Barchester Healthcare Homes Limited

Kernow House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Kernow House on 9 and 16 July 2018. Kernow House is part of the Barchester Healthcare group of homes. The service delivers care within two areas of specialism, Huntington's Disease and neurological services and Dementia with a complex presentation for up to 98 people. At the time of the inspection there were 78 people using the service.

People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. There were two units for people with Huntington's Disease and three dementia units, one of which provided care for people who could become agitated and required more intensive staff support. At the time of our inspection there were 78 people living at the service. The service is large purpose- built home on two floors with access to the upper floor via stairs or two passenger lifts. Most rooms have en-suite facilities and there are shared bathrooms, shower facilities and toilets.

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

As part of this comprehensive inspection we checked to see if the provider had made the required improvements identified at the inspection of 17 and 19 May 2017. In May 2017 we found the registered manager/provider was not ensuring the numbers of staff on duty was sufficient to help ensure people's needs were met in a timely manner. People's rights were not fully protected because the service had not acted within the legal requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards. Staff morale was extremely low. Recent changes to the way the service operated had not been effectively communicated to staff and staff's perception of these changes was very negative.

At this inspection we found improvements had been made in all the areas identified at the previous inspection. This meant the service had met all the outstanding legal requirements from the last inspection and is now rated as Good.

Since the last inspection staffing levels had been reviewed and the way staff were deployed in the service meant people's needs were being met. However, there was a continuous recruitment programme and there was a reliance on agency staff to support and maintain staffing levels.

Staff understanding of how to ensure people's legal rights were protected had improved. Additional training had supported the management team to understand the legal requirements of the Deprivation of Liberty Safeguards (DoLS). Some people lacked the mental capacity to recognise the decline in their physical capabilities, which potentially put them at risk of harm, such as sustaining injuries from falls. These people

were subject to restrictive practices or continuous supervision to protect them from the risk of harm and keep them safe. DoLS applications had been made to the local authority to seek the legally required authorisation to have these restrictions in place.

Regular engagement with all levels of staff through meetings and day to day overview meant communication had improved. Staff told us they felt supported by the management team. Staff comments included, "It's got a lot better. We (staff) see the managers a lot," "I think we get told a lot more about what's going on now. There have been a lot of changes but it's meant it's got better" and "None of us like change but it helps when we get told about what's going on and why."

Risks in relation to people's daily lives were identified, assessed and planned to minimise the possibility of harm whilst helping people to be as independent as possible. Records included evidence of reviews to make sure changes were being monitored and responded to. Care plans included information about people's general health and who was involved in the person's care and welfare.

Medicines were generally managed safely with regular audits identifying where any errors had occurred. However, the time of the morning round in one unit took up to four hours, meaning it finished close to lunchtime when the following round was due. On further investigation we found this had been due to a number of circumstances that morning. Medicines were stored securely and safely.

Some people's health needs meant they needed to have their food and drink intake monitored to ensure they received sufficient each day. We found the records for monitoring were complete and helped staff to monitor peoples diet and nutrition. This was particularly important for people living with Huntington's Disease where high calorific intake was necessary at certain stages of the disease.

Staff were supported by the registered manager through regular updates called 'stand up meetings'. These kept the staff team up to date with any changes and provide any essential information that might be needed to be shared to support peoples care and welfare.

People received care and support that was responsive to their needs because staff had the information to support them. Staff supported people to access healthcare services. These included, social workers, psychiatrists, GP and speech and language therapists (SALT). The service had its own physiotherapist and occupational therapist which helped access to these services when they were required.

Staff completed a thorough recruitment process to ensure they had the appropriate skills and knowledge. There was a wide range of training available to all staff which met the diverse needs of people being supported. Staff were supported through formal and informal group supervision. There had been some gaps in recording formal individual supervision but a new system had recently been implemented to address this.

Some parts of the service had been refurbished including lounge areas and bathrooms. However, some areas of the environment required attention. For example, some chairs had cushions torn and stained. One lounge area had a malodorous odour and the carpet was stained. We spoke with the registered manager about this. We had received negative comments about these areas prior to inspecting the service. There was a maintenance and refurbishment plan continuing and this would improve all areas of the service.

Infection control measures were in place. Where people were at high risk of infection staff were knowledgeable about the risk and action to be taken. There was a housekeeping team who told us they had the training and equipment to keep the service clean and understood key issues for infection control.

