, and the evening food is not always enough, like salad or soup or sandwiches, sometimes they get crumpets and doughnuts for supper at 17.30pm. My aunt complains to me." Staff also commented that the quality of the food had been a cause for concern. One staff member told us, "The food has been an issue. However, a new chef is in post and people are beginning to notice the improvements." Another staff member told us, "Quite a few residents have complained about the food." The management team acknowledged that the quality of food had been an issue; however, since the appointment of a new chef, improvements were beginning to be noticed. One person told us, "There is no hot food at night and not enough although I think they have recently started to make improvements." The management team reflected that it would take time for the changes to be embedded.

Guidance produced by the Social Care Institute for Excellence advised that mealtimes can be a significant event in people's lives and supporting people with engagement can enhance their experience. On both days of the inspection, we observed the mid-day meal. Tables were neatly decorated and laid and people were asked where they would like to sit. A menu was displayed on various notice boards throughout the home and taken to people's individual rooms. However, on both days of the inspection, the weekly menu had not been delivered to people who remained in their room. This meant people only had access to last week's menu. The registered manager told us that the chef normally completed this task but was currently on leave and the interim chef had not completed this task. One person told us, "I don't know what's on offer today. We usually get asked the day before what we want for lunch, but I can't always remember what I've chosen."

Another person told us, "I have never had a menu they just tell me what I'm having." Another person told us, "I have no idea what I'm having today." We found the system for ordering and choosing food was inconsistent. Staff told us that people were asked the day before what they would like for lunch the following day. However we found people who ate in the communal dining rooms were asked what they would like from the menu but people who choose to remain in their rooms were often unaware of the choices available. We found this had a negative impact on people as their choice and decision was sometimes taken away from them.

On both days of the inspection, we found that people's dining experiences varied on each floor. For example, on the lower ground floor, we observed that people were supported in a timely and caring manner with eating and drinking. On the second floor, where people required one to one support with eating and drinking, this was provided in a kind manner. For example, staff sat down next to the person, allowing the person time between spoonfuls and giving them information on what they were doing, whilst asking, 'are you enjoying it?' However on the first floor, we observed interactions which did not promote people's dining experiences. For example, people's meals were left to get cool. When supporting people to eat, people were supported by various staff members instead of one staff member. Where people did not eat or finish their meals, staff did not regularly offer an alternative. This was a consistent theme throughout the home. We brought these concerns to the attention of the management team. They told us, "The impact of CQC and our external consultancy team both being here had an impact of staff and they acknowledge that lunch time on the first floor was not the best." On the second day of the inspection, improvements had been made; however, on-going concerns remained. On the lower ground floor, one person was not provided with a soft diet which they needed. A staff member told us, "I don't know why that food was given to them." Documentation also reflected that this person had not eaten anything on the first day of the inspection, but this had not been updated on the handover sheet to ensure staff encouraged food intake. The person's care plan also identified they been losing weight but a food chart had not been initiated.

The presentation of the food required improvement. For people at risk of choking or living with swallowing difficulties, a pureed diet was required. However, the presentation of pureed food was not appetising. The colour of the food ran into one another and the meal was served in a bowl. Guidance produced by the Alzheimer's society advised that making food look and smell appetising can stimulate an older person's appetite. We brought these concerns to the attention of the management team who acknowledged our concerns and confirmed they would seek guidance on the appearance and presentation of pureed food.

People's dining experience varied and the presentation of puree food required improvement. People were not routinely offered another choice of meal if they did not eat or finish their meal. People's food preferences and needs were not consistently sought or provided. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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. Staff members confirmed they had received training on the MCA 2005. One staff member told us, "You don't assume that someone doesn't have capacity regarding a situation until it is been confirmed through an assessment." Staff understood the principles of consent. One staff member told us, "We give people options and ask what they want." Throughout the inspection, we observed staff gaining consent, for example, before providing care or helping people to move. Mental capacity assessments had been completed for specific decisions such as support for care and treatment and medication. However, mental capacity assessments had not been completed for a range of decisions, such as consent to care plans and

inability to use call bells.

