Cornford House Limited

Cornford House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Cornford House is a residential care home providing accommodation and nursing and personal care for up to 70 people. The service is arranged across four floors with lift access to lower ground and upper floors. There were 20 people using the service at the time of our inspection. Cornford House also provides personal care for people living in their own homes, within the same accommodation. These people have a tenancy agreement and a separate agreement for their care provision. There were 46 people receiving personal care in their 'own homes'. People receiving personal care can choose to have their care provided by another care provider. However, everyone living in Cornford House had their care provided by staff employed by Cornford House.

People's experience of using this service and what we found
People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests.

People were not always offered choice in the care and support process. Some people had tenancy agreements in place, separate to their care agreement, and were not always aware of their rights to choose between a tenancy agreement or an agreement for accommodation with care. Tenancy agreements placed restrictions on people, for example, they were not able to have cooking facilities in their home.

People had comprehensive risk assessments in place that contained enough information for staff to support people safely. Staff had received training and people were supported by staff who knew them well. Staff had been recruited safely. The provider had systems in place to manage environmental risks, such as fire.

People and their relatives told us they felt safe and happy living in Cornford House and that it was a nice place to live. One person said, "I feel very safe, one hundred and ten percent. Everyone is so lovely." Another person said, "I like it very much. People are very nice. You've only got to ask, and they'll get it for you." A relative said, "Yes, it is safe. [Relative] is well cared for; there is a resident nurse on duty; and doors are secured."

Medicines were managed safely, and people received them as prescribed. People were protected from the risk of infection. People were supported to eat and drink enough and told us the food was good in Cornford House.

People, relatives and staff told us the management team were supportive and approachable and they were confident to raise concerns. Checks and audits had been completed on the service and actions had been taken to address any shortfalls.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 23 October 2018). At this inspection the service has been rated requires improvement and there were breaches of regulations in relation to person centred care and consent.

Why we inspected
The inspection was prompted in part by notification of an incident, following which a person using the service died. This incident is subject to further investigation by the Care Quality Commission (CQC) as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of health and safety in the service. This inspection examined those risks. We found people were no longer at risk from these concerns. We had also received some concerns about the service in respect of physical abuse and poor care practices. We found no evidence during this inspection that people remained at risk of harm from these concerns.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cornford House on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to person centred care and need for consent at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Cornford House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Cornford House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Cornford House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Cornford House is also a domiciliary care agency. It provides personal care to people living in their own rooms under a tenancy agreement within Cornford House.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. This included things the provider needs to tell us about, for example, serious injuries or safeguarding concerns. We sought feedback from professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 11 people who use the service and 12 relatives about their experience of the care provided. We spoke with 14 members of staff including the registered manager, compliance manager, deputy manager, clinical lead, nurses, care workers and supporting staff. We spoke with two professionals who worked with the service. We reviewed a range of records including 11 peoples' care records and multiple medicine administration records. We looked at four staff files in relation to recruitment and supervision. A variety of records relating to the management of the service, such as audits, meetings, monitoring activity and training were reviewed.

After the inspection
We reviewed information relating to peoples' tenancies, care agreements and local authority assessments.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Some people had expressed suicidal ideation; these people did not have effective environmental risk assessments in place and there was insufficient information for staff to manage the risks. For example, there were items in a person's room that placed them at increased risk. Although staff were aware of the risks they hadn't sought to ensure the environment was safe. We discussed this with the clinical lead who immediately put additional measures in place and updated the risk assessment accordingly.

● Care plans and risk assessments were clear, comprehensive and up to date. They contained enough information for care staff to provide safe care and manage any risks, such as falls, skin damage or choking. The provider used recognised tools for assessing risks such as skin damage, nutrition and pain.

● Where people required monitoring charts such as weight, fluids or repositioning, these were in place and had been completed correctly. Where people required special pressure relieving mattresses, the required settings were documented and checked regularly. People received safe care and treatment by staff who knew them very well. People told us the staff team were happy and they appreciated the consistency of staff, usually seeing the same people. One person told us, "The staff have really looked after me, they are so caring."

● The provider had systems in place for regularly reviewing the care plans and risk assessments and these were up to date. Any changes in a persons' needs were shared with staff during handover meetings. Relatives told us they were updated if there were any changes to their loved one's care. One relative confirmed this, "They always let me know what's going on."