Safeguarding procedures were in place and staff had a good understanding of how to identify and act on any allegations of abuse.

There was a system in place for receiving and investigating complaints. People we spoke with had been given information on how to make a complaint and felt confident any concerns raised would be dealt with to their satisfaction.

The provider had systems in place to monitor the quality and safety of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was generally safe. People were supported with their medicines in a safe way by staff who had been appropriately trained.

Risks were identified and appropriately managed.

There were sufficient numbers of suitably qualified staff on duty to keep people safe and meet their needs.

Staff completed a thorough recruitment process to ensure they had the appropriate skills and knowledge. Staff knew how to recognise and report the signs of abuse.

Is the service effective?

Good

Staff had a good knowledge of each person and how to meet their needs. Staff received on-going training so they had the skills and knowledge to provide effective care to people.

People saw health professionals when they needed to so their health needs were met. Specialist advice was appropriately sought from external healthcare professionals.

People's rights were protected because staff understood the legal requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The management provided staff with appropriate leadership and support. There was a general positive culture within the staff team with an emphasis on providing a good service for people.

People and their families told us the management were

approachable and they were included in decisions about the running of the service.

There were effective quality assurance systems in place to make sure that any areas for improvement were identified and addressed.

Quality assurance systems were in place to monitor the services operation and delivery of service to people.

People were asked for their views on the service.

Staff were supported by the management team.

Kernow House

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 9 and 17 July 2018. The inspection was carried out by three adult social care inspectors, a specialist advisor and an expert by experience. The specialist advisor had a background in nursing and the expert by experience had personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with one area manager, the registered manager and deputy manager. We also spoke with nineteen staff members, one visiting professional, a visiting relative and six people who were able to communicate their views of living at the service. Most people were not able to verbally communicate with us due to their health care needs. . We looked around the premises and observed care practices on the day of our visit.

We looked at eighteen records relating to the care of people, staff recruitment files, staff duty rosters, staff training records and records relating to the running of the service.

Good

Is the service safe?

Our findings

At the last inspection in May 2017 we found appropriate staffing levels were not in place to meet the needs of people at the service. We found evidence of people's needs not being responded to in a timely way.

We checked the actions taken by the provider since the last inspection. The design of the service had been reviewed and units combined to assist with the deployment of staff. The service used a Barchester dependency tool to assess staffing levels based on the needs of people using the service. In order for it to be suitable for Kernow House, the tool had been modified in order to reflect the complex needs of people using the service. Staff on each unit had a range of skills which helped support people's specialist needs, for example people living with Dementia and Huntington's disease. Call bells were being responded to in a timely way. Staff we spoke with told us staffing levels had improved but there were times when they were rushed. Comments included, "We [staff] work in units where we are needed. It's because the challenges are different every day" and "Staffing is OK, but there are times when we have to cover other units." Daily stand up meetings between the registered or deputy manager and senior staff identified where there might be shortfalls in units and how these could be responded to. We observed staff changes following an incident where it was recognised that, due to the challenging needs of a person, an additional staff member was required. This demonstrated action was taken to respond to challenges.

The registered manager told us they were constantly recruiting care staff and there was a continuing reliance on agency staff to support staffing numbers. A revised up to date staffing rota was on display so it was clear who was working, in what capacity and the hours they worked. Staff also had the opportunity to volunteer for additional shifts. One staff member told us, "Having the rota up makes it easier to see where the gaps are and we can fill in the shifts, otherwise we use agency staff."

During the previous inspection it was observed that staff working in units they were less familiar with were hesitant in how they communicated with people. During this inspection we noted staff were confident in their role and how they communicated with people. Staff told us that working in different units meant they were familiar with people's different needs. There was consistently positive communication taking place throughout the inspection. For example, staff took time and paid attention to what people were trying to communicate as some.

We found the service was now meeting the requirements of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The rating of the safe section had improved to Good. The service had taken steps to meet the requirements of the breach of regulations. Systems were in place to continuously review staffing levels in order to ensure there were enough staff to support people.

