Cornelius House Limited

Cornelius House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Cornelius House is a residential care home and accommodates a maximum of 20 people. On the day of the inspection there were 19 people living at the service, one person was in hospital. The home is a large Victorian property with a garden in the village of Fishbourne. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulated both the premises and the care provided, and both were looked at during the inspection.

This inspection took place on 8 March 2018. The inspection was unannounced. At the last inspection on 16 November 2016, the service was rated as Requires Improvement with concerns about the safety of medicine management and concerns about the leadership structure at the service. At this inspection we found there had been changes to improve the management structure at the service and medicine management was now safe. We found the service had improved from "Requires Improvement" to "Good", with the caring domain rated as "Outstanding".

Why the service is rated as Good:

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

People and their relatives told us staff were exceptionally dedicated, caring and kind. Staff demonstrated compassion for people through their conversations and interactions. They did special things which made people feel they mattered. Feedback about the caring nature and acts of kindness were excellent. Comments included, "Absolutely fantastic"; "Cared for in such as personal and loving way." Another person told us, "Lots of my visitors have said what a lovely atmosphere it is here, they don't feel they are coming into a home. I feel it's my home; I go about just as I please. If you want anything sorted out you only have to speak to [staff name] and it's done."

People told us their privacy and dignity was promoted. People all said they were actively involved in making choices and decisions about how they wanted to live their lives. People were protected from abuse because staff understood what action to take if they were concerned someone was being abused or mistreated.

People received care which was responsive to their needs. People and their relatives were encouraged to be part of the assessment and care planning process. This helped to ensure the care being provided met people's individual needs and preferences. Support plans were very personalised and guided staff to help people in the way they liked.

Risks associated with people's care and living environment were effectively managed to ensure people's freedom was promoted. People were supported by consistent staff to help meet their needs in the way they

preferred. People's independence was encouraged and staff helped people feel valued by encouraging their skills and involving them in decisions. The registered manager and provider wanted to ensure the right staff were employed, so recruitment practices were safe and ensured that checks had been undertaken. People's medicines were safely managed and given to them on time.

People received care from staff who had undertaken training to be able to meet their unique needs. People's human rights were protected because the registered manager and staff had an understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards.

People's nutritional needs were met because staff followed people's support plans to make sure people were eating and drinking enough and potential risks were known. People were supported to access health care professionals to maintain their health and wellbeing.

People were cared for in a service which was well maintained and invested in. The home was kept clean and smelled fresh. There was a range of activities which people enjoyed to help keep them stimulated and occupied.

Policies and procedures across the service were in place and available for people in different formats when required. People were treated equally and fairly. Staff adapted their communication methods dependent upon people's needs, for example using simple questions and information for people with cognitive difficulties and information about the service was available in larger print for those people with visual impairments.

The service was very well led by the registered manager and provider and supported by a dedicated team. There were quality assurance systems in place to help assess the ongoing quality of the service, and to help identify any areas which might require improvement. Complaints and incidents were learned from to ensure improvement. The registered manager and provider promoted the ethos of honesty and admitted when things had gone wrong. The service kept abreast of changes to maintain quality care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service had improved from Requires Improvement to Good.

The service was safe.

People were protected by safe recruitment practices and there were sufficient numbers of skilled and experienced staff to meet people's needs.

People were protected by staff that understood and managed risk. People were supported to have as much control and independence as possible.

People had their medicines managed safely.

People were protected from the spread of infection, because safe practices were in place to minimise any associated risks.

People were protected from avoidable harm and abuse.

Is the service effective?

Good

The service was effective. People received support from staff that knew them well and had the knowledge and skills to meet their needs.

Staff were well supported and had the opportunity to reflect on practice and training needs.

Staff had a good understanding of the Mental Capacity Act and promoted choice and independence whenever possible.

People's eating and drinking needs were known and supported.

Is the service caring?

Outstanding

The service had improved from Good to Outstanding.

The service was very caring, people came first.

People, relatives and professionals were exceptionally positive about the service and the way staff treated the people they

supported. People felt special and they mattered.

People were treated by dedicated, kind and compassionate staff. People were treated with respect and dignity

Staff supported people to improve their lives by promoting their independence and wellbeing.

People were supported in their decisions and given information and explanations in an accessible format if required.

Is the service responsive?

Good

The service was responsive.

People were thoroughly assessed to ensure the service could meet their needs. Equality and diversity was respected and people's individuality supported.

People received personalised care and support, which was responsive to their changing needs. Care records were written to reflect people's individual needs and were regularly reviewed and updated.

People were involved in the planning of their care and their views and wishes were listened to and acted on. People's end of life preferences were known and followed.

End of life care was compassionate.

People knew how to make a complaint and raise any concerns. Complaints were thoroughly investigated and learned from. People had no concerns.

Is the service well-led?

Good

The service was very well led.

There was a positive culture in the service.

The provider and registered manager had clear visions and values about how they wished the service to be provided and these values were understood and shared with the staff team and underpinned policies and practice.

People and those important to them were involved in discussions about the service and their views were valued and led to improvements.

Staff were motivated and inspired to develop and provide quality care. They felt listened to.