● Environmental risks were managed including fire safety, hot water, electrics and maintenance of equipment. Following an incident, all window restrictors had been replaced and records showed these were checked regularly. Staff had been trained in fire safety and knew how to move people safely in an emergency. Evacuation training had been completed, evaluated and lessons learned shared.

Staffing and recruitment

● The provider used a dependency tool to calculate how many staff should be deployed each day. The dependency tool was updated regularly. However, people who received personal care did not have allocated hours clearly defined on the rota.

● Staff consistently told us there weren't enough staff on one floor in the mornings and they struggled to meet peoples' needs in a timely manner. Most people on this floor required two care workers to support them safely. During our inspection we saw six people on this floor had not been supported to have their wash or get dressed for the day by 11.30am. A staff member told us people often have to wait until lunchtime to be supported with washing and dressing. One person living on that floor said, "Staff are very overworked. They are always apologetic, but I can tell how long things take." This was an area for

improvement. We discussed this with the registered manager who told us they would review the rotas.
● Staff had been recruited safely. Records were maintained to show that checks had been made on employment history, references and the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people working with people who use care and support services.
● Nurses were registered with the Nursing and Midwifery Council and the provider had made checks on their personal identification number to confirm their registration status. Nurses were required to update their registration annually.

Systems and processes to safeguard people from the risk of abuse
● People were safeguarded from the risk of abuse. People and their relatives told us they felt safe in the service. One person told us, "I feel very safe. It's the care; there is a nurse here twenty-four seven. I can contact the carers by buzzer. There is always somebody nearby." Another person said, "Yes I do feel safe because I've got people around to look after me." Relatives told us the service had put measures in place to keep people safe. One relative said, "Yes they are safe because the carers are always good, they make sure the bed sides are up." Another relative said, "All the procedures are in place, alarms and mats, to keep [relative] safe."
● Staff had received training and knew what signs to look for, what to report and to whom. They were confident that actions would be taken if they reported any concerns. The registered manager had reported safeguarding concerns to the relevant authorities and cooperated with investigations. Safeguarding records had been completed and were up to date.
● The Care Quality Commission (CQC) had received notifications about allegations of physical abuse and poor care practices. We found the provider had informed the relevant people; had fully investigated the concerns and had taken appropriate actions to prevent them from happening again. We found people were no longer at risk from these concerns.

Using medicines safely
● Medicines were managed safely in accordance with national guidance. Medicines were stored correctly in locked cabinets and in temperature controlled conditions. The provider safely disposed of medicines no longer needed.
● Medicines were administered by nurses and care workers who had been trained and deemed competent to do so. Competency checks were reviewed regularly and were up to date. Medicine administration records were completed accurately. People told us their medicines were given to them on time.
● Medicine errors were infrequent, but where they had occurred, they were fully investigated, and measures put in place to minimise the risk of the same error happening. Lessons learned were shared with the team. Medicines were checked daily by the clinical lead and a regular pharmacy audit was done by the compliance manager.

Preventing and controlling infection
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was meeting shielding and social distancing rules.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was accessing testing for people using the service and staff.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes

● Visiting was unrestricted in accordance with government guidance. During the inspection we saw visitors coming and going freely.

Learning lessons when things go wrong

● Accidents and incidents were reported and investigated. Professional advice was sought where necessary for example, from the GP or emergency services. Regional compliance managers checked appropriate actions had been taken in a timely manner and incidents signed off by the registered manager.

● Actions had been taken to minimise the risk of similar incidents happening, for example, low rise beds, bed rails or crash mats. Risks were reassessed following incidents, such as falls.

● Monthly analysis of incidents and key clinical indicators, for example, falls, weight loss or infections were carried out and shared with staff to aid continual learning.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
- Not all decisions had been made in peoples' best interests. For example, one person who had been assessed as lacking in capacity to make the decision to live in Cornford House had signed a tenancy agreement and a care agreement. Other tenancy agreements and care agreements had been signed by relatives or advocates and there was no documentation to indicate this was in their best interest.
- For other decisions, such as use of bed rails and vaccinations, best interest meetings had been held between staff, relatives and other professionals. Care was provided in the least restrictive way.
- Consent was documented in peoples' care plans. People told us staff asked them before providing care services. One person said, "Any help being given, staff always communicate with you before starting." Another person said, "Staff always talk things through with me, they explain my tablets." Relatives agreed. One relative said, "They don't start to do things without telling them."