Systems were in place for managing medicines in line with current clinical guidance. For example, staff responsible for medicines had the knowledge and skills to manage them safely and there were regular updates in medicines training. The morning medicine round on one unit took in excess of four hours. On further investigation it was noted the round commenced late due to a delay in a nurse's duty time. Also, people on that unit often stayed in bed until later in the morning and therefore medicines were taken to

them on waking. Some people were receiving pain control, the times these medicines had been administered were not being included on the Medicine Administration Records [MAR] so that the potential for an overdose would be avoided. We shared this information with the registered manager who assured us this would be addressed immediately. The system for administering medicines was the 'pot, dot and sign approach'. Pot the medicine, dot the box to show it had been dispensed and sign for once administered. This reduced the risk of errors when administering medicines.

We recommend the service seek advice in line with 'National Institute for Clinical Excellence' (NICE) guidelines about safe medicine procedures in respect of ensuring the times pain relief medicines are administered are recorded appropriately.

People's medicines were taken to them by staff rather than using a mobile trolley. The medicine room was locked when not in use. The medicines fridge temperature was being recorded regularly to help ensure medicines requiring colder storage were appropriately stored. Regular medicines audits were taking place to ensure that incidents would be quickly identified and action taken.

Accidents and incidents were consistently reviewed and action taken to mitigate risks. For example, there were 'lessons learnt' documents relating to the reporting of incidents where they occurred. An incident occurred during the inspection. This was shared immediately with senior staff and cascaded to care staff. The incident was reviewed to see if lessons could be learnt and to reduce the risk of similar incidents.

People told us they were happy with the care they received and believed it was a safe environment. Comments included, "At home I would worry, being on my own. Once, I slipped out of bed in the night and hurt my back a bit, but I was able to call for help from the night staff who came straight away and reassured me that I was fine and got me back into bed" and "I know the night staff can be busy but they never fail to come if I need help in the night."

There were procedures and systems in place to protect people from abuse and unsafe care. Staff had received training and knew what action to take if they became aware of, or suspected, a safeguarding issue. They understood what types of abuse and examples of poor care people might experience. They could describe safeguarding procedures which needed to be followed if they reported concerns to the registered provider.

There was an equality and diversity policy in place and staff received training on equality and diversity. Staff demonstrated that they were aware of their responsibility to help protect people from any type of discrimination and ensure people's rights were protected. For example, a staff member told us how important it was to support people living with Huntington's disease in the community due to people's perceptions of their involuntary movements. A staff member said, "The public don't always understand and make their own views as to why residents are behaving in such a way. I feel very strongly about it and it can be upsetting."

People had assessments in place which identified risks in relation to their health, independence and wellbeing. There were assessments in place which considered the individual risks to people such as mobility, mood and emotional need, nutrition and hydration, and personal care. Where a risk had been identified, for example a falls risk, the assessment had looked at factors such the environment and whether mobility aids remained suitable. There was a physiotherapist and occupational therapist in post to help support people quickly as their needs changed. Staff could tell us about people's individual risks and how they were being managed. Records were up to date to show where risk levels had changed. For example, a person's mood and behaviours had changed, meaning people may be at risk. Additional one to one support

was in place to support these changes.

Staff did not work in the service until all the necessary safety checks had taken place to ensure people were safe to work with people who may be vulnerable. Staff recruitment files contained all the relevant recruitment checks to show they were suitable and safe to work in a care environment, including Disclosure and Barring Service (DBS) checks.

The environment was clean however one lounge had an unpleasant odour and the carpet was stained. The registered manager told us, and we observed, there was a general decoration programme in place and the lounge area was scheduled to be redecorated with carpets, curtains and new furniture. Staff received suitable training about infection control, and records showed all staff had received this. Staff understood the need to wear protective clothing such as aprons and gloves, where this was necessary. Personal protective equipment (PPE) such as aprons and gloves were available for staff and used appropriately to reduce cross infection risks.

Each person had information held at the service which identified the action to be taken in the event of an emergency evacuation of the premises. Appropriate safety checks were completed to help ensure the building and utilities were safe. Records showed that manual handling equipment, such as hoists and bath seats had been serviced. There was a system of health and safety risk assessment. Fire alarms and evacuation procedures were checked by staff and external contractors to ensure they worked. There was a record of regular fire drills.

Good

Is the service effective?