Observations of care identified that many people had bed rails in place. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where people's movement is restricted, this could be seen as restraint. Bedrails are implemented for people's safety but does restrict movement. Bed rails risk assessments were in place. However, these failed to consider any other least restrictive options. Documentation also failed to reflect if people consented to use the bed rails. Where people could not consent to bed rails, mental capacity assessments had not been completed. Assessment of capacity should be undertaken to ascertain if the person could consent to the restriction of their freedom for example the use of bedrails. If not, it must be explained why the bed rails were implemented in their best interest and if other options were explored.

Under the MCA code of practice, lap belts whilst using wheelchairs can be seen as a form of restraint. Throughout the inspection, we observed a number of people (over 20 people) sitting in communal lounges in their wheelchairs with lap belts done up, which restricted their ability to freely move from their wheelchair. Documentation failed to record the rationale for this and individual risk assessments for the use of lap belts were not consistently in place. We brought these concerns to the attention of the registered manager who was open and responsive to our concerns.

Failure to work within the principles of the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. Where it was felt that people are deprived of their liberty and have a tenancy agreement in place, applications must be made to the Court of Protection. The registered manager had identified a number of people with a tenancy agreement who may be subject to a DoLS. For people with a tenancy agreement in place, the provider had been seeking legal guidance and working in partnership with the local DoLS team.

People were supported to have access to healthcare services and maintain good health. Referrals had been made to other health professionals when required. This included GPs, district nurses, dentists and chiropodists. People confirmed that if they needed to see their GP this would be organised as required. Staff were proactive in ensuring that the appropriate professionals were contacted to maintain people's health. The registered manager and staff had been working in partnership with the local NHS Trust to prevent unnecessary hospital admissions. The registered manager had received feedback from a local GP praising the home and staff on how they prevented unnecessary hospital admissions. With pride, the registered manager showed us this feedback and demonstrated a commitment to prevent unnecessary hospital admissions and supporting people for as long as possible whilst residing at Cornford House.

Cornford House provided care and support to people living with a swallowing difficulty. For people assessed with swallowing difficulty, the use of thickened fluids when drinking is required to minimise the risk of choking and aspiration. Thickened fluids are easier to swallow; however, the quantity and texture must be appropriate for the individual as otherwise they can place the person at risk of aspiration. Without prompting, staff could consistently tell us the quantity of thickener people required compared to fluid. One staff member told us, "One person requires one scoop of thickener to 150mls of fluid." Where people were

assessed as living with a swallowing difficulty, input from the dietician and Speech and Language Therapist had been sourced and individualised plans of care were in place.

Staff told us they were well supported and had received the training their needed to be effective in their role. For new staff an induction programme was in place to ensure new starters received the appropriate training, support and guidance to enable them to provide safe and effective care to meet people's needs. New staff were able to shadow a current staff member until they were deemed competent and confident to provide care. There was a full and intensive programme of training which included essential training for staff. Staff spoke highly of the training provided. One staff member told us, "I've been supported to obtain a level two and three NVQ." Registered nurses received on-going clinical training and supervision which also maintained their continuing professional development. Clinical nurses received specialist training in catheterisation, syringe drive, medication training, venous puncture and wound care.

Mechanisms were in place to support staff to develop their skills and improve the way they cared for people. Staff received regular supervision. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Staff told us they felt supported within their roles and felt able to approach the registered manager with any queries, concerns or questions.

Good

Is the service caring?

Our findings

People told us that most staff were kind and caring. One person told us, "I like (staff member) my carer she is so kind and caring, I always like it when she walks in." Another person told us, "Yes they are kind and caring; they more or less do what I need." Another person told us, "Staff, are very kind."

End of life care can be a sensitive subject to approach. Guidance produced by the National Institute for Health and Care Excellence advises that nursing homes play an important role in the care of older people at the end of life. Cornford House provided care and support to people who were receiving end of life care. We spent time exploring how dignified care was provided to people at the end of their life. The registered manager told us, "We want people to be comfortable and pain free. We'll also provide accommodation for family members so they can be near." A visiting relative told us, "My loved one is receiving good care. They have been attended to promptly and quickly when needed. Their pain relief medication is always given when needed." End of care life care plans were in place which followed the Department of Health's six steps for end of life care. We saw examples of detailed and personalised end of life care plans. These considered what was important to the person and how they wanted care to be provided during the last few days of their life. However, we found this level of detail was not consistent across all end of life care plans. For example, some care plans just recorded if the person wished to be buried or cremated. Information was not available on the person's individual concerns and wishes, their values and understanding about their illness or prognosis. We discussed these concerns with the registered manager who confirmed that sometimes people did not wish to discuss end of life plans, but acknowledged this was an area of care they could focus upon.