Quality assurance systems drove improvement and raised standards of care.

Cornelius House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was planned as a routine comprehensive inspection. Prior to the inspection we contacted the local authority for feedback who gave positive reports about the leadership and service people received.

This inspection took place on 8 March 2018. The inspection was unannounced. The inspection was carried out by two adult social care 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 service. The expert by experience had knowledge of caring for older people.

Before our inspection we reviewed the information we held about the service and contacted the local authority commissioners. We reviewed notifications of incidents that the provider had sent us since their registration. A notification is information about important events, which the service is required to send us by law.

We reviewed the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we met with 12 people who used the service and spoke with two visiting relatives for their views on the service. We reviewed people, relatives, staff and professional feedback during the inspection and comments left by people and relatives on a care home reviews website. We spoke with the registered manager, the deputy manager, the provider and two care staff during the inspection.

We looked at five records which related to people's individual care needs. We discussed staff recruitment processes with the registered manager, reviewed staff training and looked at the quality assurance processes used to review the quality of the care provided. We discussed complaints, safeguarding and

incidents which had occurred within the home over the past 12 months, with the registered manager. We also reviewed policies and procedures, and the complaints process.

Following the inspection one health care professional provided feedback by email and three relatives contacted us to provide feedback. We received six questionnaires from relatives after the inspection.

Good

Is the service safe?

Our findings

At the last inspection of Cornelius House in November 2016, we found medicine management was not always safe. Following the last inspection, the provider sent us an action plan detailing how medicine management would be improved. We found robust medicine procedures were now in place to help ensure people received their medicines as prescribed.

People were safely supported with their medicines if they required. People told us, "I don't keep my medicines, the staff bring them to me"; "I get a sick feeling at times. When I tell someone I'm offered one of my anti-sickness tablets"; "The care staff give them to me. Yes, I get them on time as far as I know"; "Yes I can ask for something for a headache"; "I don't have regular pills, I just have a slug of whisky a day!"; "If I can't sleep and have a headache I'd ask for some paracetamol" and, "They bring them upstairs to me. I seem to get them on time."

The registered manager had overall responsibility for medicines and had undertaken training in this area to teach others. They were attending a conference concerning medicines in care homes to further enhance their knowledge in relation to safe practice in this area. Staff responsible for administering medicines received training and their competency was checked to ensure they were safe and followed the provider's medicine policy. The service reflected and learned from medicine errors. This led to improved practice and additional questions being added to competency checks.

Staff ensured medicines required at a specific time, for example before food, or at set times related to people's preference were administered. Medicine rounds had been reduced from seven at the previous inspection, to four. Non-standard medicine times were highlighted in colour on people's medicine records (MARs) and the actual administration times were recorded in the MAR.

Medicine keys were kept safely with one delegated senior staff with responsibility for the keys, who was medicine trained. Senior staff signed for handover of medicine key responsibility which also involved checking the MARs. There was a policy of keeping minimal stocks. Medicines which required additional security were regularly checked and counted.

Medicine administration records were fully completed. The service encouraged people to self-administer. This helped people to stay as independent as possible. A self-administration risk assessment was used to establish the person knew what medicines they took and what they were for, as well as awareness of keeping them safely. Staff regularly checked these people remained safe managing their own medicines.

We observed medicine administration was safe. Staff wore "do not disturb" tabards and people had choice where they were given medicines including eye drops. Care records were specific and detailed regarding how to support people with protected characteristics, for example those registered blind.

People living at Cornelius House all confirmed they were safely cared for. The systems, process and practices at the service enabled people to remain safe. "Yes, it's a safe place because it's made perfectly

clear we must ask for help when we need it"; "Yes it's safe here, just because it feels that way, I've no worries" and, "It's a superb home. My son and I feel it's secure as well."

People were kept safe by staff who understood how to identify the signs of abuse and what action they would need to take if they witnessed or suspected that someone was being mistreated. This included an understanding of which external agencies they would need to alert. There was an up to date safeguarding policy in place along with local reporting procedures which staff were aware of. Incidents of a safeguarding nature were recorded and analysed for trends and learning. Staff told us, "Safeguarding was stressed all through induction. The training is repeated annually. I feel confident recognising and responding to potential abuse."

Policies and regular feedback from people using the service helped confirm people were protected from discrimination and ensured all people were treated equally. Staff confirmed they had undergone training in this area, knew how to safeguard people and care for their property and belongings. Refresher training was ongoing so staff remained up to date with best practice. Staff all confirmed they would not hesitate to raise any concerns. People's comments included, "Yes, Staff always present. I feel secure, equipment is maintained. A good, effective call bell system."

Some staff supported people to manage their money, buy their shopping and go on outings. Where staff handled people's money, clear processes were in place and receipts of expenditure kept. People's money was kept securely if people wished the service to support them with their money. During the inspection period, a theft was reported by one person. The service took prompt action to alert the police, reimburse the person and encourage them to keep personal belongings safe. The registered manager also raised this with all residents.

People were supported by staff that were safely recruited. Checks on new staff were undertaken to ensure staff were safe to work with vulnerable people. Recruitment processes such as interviews helped the registered manager check the values and caring attitude of new staff. People were involved in the recruitment process for example, the interviews involving the new activities co-ordinator.