Our findings

At the inspection in May 2017 people's legal rights were not fully protected because management did not have a full understanding about the legal requirements of the Deprivation of Liberty Safeguards (DoLS). One person's care records did not clearly state on what legal authority staff were providing care. There were conflicting records in relation to whether or not the person had mental capacity. Records to show that staff were spending meaningful time with these people had not been kept. There were no records to evidence that staff had asked people who had a condition for administering medicines covertly.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked to see what action the provider had taken to meet the requirements of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Also, whether the service was working within the principles of the MCA, and that any conditions on authorisations to deprive a person of their liberty were being met. During this inspection we identified people who had DoLS authorisations in place. They were current and clearly informed staff of the conditions and how to meet them. For example, supporting a person for specific time periods to access the community. Also, to support a person in the least restrictive way possible. Staff were able to identify who received medicines covertly by using the information board in the clinical room and complete the necessary records. There were restrictions in place including locked entrance and exit doors with key pad codes and pressure mats to monitor movement. Records showed 'Best Interest meeting's' had taken place and reviews to meet any conditions had been held.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Best interest meetings had been recorded. In one instance with the support of a family member with the legal authority of Power of Attorney in respect of managing the person's movement. The service held an appropriate MCA policy and staff had been provided with training in this legislation. Where people were receiving medicines covertly staff were reminded of this using an information board in each office.

Staff were aware of the importance that people who lived at Kernow House were given the opportunity to consent to receive care and support. Where people did not have the mental capacity to agree to consent their legal representative, where possible, acted on their behalf. There were a number of people who had independent support from advocacy services so their human rights were represented and upheld.

This meant the service was now meeting the requirements of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff received training in equality and diversity which focused on the Equality Act and ensured staff understood what discrimination meant and how to protect people from any type of discrimination.

People's healthcare needs were being monitored and discussed with the person or relatives as part of the care planning process. Care records showed health professionals including general practitioners (GP's) and a range of other health professionals were involved with people when necessary. They included social workers and dieticians amongst others. The service employed its own physiotherapist and occupational therapist. This helped to ensure people received this support in a timely way. The service worked closely with the Dementia Liaison Team. There was also a dementia champion working at the service so they could advise and guide staff where necessary. A visiting professional told us, "Can't fault the staff, always friendly and supportive." Staff were available with the knowledge and skills to support people with dementia conditions, through specialist input and assessment to measure progress of the disease. Also, to provide the service with any specific advice to enable them to effectively respond to peoples changing needs.

On the first floor one unit had doors to people's rooms with glass viewing panels. The registered manager had identified this had the potential to impact on people's privacy and dignity and had arranged for opaque glass to be fitted over the panels. However, they were in the process of arranging for them to be completely removed due to the potential for people to be disturbed by excessive light especially during the night time.

There was a refurbishment programme in place. Some areas of the service had been decorated and furniture and fittings replaced. Prior to this inspection people had made comments to us about the poor standard of some areas of the service. We noted areas where a refurbishment had not taken place. These areas were sparse and furniture looked worn. The registered manager confirmed the refurbishment programme was planned to improve these areas. The external garden areas were not being maintained. Planting containers were empty with weeds noticeable. A grassed area had not been cut. The first day of inspection was hot and sunny, the external areas were not inviting and were not being used by anybody. On the second day of inspection all garden areas had been maintained and improved. The registered manager told us the gardener was on sick leave but that staff and volunteers had worked together to make the areas more appealing for people. We were assured by the registered manager this would be maintained regularly.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. This enabled us to observe and record the day-to-day activity within the home and helped us to look at the interactions between staff and those who lived at Kernow House. We observed staff positively engaged with people. For example, some people chose to sit alone or did not engage with those around them. Staff were observed to stop and speak with them to ask if they were comfortable or wanted something. Where a person required one to one support this was being carried out in a dignified and sensitive way, and the rights of the person was respected by the care worker who gave them the space to move around unrestricted. During the SOFI observations we found that staff were continuously engaging with people. For example, the first day of inspection was very hot and sunny. Staff were frequently encouraging people to drink. Where people lacked capacity, staff were observed to be gently encouraging them with prompts. For example, "There is a drink in front of you." Staff were discreet when speaking with people for example, kneeling down and speaking into a person's ear. People responded positively to this approach.