We recommend that end of life care plans are reviewed and personalised to the individual wishes and goals.

A safe, well designed and caring living space is a key part of providing dementia friendly care. A dementia friendly environment can help people be as independent as possible for as long as possible. Cornford House had a dedicated dementia floor which was designed to specifically meet the needs of people living with dementia. People living with dementia often make use of past experiences to make sense of the present. The design of the dementia floor had been coordinated so that each wall was a different theme from a different era. One wall was an old film wall which had pictures of old films from the 1950s and 1960s. This helped to trigger memories and enhance people's past skills, hobbies or occupations. To help orient people, signage was available throughout the home and people's pictures were displayed on their bedroom door to help them recognise that bedroom as theirs.

People's equality and diversity needs were respected and staff were aware of what was important to people. Support was provided to meet people's religious and spiritual needs. A church service was held every week at the home which people spoke highly of. Clergymen also visited weekly and spent time with people who preferred to stay in their bedroom/suite and read passages from the Bible. On the first day of the inspection, we heard people singing hymns in the church service.

People told us they were able to maintain relationships with those who mattered to them. Visiting was not restricted; people were welcome at any time. Throughout the inspection we observed friends and family

continually visiting, taking people out and being welcomed by staff.

During the inspection, staff and 'residents' were preparing for Christmas. A range of Christmas trees were displayed throughout the home and people told us how they enjoyed decorating the home in preparation for Christmas. Upon entrance to the home, Christmas carols were playing softly in the background. The registered manager told us, "At the weekend, we had a Christmas party which was well-attended by people, relatives and staff. What was a surprise was that staff had organised between themselves to sing a Christmas carol to the 'residents' which they thoroughly enjoyed."

With compassion and pride, staff told us they supported people to remain independent. One staff member told us, "I encourage people to always wash their face and front independently." Staff told us how they promoted people's privacy and dignity. One staff member told us, "When washing someone, I always ensure I cover their top half when supporting them to wash their lower half." Staff knocked on people's room doors before they entered, saying, "Hello, how are you today?" Throughout the inspection, we observed kind and caring interactions. Staff used affectionate terms of address and gentle physical contact as they supported people, and people responded with smiles. As one person was supported to get their hair cut, a staff member commented, "You look lovely today."

Guidance produced by the Social Care Institute for Excellence (SCIE) advises on the importance of choice and control for older people within care homes and empowering people to retain their identity. Staff recognised the importance of supporting people to dress in accordance with their lifestyle preference and promote their identity. Staff told us how they empowered people to make their own decisions on what they wished to wear. Some ladies took great pride in their appearance, wearing jewellery and clothing which reflected their lifestyle preference. This helped communicate to others a very clear sense of their values and priority to look after themselves. Staff told us how they supported people to dress and maintain their sense of style. One staff member told us, "One person loves to wear matching clothes, so we make sure their skirt matches their blouse. They love it when they have curlers in their hair and you can see how happy they are once they've had their hair done."

Requires Improvement

Is the service responsive?

Our findings

People had mixed opinions about the opportunities for social engagement and activities. One person told us, "The activities are very good. We receive a weekly timetable, and we can choose what we attend." However, for people who spent all day in their room, people commented that they felt lonely. One person told us how no one listened to them about their past time occupation and this made them feel lonely at times.

At our last inspection in January 2016, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because personalised risk assessments were not in place. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by May 2016. At this inspection, we found changes had been made and the provider was meeting the regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014. However, we found a new breach of Regulation 9. This was in relation to poor care planning around social isolation.