Failure to ensure people always had information and support to consent to care is a breach of Regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- Peoples' care plans were comprehensive; they contained enough information for staff to know about peoples' individual choices and wishes. Relatives told us they had been consulted about their loved one's

care plan. Care plans were reviewed and updated regularly.
● Care delivery was person focused and responsive to peoples' needs. Peoples' assessments included needs relating to their culture and spiritual needs. The service used recognised tools for assessing some risks, such as potential skin damage, nutrition and pain. The provider followed current guidance from the National Institute for Clinical Excellence (NICE). These guidelines help nurses and care workers improve the quality of care and promote good health.
● Staff had a very good knowledge of people and their individual preferences and choices. Staff understood risks, for example, choking or falls, and knew what to do to keep people safe. People and their relatives told us they were supported by staff who knew them well and were involved in developing their care plan. One person told us, "I have my say in how I am supported. The staff know what I need, and my care needs are met."

Staff support: induction, training, skills and experience
● New staff had an induction before starting work and all staff attended mandatory training regularly. Training records showed training was completed in a timely manner. Staff had the required knowledge to provide safe care and support to people, including knowledge of medical conditions, such as diabetes. People and their relatives agreed staff were well trained. One person said, "Yes they are well trained, I have heard them doing the training." A relative said, "I think the staff are well trained; they are very well informed."
● All staff told us they received supervisions regularly and felt well supported by the management team. Staff told us they could use their supervision sessions to discuss training needs and request more training if they wanted to. Staff said they were well supported by the management team.
● Nurses attended clinical meetings with the manager and clinical leads and had regular clinical supervision. Nurses worked within the Nursing and Midwifery Council's Code of Conduct and revalidated in accordance with regulations.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough. People told us they could choose what to have for their meals. One person said, "The food is excellent, I enjoy the meals." There were enough staff to support people to eat their meals. Show plates were used for people who could not understand the menu. People had access to hot and cold drinks throughout the day.
● Some people had been assessed by the Speech and Language Therapists (SaLT) and needed a modified diet to reduce the risk of them choking. These people were supported to eat and drink safely in line with SaLT recommendations. Kitchen staff had received appropriate training and were knowledgeable about peoples' allergies, intolerances and dietary needs.
● There were enough staff to support people to eat and drink, either in the dining room or in their own rooms. People who needed help with their meals were supported patiently by staff. The meals looked appetising and people had chosen their meals. Peoples' individual food preferences were respected.
● The four weekly rolling menu was designed by the head chef after meeting with people living in the service. The menu was varied and included vegetarian options for each meal. Kitchen staff told us people could choose alternative food if they wanted to, for example, omelettes or jacket potatoes.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Assessments and care plans included peoples' health care needs and there were details of healthcare professionals' visits in individuals' records. There was input from other professionals such as dieticians or podiatrists. Hospital passports were printed if someone needed to go to hospital so information could be shared.
● Staff were very knowledgeable about peoples' needs and knew how to support them to achieve good

outcomes. Risk assessments and care plans for specific health conditions such as diabetes or epilepsy were detailed and contained signs for staff to be aware of and actions for them to take, for example if someone had a seizure.

● People and their relatives told us they could see a healthcare professional if they needed to and staff would arrange it for them. One person said, "Staff are in touch with the doctor if there are any issues. The GP has come to me a few times." Another person told us, "If I'm not well they get the doctor. They come to the home every Monday." One relative confirmed their relative had seen the chiropodist. Another relative said, "If [relative] is unwell they call the doctor. It's picked up quickly and they let me know."

Adapting service, design, decoration to meet people's needs

● The service was arranged across four floors with lift access to lower ground and upper floors, suitable for all abilities. We saw people walking around the service safely or using wheelchairs, including in the communal areas.

● People and their relatives told us their rooms and communal areas were kept clean and tidy.