People were kept safe by sufficient numbers of staff. Staffing levels were dependent upon people's needs. Staff interacted with people in a calm, unhurried way. In addition to care staff, there was an activities staff member, kitchen staff, cleaning staff, a gardener and maintenance that helped run the service. The staff team worked flexibly to provide cover for sickness and unforeseen events; this helped to provide continuity for people. There was no recent use of agency staff due to the flexibility of the team. Staff told us, "It feels like enough staff, I don't feel pressured. Everyone gets the time they need, it doesn't matter if today someone needs more time than usual, and we give as much as they need. We help each other out. If someone needed two staff, it would be allocated that way. Some people just need you there with them, without having to give a lot of hands on care. In the afternoons there is enough time to be able to sit with people and have a chat or look at the papers with them." Another staff member told us, "There's 100% enough staff. You can see people's needs and wishes are the top priority."

People confirmed they felt there were enough staff on duty and their call bells were answered promptly, "I wear a call bell pendant round my neck. It doesn't take long for someone to answer it"; "No you don't wait for long. I don't use it at night unless I want the loo"; "No, I don't wait for long."

People were supported by staff who managed risk effectively. People told us, "I fell on the floor when I first came in, they helped me up and impressed on me that I must ask for help or ring my bell when I want to get up" and, "I kept falling over at home but not here. I can walk on my own with my frame but I usually walk

with someone and we use the lift." People's safety was discussed in staff meetings and regular handovers. There were systems in place to report accidents such as trips and falls and analyse these for prevention purposes and learning. Prompt action was always taken to reduce the likelihood of a reoccurrence. For example by considering liaising with people's GP, using falls prevention equipment and where required, additional staff or increased observation to support people's mobility.

Staff understood the importance of a person's choice, regardless of disability, to take everyday risks and to keep people safe. Staff balanced actively supporting people's decisions so they had as much control and independence as possible with ensuring their safety at all times. Staff gave examples of how they supported people to manage their own mobility as far as possible but being mindful of potential risks and ready to step in and support as required.

People had documentation and processes in place relating to the management of risks associated with their care. The risk assessments were detailed and provided staff with specific information on all areas where risks had been identified. Since the previous inspection these were now held electronically. Care plans were person-centred and developed to mitigate identified risks, for example in relation to skin care, falls or nutritional needs. Where people had additional risks in relation to health needs, the service worked closely with external professionals to provide safe care. For example, one person had been unwell prior to the inspection and had developed delirium (an acutely disturbed state of mind characterized by restlessness, illusions, and incoherence, occurring in intoxication, fever, and other disorders). This had made them act out of character and leave the home without informing staff. Staff had considered the risks should this occur again.

People were protected from the risk of infection. The home looked clean and smelled fresh. People told us, "Yes, it's very clean here, you can see that for yourself"; "The windows are cleaned regularly and it's very clean and tidy." Visitors said, "Yes, you've only got to look around you to see how clean and tidy it is" and, "It's very clean here, not just the downstairs lounges but the bedrooms as well." People told us staff took the necessary precautions when undertaking personal care, for example wearing protective clothing such as gloves and aprons. During periods of sickness at the service, staff maintained infection control processes, visitors were requested to avoid the service and deep cleans had occurred. One person told us, "Always clean, no unpleasant odours. Staff always wear aprons and gloves."

Robust fire safety checks and procedures were in place. Personal emergency evacuation plans detailed how people were to be safely evacuated if necessary. A contingency plan was also in place and prior to the inspection due to adverse weather this had been put into action. For example, staff had sought dressing advice by phone from the district nurse unable to attend; specific duties had been requested promptly of the maintenance staff including clearing the car park of snow and ice to prevent falls, checking the operation of the heating system so people were warm and assessing the risk of burst pipes. Staff had car shared to get to work and the registered manager had used their 4x4 car to collect others unable to travel safely in the snow. This had ensured people continued to receive safe care.

Regular health and safety audits and environmental checks ensured Cornelius House was safe for people, staff and visitors. The home was well maintained by the maintenance staff and external contractors where required to ensure electrical, gas and water checks were completed as required.

Good

Is the service effective?

Our findings

The service continued to provide effective care.

When staff joined the organisation they received an induction which incorporated the care certificate standards. The care certificate was a recommendation from the 'Cavendish Review' to help improve the consistency of training of health care assistants and support workers in a social care setting. Staff also shadowed more experienced members of the team as part of their induction. The registered manager advised the induction and shadowing was flexible dependent upon staff need and continued until new staff felt confident with people. New staff shared, "Induction has been really good. I had plenty of time to meet all the residents, been able to sit and talk with them. I did a shadow shift. I'm doing the care certificate and I'll work my way through the training programme through the year. I did moving and handling as a priority. Did fire safety with the maintenance staff. Safeguarding responsibilities were covered in induction. I will get three months feedback at the end of my probationary period. I've been observed working by seniors on shift."