Guidance produced by Social Care Institute for Excellence advises that older people are particularly vulnerable to social isolation and loneliness owing to loss of friends and family, mobility or income. Social isolation and loneliness have a detrimental effect on health and wellbeing. Throughout the inspection, we identified a large number of people who spent all day in bed (with the bed rails up).Some people preferred to stay in their room as this was their own preference whereas other's stayed in their room due to reduced mobility. The service provided on-sight activities for both tenants and non-tenants. However, some people (both tenants and non-tenants) told us that didn't participate in the group activities. We queried with staff how the risk of social isolation was mitigated. One staff member told us, "We spend time reading with people, listening to classical music and giving hand massages." The activity coordinator also told us that they provided weekly one to one activities with people who preferred to stay in their bed. They commented, "We've got to know people's interests and talk to them about family, sport and other things. We've also started some food tasting for people in their bedrooms." Although systems were in place to manage and address social isolation, we found these systems were not robust. We were informed that one to one activities would be recorded within people's daily notes. We reviewed a sample of daily notes dating back a month, but found documentation did not consistently include that people had received this one to one interaction. This meant the provider was unable to evidence that people were receiving weekly one to one interaction.

People's social needs had been assessed and a care plan was in place. However, we found these were not consistently robust and did not fully mitigate the risk of social isolation. For example, one person's social care plan noted, 'Person does not usually take part in the homes activities, but does enjoy attending monthly lunches in the home.' The actions required to manage this were recorded as, 'For (person) to continue to enjoy their current pastimes and to join in the home activities if they so wish. 'Information was not recorded on their current pastimes or how to provide meaningful activities when they did not wish to participate in the home's activities. We spent time with this person and they spent time talking to us about their life and enjoyed showing us magazines. They told us, "I do feel lonely; they don't have time to talk with me." We discussed these concerns with the social coordinator who was aware of this person's career and

told us how they spent time with them talking about their magazines. However, documentation failed to reflect and consistently record this interaction. Other people also commented that they felt lonely. We found this was a consistent theme across the lower ground, ground and first floor. The risk of social isolation had not been fully mitigated. Care plans failed to assess whether a weekly one to one visit from the social coordinator was sufficient in meeting people's social, emotional and psychological needs.

Personalised care planning is at the heart of health and social care. It refers to an approach aimed at enabling people to plan and formulate their own care plans and to get the services that they need. Personalised care plans consider the person's past, their life story, their wishes, goals, aspirations and what's important for them when receiving care. We found for people receiving care on the second floor (dementia floor), care plans were personalised, detailed and contained information on people's life history. However, we found this person centred approach to care planning had not been cascaded down to the other floors. For example, care plans contained the questions, 'what is important to the person', 'How best to support the person', and a 'typical day for that person.' We found these had not been completed for most people residing on the lower ground, ground and first floor. The lack of personal information on the people's past hobbies, interests and personality traits meant staff lacked vital information on the person and would be unable to engage with the person about their history. From talking to staff, it was clear they had a clear awareness of people's likes, dislikes, preferences and understanding of what was important to people. One staff member told us, "One lady loves singing, so every morning we have a sing along." However, the knowledge held by staff was not reflected in people's individual care plans.

Failure to plan for person centred care and provision of care that mitigated the risk of social isolation is a breach of Regulation 9 of the Health and Social Care 2008 (Regulated Activities) 2014.

The management of continence care and risk of skin breakdown required improvement. Guidance produced by the Royal College of Nursing advises that urinary incontinence can restrict leisure opportunities, and lead to social embarrassment and isolation, affecting both physical and mental health. It is vital that people who are incontinent are given every opportunity to regain their continence. High quality comprehensive continence services are an essential part of health care and help to reduce the risk of skin breakdown. People had individual elimination care plans which identified that support was required to meet their continence needs and whether they wore incontinence pads. However, information was not recorded on how often people should receive support to meet their continence needs. For example, whether their continence pad should be checked every two, three or four hours. Documentation identified large gaps in recording at times. For example, on the 11 December 2016, documentation reflected that one person received support at 08.15am with their continence needs and nothing until 14.20pm. We found this was a consistent theme throughout the home. A large number of people had 'topical medicine application records' in place which reflected they were prescribed a barrier cream which must be applied after each continence pad was changed. Application of barrier cream is also a key step in reducing the risk of skin breakdown. Documentation often reflected that this cream was only applied once a day, despite directions to apply after each continence pad was changed. For example, one person's 'topical medicine application record' reflected that on the 18, 21, 22, 23, 24, 25, 26 and 27 November 2016, the barrier cream was only applied once. The absence of a robust elimination care plan and poor documentation meant we could not conclude whether people were receiving sufficient and personalised care which met their individualised continence needs and reduced the risk of skin breakdown. The provider was unable to demonstrate how the risks associated with poor continence care and skin breakdown were mitigated.