Some people's health needs meant they needed to have their food and drink intake monitored to ensure they received sufficient each day. We found the records for monitoring this were complete and meaningful. For example, the individual daily amount was recorded, the types of food and fluids were recorded as well as the amount taken. Night staff reviewed these records and where people had not reached their individual target advice was provided as to action to take. For example, 'encourage regular drinks', 'Check weight and possible referral to GP'. These records were stored in the nurse's office in each unit.

Due to people's individual health conditions there was a strong focus on ensuring diet and nutrition was

closely monitored. Peoples weight was particularly focused on and any fluctuations picked up quickly. For example, where a person's weight was being monitored due to a health condition the loss of weight had prompted a nutritional review of risk and the assessment changed accordingly.

We observed positive behavioural support plans which provided staff with detailed information about people's fluctuating mental health needs and what people's coping strategies were. Staff were supported through training including restraint management strategies to effectively support people at times of anxiety.

Arrangements were in place through care planning and review to identify, record and meet the communication and support needs of people with a disability, impairment or sensory loss. Care plans identified information about whether the person had communication needs. These included whether the person required easy read or large print reading materials.

Staff were supported with an induction programme and ongoing training. Where staff were working on units where people had specialist needs due to their health needs they were supported through a process of shadowing and training. The induction was in line with the Care Certificate which is designed to help ensure staff that are new to working in care had initial training that gave them a satisfactory understanding of good working practice within the care sector. Staff were supported through formal and informal group supervision. There had been some gaps in recording formal individual supervision but a new system had recently been implemented to address this.

There was some use of assistive technology to support people. This included pressure mats to alert staff when people were moving around. These were used only as necessary and identified as part of the risk assessment and mental capacity assessment.

We observed the support people received during the lunchtime period in one specific unit. The atmosphere was warm and friendly with staff talking with people as they ate their meals. Tables were pre-laid with a clean tablecloth, napkins, cutlery and condiments. Some people preferred to sit up at the hard counter dividing the food preparation area from the rest of the room.

People had a choice of meals and staff were knowledgeable about people's likes, dislikes and dietary needs. Where people needed assistance with eating and drinking staff provided support appropriate to meet each individual person's assessed needs. As people waited for their meal to be served, members of staff chatted with them, or gently reassured them if necessary. It was observed the process was long and that people had to wait some time for their meal to be delivered. This was shared with the registered manager for consideration.

At the previous inspection it was noted there had been a change to snacks available to people in the unit's kitchen areas. People felt the change to a healthy option only had not been communicated or discussed with them Since the last inspection the chef and staff confirmed healthy snacks were still promoted but that 'empty' snacks such as chocolate or crisps were available if requested.

The chef told us, "We have a regular nutritional meeting where every resident's nutritional needs can be identified from their care plans and menus adjusted to suit, or special meals made. If people are gluten free and we're making pies, we can take the pie filling and make a separate stew dish or casserole for them with no pastry. There are many gluten free alternative ingredients available now, some of which can be nice, but we'd rather give people something nice than make a similar meal to everyone else with substandard ingredients."

Good

Is the service caring?

Our findings

Each unit of the service was distinctive in how it supported people. For example, due to the health needs of people some areas were often noisy and challenging to staff. It was clear staff understood how to respond in a caring, patient and dignified way. For example, staff were seen sitting with a person suggesting to them, "Lets walk you back to your room." Two staff ensured the person was supported safely and made sure the person had time to steady themselves before being supported to walk. Where people were more independent they were being supported to do things they liked, for example moving around the service at their own pace but with staff being alert as to their wellbeing. Where people had very limited mobility staff were frequently checking on their wellbeing. For example, a person was unable to use the televisions remote control. A staff member asked if they wanted to watch the tennis as they knew the person had an interest in this. The person responded with positively.

People had developed positive and caring relationships with the staff that supported them. People made positive comments about the approach of staff saying they were kind and caring. One person told us, "They [staff] manage really well." Feedback we received prior to the inspection included, "Kernow House is amazing and the staff have built up their own personal relationship with [relative name]," "[Relatives name] key staff are very person centred knowing what they need, but also interpret their behaviour to give a specialist approach, "The care is generally excellent and so important for patients with Huntington's Disease who are otherwise frequently misunderstood by staff who have very little experience of this rare genetic condition."