People were supported by staff trained to meet their needs. Staff underwent training on essential subjects such as moving and handling, first aid and safeguarding as well as training that was specific to the people they supported, for example diabetes care. All staff confirmed the training was good and they were encouraged to complete nationally accredited qualifications. Topics of learning included, safeguarding, equality and diversity, medicine administration, a dementia friend's workshop, fire awareness and fire evacuation. The registered manager described positive working relationship with the external trainer. They told us individual staff strengths and weaknesses were identified in evaluations and discussed in supervision. Five staff were completing additional health and social care qualifications. Staff told us, "I just did the dementia friends training, had my eyes opened, I want to further my understanding as a result. We use the lounges for training sessions, that's why staff training is shown on their activity programme, to show we need their space. But they are welcome to sit in on our training; some did when we did first aid recently."

Staff were supported by ongoing informal and formal face-to-face supervision, spot checks, competency checks and an annual appraisal. Staff were invited to come into the office regularly and the deputy and the registered manager confirmed an "open door" policy. Open discussions provided staff the opportunity to highlight areas of good practice, identify where support was needed and raise ideas on how the service could improve. The registered manager told us, "Supervision aims to be six a year but can be group meetings as well as individual." For example, the registered manager had recently conducted a supervision meeting with two night staff to follow up on their experiences and support them in relation to a person's death.

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. No one at the service was unable to make decisions about their own care and treatment. At times

of ill health, for example a urine infection which might affect people's decision making ability, staff acted in their best interests or delayed any decision which was required to be made until they were better.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. No one who lived at Cornelius House required this authorisation. However, the registered manager understood how to apply for a DoLS should this be required.

People's nutrition and hydrations needs were met with frequent meals, snacks and drinks offered and available throughout the day. Feedback from people and relatives included, "Oh yes, there's plenty. Too much for me in fact"; "I always ask for small portions. The chef's always very good if I don't like what they've got planned I can have an omelette or soup" and, "There's always fresh fruit available if I want some". A visitor said, "The food is pretty good here. Mum never mentions any problems." Other's shared, "It's what you'd cook for yourself" and "I'm allergic to shellfish and chicken. The staff are aware of this and make sure I'm not offered it".

Resident meetings encouraged people's involvement and choice with the menu and the registered manager monitored the quality of food. Mealtimes were unhurried and people could choose to eat where they wished. The registered manager told us, "A home cooked meal is appreciated by all residents and chef will always prepare what they feel like, even if that means cooking three-four different meal choices."

People's care plans provided details to help staff know what people's nutritional likes and dislikes were and highlighted any people who required support with their health needs or weight. Staff gave examples of how they had supported people who had special dietary requirements, for example those needing a low fat diet or people who had diabetes. Staff knew who required their food and fluid intake to be monitored and when they needed to encourage people to eat and drink.

People's healthcare needs were met by staff that made prompt referrals to relevant healthcare services when changes to health or wellbeing had been identified. People told us, "Yes, we can see a Doctor whenever necessary they visit here"; "They make all my appointments for me, teeth and hearing tests"; The chiropodist is coming today" and, "Yes, I've seen a GP here twice. I had a chest infection when I came in and then I had vertigo so needed the doctor."

Staff knew people well and monitored people's health on a daily basis. The service were working with local services to improve people's life experiences who had complex long term conditions such as diabetes or heart conditions. The "Digital Health Transformational Programme" enabled staff to take people's blood pressure, blood sugar levels, oxygen levels and heart readings and these were sent electronically to their healthcare professionals. This helped professionals to intervene early and prevent exacerbation of people's symptoms.

Changes in people's health were communicated to staff via regular handovers so staff were aware. If staff noted a change we observed them seeking the advice and support of the senior care staff. One staff member told us, "I carry a notepad as well as the handset (this records people's care electronically). It's good that we record things instantly. There is always a senior person we go straight to with any information. We get feedback on how it's been referred on and the outcomes. There is very good communication all round.

Health professionals are brought in quickly. We have to do some prompting to people to look after their oral care and I've seen people helped to access the dentist. People's eyesight and glasses, hearing aids, hair brushes get routine attention as part of essential personal care. We have good communication with the kitchen staff to ensure there is information about individual needs." Working together in this way ensured people received effective care.

Cornelius House was well maintained. Adaptations had occurred to provide a safe and accessible environment for people to mobilise. Handrails were available for people to move around the corridors safely.

The provider had looked at how technology could improve people's lives and the service they then experienced. Wi-Fi and internet access was available for people to use to connect with family who lived away. A new computerised care planning system meant staff intervention with people was recorded as it occurred. A new call bell system had been installed since the previous inspection and the provider was looking at ways to ensure they met the new data protection standards through technology.

Outstanding ☆

Is the service caring?

Our findings

People received excellent care at Cornelius House.

People shared their views on the caring service they received, "Absolutely fantastic"; "Cared for in such as personal and loving way." Another person told us, "Lots of my visitors have said what a lovely atmosphere it is here, they don't feel they are coming into a home. I feel it's my home; I go about just as I please. If you want anything sorted out you only have to speak to [staff name] and it's done."