Failure to adequately assess people's continence needs and do all this is reasonably practicable to mitigate the risk of skin breakdown is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For people who enjoyed participating in group activities, a variety of activities were available. People spoke highly of the social coordinator and the opportunity for social engagement. One person told us, "I like the singers that come in." Another person told us, "There's always something going on and the coordinators are very nice." The provider employed three dedicated social coordinators who worked throughout the home five days a week. A social coordinator told us, "We have recently been to Tunbridge Wells for shopping and went to a garden centre the other day to see the Christmas lights and had coffee and cake. We also do boat trips in the summer which caters for wheelchairs, so people with reduced mobility can also come along." On the first day of the inspection, we observed movement to music which people appeared to enjoy. On the second day of the inspection, two entertainers were performing and singing Christmas songs. Staff sat with people, holding hands and dancing along with people. The service also engaged with the project 'Ladder to the Moon.' Each month, 'Ladder to the Moon,' delivered a box full of surprises. For example, when it was the Queen's birthday, 'Ladder to the Moon' delivered a cardboard cut-out of the Queen, along with top hats, gloves and crowns. With pride, the social coordinator showed us pictures of people, staff and visitors next to the cardboard cut-out of the Queen. Staff and people also enjoyed dressing up as the Queen. Staff spoke highly of the activities and prompts provided by 'Ladder to the Moon.'

For people living with dementia a dedicated social coordinator spent time on the second floor (dementia floor) to provide stimulation and activities specifically for people. The social coordinator told us, "We adapt the activities to people's needs. For example, we do sensory activities as some people are non-verbal. Some people enjoy singing whilst one person is interested in cricket and football, so we get news cutting of their favourite team." During the inspection, we observed a range of activities from seated games and exercise to reminiscence activities.

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. Care plans covered a range of areas, such as communication, moving and handling and mental health well-being. Where people had been identified at high risk of skin breakdown, care plans were in place and repositioning charts were completed by staff. Where care plans identified that people required support to reposition every two hours, documentation confirmed that people received this level of support.

There was a complaints procedure in place and people and their representatives told us they knew how to access and use this. People also told us they could bring up any concerns and issues at the residents meeting. People and relatives felt they would be listened to and would usually approach the registered manager or deputy manager as they were both available and approachable. Since the last inspection in January 2016, the provider had received two formal complaints. We saw evidence that complaints which had occurred had been recorded and responded to appropriately.

Inadequate

Is the service well-led?

Our findings

People and staff spoke highly of the registered manager. One person told us, "The manager is very approachable; she comes round and talks to us." Staff told us how the registered manager was approachable and operated an open door policy. Whilst all feedback about the management was very positive we found the leadership of the service was not effective in all areas.

At our last inspection in January 2016, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the provider's internal quality assurance framework was not robust. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by May 2016. At this inspection, we found internal quality checks remained ineffective.

At the last inspection in January 2016, we raised concerns around staffing levels, people remaining on continuous bed rest and people not receiving adequate support to meet their nutritional needs. Throughout this inspection, we spent time on each floor at Cornford House making observations assessing whether the provider had made changes and met their action plan. From our observations, it was clear that changes were in the process of being made and these changes were most noticeable on the second floor (dementia floor). On this floor, everybody, apart from one person had been supported to access the communal lounge and engage with activities that were meaningful. Staff were seen having one to one chats with people and there was minimal use of restrictive practice. For example, low profile beds with crash mats had been implemented instead of bed rails. However, these changes had not been cascaded down to the other floors. A number of people residing on the lower ground, ground and first floor remained in bed all day with bed rails up. Steps to mitigate the risk of social isolation and not fully been addressed and poor staff deployment and visibility of staff added to the risk of social isolation.