● All rooms had names on them but very few had pictures and there were no memory boxes to help people who were living with dementia identify their room. Communal toilets and bathrooms did not have pictures on the door. Apart from that, signage was good around the service and people were able to find their way around. The registered manager told us the service had a refurbishment plan in place and guidance on 'dementia friendly' environments would be considered.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- Overall, people spoke highly of the care and attention they or their relatives received.
- People told us staff were caring, spoke to them nicely and treated them well. One person said, "The staff are very kind, exceptionally so." Another person said, "Staff are very friendly, kind and respectful, 11 out of 10." Another person told us they considered the staff to be their friends.
- People were cared for by staff who knew them well. Staff knew peoples' preferences but still offered choice, for example where they wanted to eat their lunch. Staff were patient with people and gave them time to respond to questions; talking with them at their own level. People and their relatives, without exception told us staff knew them well and knew their needs.
- Relatives described the staff as kind, caring and respectful. One relative said, "Staff are kind and respectful. Everybody knew [relative's] name within a week of their arrival. They also know me."

Supporting people to express their views and be involved in making decisions about their care

- People were supported to be involved in making decisions about their care. For example, people were able to choose where to eat their meals. People were encouraged to share their life experiences so staff could get to know them better. Peoples' likes and dislikes were documented, such as what time they like to go to bed at night and get up in the morning.
- Communication needs were documented so people could be supported in the best way to be involved in decisions about their care. Most people had family, friends, social workers or other advocates who could support them to express their preferences.

Respecting and promoting people's privacy, dignity and independence

- People and their relatives told us their privacy and dignity was always respected. We saw staff knocking before entering peoples' rooms and doors were closed whilst people were having personal care. Staff told us and we observed they knocked on doors and closed curtains and doors during personal care. One person told us, "The staff are friendly and speak to me nicely." Another person told us that communication with staff was lovely and respectful.
- Peoples' confidential information was kept securely, accessed only when required and by those authorised to do so.
- People told us staff encouraged them to do things for themselves if they could. One person told us, "They do encourage independence, they have helped me to get up. They have been very supportive. The physio has been brilliant as well." One staff member told us they gently encourage people if they know they can do something rather than do tasks for them.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. The rating for this key question has remained good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Peoples' care plans were detailed and extensive and reflected peoples' preferences in all areas. For example, food likes and dislikes, hobbies and interests. Spiritual and religious needs were documented. Care plans were reviewed and updated regularly to ensure their needs were continuing to be met by nurses and care staff, and people and their relatives told us they were involved in the review process.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Staff were observed communicating effectively with people. When people required spectacles or hearing aids, staff made sure they were working, and people used them properly to support better communication. Some people didn't like wearing their hearing aids and this was documented in their care plan.

● Important documents could be made available in alternative languages and formats if this was required, such as large print or Braille.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● The service had a team of activity coordinators who developed and delivered a regular programme of activities. There were no meaningful activities happening during our inspection; the afternoon activity had been cancelled. We were told this was due to lack of staff. A staff member said, "Yes, that happens some days."

● People and their relatives were generally complimentary about the activities being offered. One person told us, "I join in all the activities. I help with gardening and enjoy it." Another person said, "The activities staff are wonderful. They involve you and make you feel wanted." A relative told us, "The entertainments lady encourages [relative] to take part in activities."

● There had not been any activities outside of Cornford House, but staff told us this was 'work in progress'.

Improving care quality in response to complaints or concerns

● The service received very few complaints. When complaints were received the registered manager investigated and responded in line with the company's policy. Where things had gone wrong, lessons learned were shared with the staff team through meetings or internal message platforms.

● People and their relatives mostly told us they had no complaints. When they had any minor day to day concerns they raised them with the manager or a nurse and issues were dealt with effectively.

End of life care and support

● The service was able to provide end of life care and support which enabled people to remain in the service if their needs increased and not have to move to a new service.

● Care plans included clear instructions about end of life care wishes and staff were aware of these. These plans had been written in partnership with the person and their relatives if appropriate.