Cornelius House had an established set of values all staff worked to. These were Integrity, Respect, Nurture, Quality and Optimism. How people, relatives and staff spoke with us demonstrated the service was working to these values to an exceptional level. These values and the caring nature of staff were monitored closely by the provider and registered manager through spot checks, team meeting discussions, feedback from visitors and supervision with staff. This helped ensure compassion, kindness, dignity and respect. For example, during the inspection staff were helping family make birthday preparations for one person. The staff stressed to the family the person's wishes must take precedence and the service would work around those arrangements. Other staff gave examples of how they went "the extra mile" for people. They told us some people living at the home enjoyed pets visiting. The registered manager said, "Many staff bring in their family or pets to visit people. Dogs are a particular favourite of the home and visiting dogs have to do "the rounds." We keep dog biscuits in the kitchen for visiting dogs. There are examples of staff bringing in favourite magazines or articles of interest from the paper for our residents and our home ethos is about going 'the extra mile' for them as a basic expectation."

People, relatives and professionals all told us staff were exceptionally caring. One health professional said, "Exceptionally kind and caring. When staff accompany me to see a patient, the staff member will always introduce me, and often hold the resident's hand, or explain things if they are hard of hearing or anxious." People told us, "They do treat us very well. The carers; they're kind and don't rush me"; "The staff are wonderful here, we do have a laugh together and I'd sum it up as, I'm content!"; "They are very good"; "They are lovely, they treat me well" and, "I'm very happy here. I used to visit a friend who lived here so chose this place when I needed it. They're very good here." Relatives also confirmed exceptional care, "They are very special people, who do a very special job. We knew Cornelius House was the best Residential Home for miles around (and probably anywhere), and we are so lucky that you were able to take mum 4 years ago. She could not have been happier anywhere, nor surrounded by more love and care from the moment she first arrived. We are so grateful." A further relative we spoke with said, "I looked at lots of homes. I was so thankful that they had a vacancy here, this one is just right." A health professional commented, "Cornelius House is the nicest home I visit."

Staff who worked at Cornelius House were recruited and appraised using the "mum test". The registered manager told us that meant asking, "Would the managers and owners consider them suitable to look after their own mum?" They added it promoted compassion, patience and a loving environment that made the service quite individual. Staffing levels were organised around people's needs and arranged so staff had time to listen to people, provide information and involve people in their care. The registered manager told

us, "We listen to residents' needs and wishes and respond appropriately. For example, when a resident wanted to visit a previous resident who had moved out, we took him to meet his friend and they wanted to make it a regular outing, we committed to making this happen." This helped maintain this friendship. Staff spoke of people in a very caring, thoughtful way. Staff told us how much they loved their work and the people they cared for. Good relationships with people had been built up over time; people were encouraged to express their views and contribute to their care. A new member of staff shared their first impressions, "I've found it a calm family atmosphere. Residents are engaging and obviously happy. I have an impression of a very close staff team, it has been very welcoming."

When people arrived at the home they were made to feel they mattered. They were asked about the small things which were important to them so Cornelius would feel like "home from home." The staff recognised what a big step moving to a residential service was and people were asked their preferences for how they liked their drinks, and meals they enjoyed, bedding preferences, for example blankets, duvets and / or sheets, soft or firm pillows. Anything that needed to be sourced to make people feel comfortable, for example their favourite cereal was arranged. People's rooms had fresh flowers to welcome them and they were always greeted by a familiar face, usually the staff member they had met at their assessment. Introductions were then made to others' who lived at the service and to staff. A care plan was circulated to all staff so people's needs were met immediately on arrival. This helped people settle in and feel at home. We observed staff introducing a new person to others in the lounge during the inspection so they knew who they were sitting next too. They told us how they appreciated this.

Relatives confirmed, "There is a lovely atmosphere in the home and all staff members I have interacted with have been helpful, caring and friendly." A Health professional commented, "The staff all have a lovely attitude to the residents. They take time and get to know them personally. They seem to have a genuine care for people." People told us about the small things staff did which as a result, made them feel special, "When it was someone's birthday recently they had a lovely big cake. They showed it to her at lunch time and we all had a piece with a cup of tea in the afternoon"; "They always have a beautiful birthday cake with candles on here. We all have a slice and they make a fuss of you on your birthday." One person showed the inspection staff a pile of books they had and said, "I'm a voracious reader I love books. There's a member of staff here who collects up paperbacks for me and bring them in, she's so kind." Another told us, "When I'm in the bath the carers help me, people can hear me laughing right down the corridor!" One person showed us small bags of breadcrumbs that they kept by their side. They said, "I love to feed the birds. I go out every day to feed them from these bags which the kitchen staff make up for me. They are very good to me" and another person said, "Look at these lovely hair slides. One of the carers gave them to me because I like them." These kind gestures staff did as a matter of course, which made people feel valued.

People's needs in relation to equality and diversity were met. Cornelius House supported three residents who were registered blind or partially sighted at the time of the inspection. Ensuring these people had magnifying glasses if they wished, regular eye checks, and clean glasses to assist them to read, were able to see their meals and interact with each other was always considered. Staff told us, "One resident has a computerised magnifying machine provided by the RNIB. We have arranged for contact through local charities like Articles for the Blind to access audio content such as local newspapers and audio books". Staff provided assistance to play these recordings when requested. Staff also posted the returns envelope on behalf of the person to exchange recordings. Staff read and wrote greetings cards on a regular basis for people, so they could enjoy those special sentiments with friends and family.