A range of quality assurance audits and checks were in place and had been implemented since the last inspection to drive improvement. However, we found these audits and checks were not consistently robust or had not been fully acted upon to drive the necessary improvement. Monthly management audits and reports were completed by a consultant employed by the provider. We reviewed these, and saw that they had identified and reported shortfalls in care plans and other areas that we had identified. However, these had also failed to bring about improvements. For example, actions from the month of July 2016 identified concerns with the use of a lap belt for one person. Action was taken, however, a review of other lap belts was not considered. During the inspection, we identified a large number of people sitting in their wheelchair with their lap belt done up. The rationale for this was not consistently clear. Another action point from the consultant's July 2016 audit included a review of the main meal served at lunch time. The audit recorded this action as closed. Steps taken as part of this action included the appointment of a new chef, meeting with the chef and gaining feedback from people. We could see that action had been taken. However, our inspection identified on-going concerns with the quality of food and people's dining experience. Despite a range of quality audits and checks, the provider's internal governance framework had failed to consistently identify the shortfalls we found during the inspection. Where changes had been made, these were not yet fully embedded into practice or sustained.

At our last inspection in January 2016, concerns were identified in relation to monitoring charts. We found there were inconsistencies in the completion of these charts. In their action plan, the provider told us that all monitoring charts (including repositioning, food and fluid, topical medicines records) were collected at the end of each day and reviewed by the registered manager and clinical nurses. We found improvements had been made to repositioning monitoring charts. However, the provider and registered manager had failed to identify discrepancies with other monitoring charts. For example, that topical medicines records were not being completed correctly, and monitoring charts for well-being checks were not in place. We also found omissions with recording. For example, three repositioning charts were initialled at the same time by the same staff member. This indicated that this one staff member supported three people to reposition at the same time. We brought these concerns to the attention of the registered manager who confirmed that it was most likely the staff member initialled the documentation at the same time after supporting people to reposition. However, they acknowledged that this was something they would need to look into.

The service had a number of policies and procedures available for staff. However, we found some of these policies did not reflect best practice guidelines or current legislation. For example, the provider's safeguarding policy failed to reference the Care Act 2014 and the new categories of abuse. The consent to examination, care and treatment policy failed to follow the principles of the Mental Capacity Act 2005. The service's restraint and dealing with violence and aggression policies did not refer to current best practice.

The provider had started to make changes since the last inspection in January 2016. However, these changes had not yet been fully embedded or actioned. The failure to ensure effective quality and safety assurance systems is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in January 2016, we identified that a large number of people were falling between the hours of 14.00pm and 22.00pm. Action had been taken and the number of falls each month had greatly reduced. On a monthly basis, incidents and accidents were audited for any trends, themes or patterns. Despite a monthly audit taking place, documentation failed to record what action would be taken to prevent any future reoccurrences.

We recommend that the provider reviews their incident and accident analysis in line with best practice guidelines.

All care providers must notify us about certain changes, events and incidents affecting their service or the people who use it. These are referred to as statutory notifications. This includes any allegation of abuse, any serious injury to a person and Deprivation of Liberty applications and their outcomes. The registered manager was aware of their responsibility and had notified us about deaths, allegations of abuse and serious injuries to people.

Staff spoke with pride about working at Cornford House. One staff member told us, "I really enjoy working here. I like the management structure and seeing the 'residents' happy." Another staff member told us, "What I enjoy about working here is the contact with the 'residents'." Staff commented that the registered manager was approachable and operated an open door policy. One staff member told us, "She's very approachable. Any problems, I can go to her, whether they are work related or personal." Staff's commitment and dedication was recognised and annual staff achievement awards took place. The registered manager told us, "Every year, the 'residents' nominate staff for carer of the year. The ceremony is due to take place soon and a couple of staff from Cornford have been nominated.

Staff told us that a key strength of the service was its homely atmosphere. One staff member told us, "What I

really like about Cornford House is the homely atmosphere." The registered manager told us, "I would describe Cornford House as very homely and its key aim and goal is to ensure that the service is as friendly and homely as possible."

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 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 11 HSCA RA Regulations 2014 Need for consent The provider had not provided care and treatment of service users with the consent of the relevant person. Regulation 11 (1)