● Staff worked closely with other health care professionals, such as hospice teams and GPs to provide end of life care when required. Medicines were available to keep people as comfortable as possible.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There were 46 rooms in the service that were not available for the regulated activity of accommodation with nursing or personal care. This was because they had been let to individuals under a tenancy agreement.
- Some people had tenancy agreements in place with a separate care agreement and some people had respite agreements covering both their care and accommodation. People with tenancy agreements and their relatives told us they did not have a choice about whether to have a tenancy agreement or not, although relatives confirmed they could choose to use a different care home. Not everyone who had a tenancy agreement were aware they had this in place. These were not always signed by the individual and some people with tenancies did not have the capacity to make these decisions.
- Taking on an occupancy agreement means entering a contract. If a person does not have mental capacity to make decisions about entering into a legal agreement, any decision made on their behalf must be made in their best interest. We could not see evidence the provider was fully meeting the 'Provider guidance on housing with care'.
- People who had tenancy agreements in place had restrictions placed upon them. For example, if they wanted a care provider other than people who worked in Cornford House, they could only have a care provider that was registered with the Care Quality Commission. This meant they could not choose to have a personal assistant or a family member of their choice to provide their care. People with tenancy agreements did not have access to cooking facilities, so could not choose to cook their own meals if they wanted to.

Failure to ensure people always had the right information to make informed choices about their care and support is a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had quality monitoring processes in place. However, the provider's systems had failed to identify the concerns we found at this inspection, for example, environmental risk assessments for people with suicidal ideation, staff not having enough time to support people safely and ensuring DoLS applications were made to the appropriate authorities.

Failure to have robust governance systems in place is a breach of regulation 17 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

● A range of audits were undertaken, for example, infection control, medicines and clinical indicators. Registered managers received daily management reports from the provider based on quality indicators, for example, complaints, call bell response times, accidents, incidents and care plan reviews.
● Services providing health and social care to people are required to inform the CQC of important events that happen in the service. This is so we can check that appropriate action has been taken. The registered manager had correctly submitted notifications to CQC.
● There was a management structure in place and nurses and care staff understood their responsibilities to meet regulatory requirements. Staff told us the management team were supportive and approachable and were confident in reporting any concerns. Staff told us Cornford House was a good place to work.
● Staff were invited to meetings regularly and nurses had clinical meetings. Staff told us they were encouraged to contribute. Staff surveys had been done and the provider was working through an action plan based on the results.
● The registered manager was visible in the service and people and their relatives knew who the manager was and were happy to discuss things with them.
● Staff told us they had regular supervision sessions with either the manager or a clinical lead. Staff told us they could ask about additional training needs during their supervision sessions, particularly specialist training, such as Parkinson' Disease or Huntingdon's.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The registered manager had an open-door policy and encouraged staff, people and relatives to share their views. Relatives told us people were supported in the way they wanted to be.
● People told us the home was well organised and the managers were very approachable. One person said, "Management are very good. They're considerate and readily available. You don't feel as though you're wasting their time." Relatives agreed that the home was well managed, and the managers were easy to talk to. One relative said, "The manager is always helpful and approachable."
● Staff told us the culture was open and honest with good teamwork. One staff member said, "There are good staff that work well together as a team in an open and friendly culture."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The Care Quality Commission (CQC) sets out specific requirements providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing support, truthful information and an apology when things go wrong. The provider and registered manager understood their responsibilities.
● Relatives told us, and records confirmed that staff were in regular contact with them. One person told us, "The staff are very good at keeping my family informed." Relatives confirmed staff contacted them with updates when necessary. One relative said, "If [relative] is unwell, they always let me know." Some relatives had access to electronic care notes to help them keep up to date with their relatives' care and support.

Continuous learning and improving care; Working in partnership with others
● There had been a serious incident in the service since our last inspection. We discussed this with the registered manager and the staff. Preventive measures had been put in place since this incident and lessons had been learned to minimise the risk of similar incidents in the future.
● Nurses attended regular clinical meetings where key clinical issues were discussed, such as wound management, weight loss and falls. Action plans were in place to ensure any issues were addressed.

● The registered manager worked in partnership with local health and social care teams and had a good working relationship with safeguarding and commissioning teams. Managers and nurses liaised regularly with other health professionals, such as GPs, dieticians, speech and language therapists, specialist nurses and hospice teams.

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 Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not always person centred because people were not given choice over their care and support process.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People did not have information and support to consent to care. DoLS were in place but it was not clear if the application had been made to the right authorities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems had failed to identify concerns found during our inspection.