People's communication needs were met in a very personalised way by staff. For example the registered manager told us, "For those residents with a hearing impairment we have purchased a communicator device that amplifies sound. This is often used by the NHS services to communicate with patients. We felt it

benefited our residents as hearing aids get lost and broken and some of our residents hearing loss is so significant we would struggle to communicate with them. Residents can now make their wishes known, remain interacting with other residents and improve their confidence when speaking with anyone. Our telephone system has a hearing aid setting so not to distort the call and residents can keep in touch with friends and family, breaking that feeling of isolation. Our TV lounge has a hearing aid loop system installed so residents get the benefit of hearing their favourite programmes, without disturbing other residents. We find this leads to a more harmonious atmosphere" and, "We have a communication chart available for any resident that may struggle with verbal communication, this is a dementia friendly resource with both pictures and words, so it is fully inclusive."

Staff ensured people were supported and cared for as they would their own family. Staff checked people's well-being and were genuinely concerned for their welfare. We observed one person who was sat in an armchair in the lounge before lunch. They told staff they felt tired and didn't want to eat lunch. The staff appeared concerned and let the deputy manager know. Several people approached the person to check that they were alright and to offer a cup of tea and said they would save a lunch for later. The deputy manager spoke quietly with the person and ascertained that they did not feel ill, just tired.

People's care plans detailed family and friends who were important to them. This helped staff to be knowledgeable about people's family dynamics and enabled them to be involved as they wished. People and their relatives were encouraged to express their views and be involved in all aspects of care. Regular reviews with people and those that mattered to them were in place. No one we met required or wanted their care plan presented in an accessible format; however care reflected people's diverse needs and social situations. Care plans and information could be provided in larger fonts and the registered manager was looking at how the accessible information standards could be further incorporated in to people's care (The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.)

People told us, and we observed, their privacy and dignity was maintained, "Yes I can sit here in my room with the door closed if I like". A relative shared, "Without exception staff have shown a high level of care treating both my parents with respect and dignity. Mum and Dad always looked well cared for and they took time to help Mum do her hair and put on jewellery." We saw a person who was sat in the dining room after lunch. They asked staff if they could use a telephone to ring their daughter. The deputy manager asked inspection staff if they minded leaving the room so the person could have privacy to make the call.

Staff understood the need for confidentiality, the safe storage of people's records, and knew not to share information without people's consent or unnecessarily. The registered manager confirmed, "Residents fill in a consent form to share information and appoint people they are happy for us to communicate with. The management team are readily accessible and have meaningful relationships with each individual. Families receive regular updates from the staff and are fully involved in care planning."

Family we spoke with shared how kind and welcoming the staff were. Cups of teas and biscuits were always provided for visitors, and staff worked to keep family up to date and engaged with people's lives in line with people's consent. For example staff shared, "We take photographs of residents enjoying activities and family pictures together when they visit, and these are then displayed in their room or around the home if they have given permission. We also send them to families to help them see how residents are getting on and have something to talk about on their next visit."

Good

Is the service responsive?

Our findings

The service continued to provide responsive care to meet people's needs.

Cornelius House prided themselves on the end of life care people received. They worked hard to ensure people who wished to remain at the home during their final days were able to, comfortable and pain free. Staff had attended training on end of life care with the local hospice and regularly attended meetings to ensure their practice remained up to date. Staff worked with the community nurses and GPs providing best practice end of Life care for residents. Staff had good working relationships with doctors and nurses to ensure people who might require pain relief had this promptly. This included privacy, comfort and dignity, and any equipment provided. This meant staff were skilled at delivering compassionate care in people's last days.

A relative spoke with us and wrote to the service about their mother's end of life care at Cornelius House, "Completely above and beyond – not done out of duty but because they loved her".

Other comments the service had received included, "Just to say thank you again to you and absolutely everyone at Cornelius House for the wonderful, genuinely loving care that you have given [X – person's name] over the last 4 years, and especially in the last 2 weeks of her life. It is impossible to imagine how anyone could have done more for her or for us, her family, during her last few days, and what came across so strongly time and again was that the care you gave her was not an obligation or a duty, but was born out of a real love for her, which was very, very special."

The registered manager shared how they were very thoughtful in approaching people at the end of their life saying, "We have sympathetic practices like always leaving a chair by the bed when you leave the room as it shows someone has been sitting there and will be coming back, and this provides comfort and reassurance. Fresh flowers play an important role in our practices during end of life care and afterwards. It is regular practice to place a rose or flower from our garden on the deceased before viewing by the family." Relatives were also supported to stay over, with staff providing blankets and pillows and even a spare bedroom and shower on occasions. Relatives are provided with an overnight bag that enables them to stay comfortable, this contains a toothbrush, toothpaste, soap flannels, disposable razors. Their meals and plenty of drinks are catered for while they are with us and the staff offer them plenty of breaks and fresh air.

Following death the service supported families. Condolence cards were sent to relatives. Staff continued to stay in touch with previous relatives and remember them at Christmas, mother's days and birthdays with a special card or text message. Staff attended people's funerals and Cornelius House had previously held wakes at people's home for no charge so other residents can join in.

People's faith needs were met. The service shared, "Staff provide comfort and share their faith where appropriate. There are examples where a certain staff member has offered to light a candle at Chichester Cathedral and a prayer being said has provided great comfort. Other examples are when a resident lost her rosary before being admitted to hospital, she took a turn for the worst and a staff member rushed to

purchase a new one and deliver it to the hospital in time. Her daughter decided to place this in the coffin with her, it meant that much to her mother."

People enjoyed an active lifestyle if they wished at Cornelius House. A relative shared, "An enormous amount of stimulation for example scrabble, crosswords, - just fantastic!"; "They did a country a month theme for example Venice; everything was Italian food, ice cream, talks about Venice." There was a home car available to facilitate trips out, including hospital visits to avoid waiting for hospital transport. Extra staff were put on shift for this. We saw a range of activities in place for March including exercise, board games, massage, and themed days for St David's and St Patrick's Days.

On our arrival two people were already waiting in the lounge looking forward to the start of the externally facilitated exercise session. They told us they were very much looking forward to it and saw it as an important fixture in their week. Other told us about the pastimes they enjoyed, "[X] can play the ukulele I love to listen to her"; "We had some Irish singers here last week, they were very good"; "I like the quizzes and the singing" and, "[the activities coordinator] is very good, she has craft sessions with us. We made cards last week we will be looking at fleece next week, I'm sure it will be interesting. Last week and did some flower arranging." Staff shared, "On Friday afternoons we have a set time to look at the local papers together and on Tuesdays we have music and dance time, which is something [X] especially has asked for. The activity calendar was available in larger font and print if required with pictures to help differentiate between activities.

The registered manager advised referrals came through word of mouth and through the local authority system. The service undertook their own assessment of people's strengths and needs. These included assessments of people's skin care and nutritional needs, level of dependency and pain and depression assessment tools if required. Comprehensive, individualised care plans were being developed on a new computerised system.

People had support plans in place which were individualised and encouraged choice. People and or their families were proactively involved in putting their care plans together. Care plans reflected how people liked to receive their personal care, be dressed and the aspects of their care they could manage themselves to maintain their independence. They provided clear guidance and direction for staff about how to meet a person's needs, their likes and dislike and routines. Support plans included information for staff about how to communicate with people if they had cognitive difficulties, had sight difficulties or hearing needs. People's care plans were personalised and written using their preferred name. People's care records were reviewed with them regularly and where appropriate, those who mattered to them and staff who knew people well were also involved. Care plans were located on the computer but could be easily printed out for people who wished to have a copy, moving to a different service or going to hospital.

Staff shared examples of personalised care they provided. For example, staff were aware of people who had a gender preference for personal care, those who preferred their own company and people who had particular areas of the home they preferred to relax in. Bedrooms were personalised with people's belongings and the things which mattered to them and people proudly showed us their bedrooms. The registered manager told us, "We have invested significant time in personalising our care plans and risk assessments. Every resident has a "this is me" document in their care files and this helps us get to know what and who is important to them. It helps us facilitate relationships, get to know them better and create a meaningful activity programme to enrich their lives. People's preferred times are accommodated and recorded in their care plan, autonomy is promoted at every level." The staff shared how they met people's particular likes for food and drink, "Individual requested branded products are sourced and kept in stock, even if it is only for one resident ie that is, foods like dates, cheese crackers and branded beer."

There was a system in place for receiving and investigating concerns and complaints. People told us, "Yes, I do. I haven't needed to and would feel a bit disloyal if I had to" (Discussed this further and person told us that they wouldn't like to get anyone into trouble but there had been no incidents); "Yes I think I'd know, I'd speak to one of the senior people"; "Yes I'd go to the top, the Manager". Visitors said, "I'd go straight to the top. The named manager or deputy" and, "I'd tell the boss."

Good

Is the service well-led?

Our findings

We found the service had improved from "Requires Improvement" to "Good". At the last inspection in November 2016 people raised concerns that in the absence of the previous registered manager and deputy they did not always know who was in charge. Concerns were also raised about the communication systems at the service. The previous report noted there were too many places staff were required to look to find relevant information they needed to know about people's care and any changes. We found both of these areas had been addressed by the provider and new management team.

Since the previous inspection, the former, long standing manager had retired. A new management team was now in place which included a new registered manager, deputy, and team leader roles. The provider, registered manager and staff vision was, "For people to recognise the benefits of living, a "home from home", to invest in high quality food and offer a bespoke service. Staff and resident meetings reiterated the ethos to have, "Happy, healthy residents and to support, listen and train staff."

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

We found the service was very well-led. One person shared, "It's an extremely well-run home." A health professional told us, "I think it is amazingly well-led. Staff team are stable, and all the staff seem happy and to genuinely enjoy their work. The atmosphere at Cornelius House is that of a big, happy family. It is a pleasure to visit as a GP."

We spoke with the provider and registered manager about changes since the last inspection. Robust quality assurances processes were now in place for example medicine audits, environmental audits and health and safety checks. The provider and registered manager made a yearly improvement plan to focus quality improvement. For example this year the focus had been on improving medicine practices. We saw excellent processes were now in place. The provider had also moved to an electronic care planning tool in September 2017 which enabled instant recordings of people's care as it was delivered. A new call bell and fire alarm system was had also been installed. Improved internet connection had been invested in for the new phone system and new computers. Plans were in progress for a new bathroom for people to enjoy. Internal décor updates had occurred for example, new carpets. Investment in end of life care and dementia training had occurred to enhance the quality of care provided to people. Plans for the next 12 months included moving to an electronic medicine system and a garden room.

The staffing structure had developed since the previous inspection to share the leadership roles across the staff team. This had been achieved while ensuring the provider and Registered manager demonstrated they retained accountability. All staff were clear about the limits of their roles. One staff member newly recruited to the team leader role told us, "I saw the post advertised on line, applied and got a quick response, interviewed by [the registered manager and deputy]. It was presented as a new role between the deputy

manager and senior carers. I'll be giving live supervision on the floor and overseeing meds competence". The registered manager told us they saw the new team leader role as providing an additional supervisory role in a more dynamic way and able to "filter" issues to bring back to management. The new, "live" electronic care planning tool had also improved communication and staff were alerted to changes when they came on duty. This kept everyone up to date.

Feedback from people and relatives included, "Yes, I know who is in charge and who they are, the two in charge. They're both very approachable" and, "Yes, the two managers are both very good". People told us they felt the management team was approachable and "hands on".

People's views were actively sought to ensure the service was run in the way they liked it to be. People and relatives were sent annual quality assurance questionnaires, the results of which were audited in order to drive continuous improvement of the service. Results we reviewed were very positive. Feedback included, "Fabulous staff"; "Excellent establishment"; "100% of people knew who to contact if they had a complaint"; "100% of people felt they were respected and treated with dignity".

People and relatives told us the culture at the service was very positive. People felt involved in the running of the service and some like to attend the resident meetings when they were held which kept them informed and involved, "I haven't been here long but I will go to any meetings they have here to hear what they say and to say it suits me here" and, "I don't have any suggestions really I'm quite happy here."

People were involved not only in designing care according to their needs, but also in the development and equipment changes at the service. We heard from people and the registered manager about the new bath, "Recently people had the opportunity to observe a demonstration of a new accessible bath; they asked the salesman lots of questions and put ideas forward for the new bathrooms decoration and layout. We feel this evidences we actively seek out our residents points of view and communicate well with them, making them fully involved in making their home like home." People were actively involved in creating menus and planning the annual parties held such as Christmas. People's views of new staff were also important. Staff told us, "Residents have been involved fully in the appointment of a new activities co-ordinator; they interviewed each candidate and chose the successful candidate themselves. We felt this empowered them, in a post specifically created to enhance people's wellbeing. The feedback we received said this was appreciated and it was a great way to introduce [the new member of activity staff]". Staff felt this meant residents felt invested in the outcomes of the activity programme.

Staff shared their experience of the leadership, "Highly motivated to provide a service to modern standards, they are well known and involved in the home"; "We have staff meetings and there is a suggestion box. The registered manager is very responsive. We had a good meeting recently. [The registered manager shares how she wants the home to develop. Currently we are concentrating on person centred care. We do it, but there's room for improvement." They also explained why the team leader role was introduced, "it's about quality improvement." Other staff confirmed, "Management are very open and they would be approachable about anything, they keep us in the loop."

Staff had confidence in the leadership team. The provider and registered manager were open, transparent and person-centred. We were told by the provider and registered manager the focus of the service was to ensure people came first and received good outcomes. People and staff told us they knew the senior staff, manager and provider were.

The service encouraged staff to provide high quality care and support. We observed the management team role model the organisation's values. Staff told us they were happy in their work, understood what was

expected of them and were motivated to provide and maintain a high standard of care. Staff were encouraged to develop themselves to enhance care, for example through additional training. We heard about the development of dementia champions to enhance care, "We run a Dementia Friends programme with a qualified Dementia Champion. We have three residents with a dementia diagnosis and having a staff understanding of their behaviour and anxieties is essential to happy residents. Staff have found the friends programme very useful and we have opened it to other residents as a couple expressed an interest in joining in."

The registered manager worked in partnership with other agencies when required, for example primary healthcare service, the local hospital, the local hospice, pharmacy and social workers. The registered manager and senior staff attended forums where best practice was discussed, for example the local authority forums. Through this forum they implemented the digital health monitoring so people with long term conditions had regular monitoring and any changes in their health statistics was quickly identified.

The registered manager and provider had a range of organisational policies and procedures which were available to staff at all times. Staff had access to these at the office. The provider's whistleblowing policy supported staff to question practice. It defined how staff that raised concerns would be protected. Audits and a range of meeting with key staff occurred to maintain the high quality of care at Cornelius House.

The registered manager and provider understood their responsibilities. They promoted the ethos of honesty and learned from mistakes, this reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment and apologise when something goes wrong.

CQC registration and regulations requirements were understood by the management team. The registered manager kept up to date with ongoing training and communicated changes to staff through staff meetings and one to ones.