Staff demonstrated they knew and understood people's life history, likes, dislikes, needs and wishes. They knew and responded to each person's diverse cultural and spiritual needs and treated people with respect and patience. A staff member told us the use of life books had really helped them get to understand the person they were caring for and the life experiences they had gone through. They told us, "It's really useful if we can get some background because it gives us a starting point when we speak with people and open conversations." Peoples rooms were personalised with photographs of family, friends and live events. Signage supported people to get around the service with ease.

Staff had a good understanding of protecting and respecting people's human rights. Staff members and people who lived at Kernow House were observed throughout the inspection to have easy and friendly relationships. People told us that staff listened to them, respected and considered their wishes and choices. Staff ensured they were at the same level as people and gained eye contact when communicating with them so that people could clearly understand them. Staff took time to talk with people and put them at ease if they appeared confused or distressed. For example, where people had limited communication due to an advanced condition. Where people lacked the ability to verbally communicate, we observed staff used facial expressions to support communication such as whether they were hungry, tired or restless. On the first day of inspection the weather was extremely hot and staff were frequently asking people if they would like drinks.

People told us their privacy and dignity was always respected and this was observed during the inspection.

We observed staff members knocking on bedroom doors and waiting to be invited in where possible before they entered. Personal information on boards in the nurse's office were covered to protect and uphold confidentiality.

A 'Meet the team' board supported people and visitors to recognise the staff team through photos and names. An additional board was in place which would show photographs of staff on duty that day. This was planned to be in place soon and would support people in recognising who was caring for them.

People were at the centre of the service and routines were flexible. There were some restrictions in place for some people as part of their health and welfare plan. Staff understood this and supported those people in a way which meant it was the least restrictive way possible. For example, some people liked to walk around the service. They were not restricted from doing this as and when they chose to. Staff supporting them were discreet. Staff were observed encouraging those people to think about what they wanted to do or talk about. In one instance a person wanted to be quiet and the staff member supporting them respected this. It was clear that the culture of the service was one where each person was treated as an individual rather than being defined by the type of service they were living in.

Where necessary people had access to advocacy services which provided independent advice and support to represent a person's human rights and support decisions in the persons best interest.

Staff could describe the importance of acknowledging people's individual characters and helping to protect people from any type of discrimination and ensure people's rights were protected. For example, respecting the person for who they were, asking people sensitively if they needed assistance. There was a sensitive and caring approach observed throughout the inspection visit. It was clear staff understood how to use individual prompts to effectively communicate with people. For example, through changes in mood and behaviour.

Care files and information related to people who used the service was stored securely and accessible by staff when needed. This meant people's confidential information was protected appropriately in accordance with data protection guidelines.

Good

Is the service responsive?

Our findings

The registered manager met with people in hospital, at their home or at their previous care placements to complete detailed assessments of their individual care needs. This information was combined with details supplied by care commissioners and people's relatives to form the person's initial care plan. People received care and support that was responsive to their needs because staff were aware of the needs of people who lived at the service. Staff spoke knowledgeably about how people liked to be supported and what was important to them.

Care plans were personalised to the individual and gave clear details about each person's specific needs and how they liked to be supported. The care plans were detailed and included information about people's nursing care needs as well as their emotional and social support needs and how they would be met. For example, end of life care, positioning charts and dementia care. Care plans were clear where people required additional nursing care, for example with medical interventions. This information was shared with other relevant health professionals to ensure they had information about individual nursing needs.

At the previous inspection we identified a person's specific needs for mobility equipment was not included in their care plan and we made a recommendation about this. During this inspection we identified the service had ensured all care plans contained information on a range of aspects of people's individual needs including mobility, communication, nutrition and hydration and health. These records were accurate, complete, legible and contained details of people's current needs and wishes. Care plans gave direction and guidance for staff to follow to meet people's needs and wishes. Staff were aware of each person's care plan, and told us care plans were informative and gave them the guidance they needed to care for people.

Most people did not have the mental capacity to comment on their personal care due to health conditions. However, feedback we received told us people were satisfied with the level of care and support they were receiving at Kernow House. A relative told us they were particularly impressed with the way staff responded when they knew it was a special anniversary. They told us, "We recently celebrated our golden wedding anniversary and the team provided a special cake, a card and golden wedding photograph. One of the carers came in on her day off [unpaid] to do my relatives hair the way she likes it."

The service had a range of activities available to people. Since the previous inspection an additional activity coordinator had been employed. They were deployed around each unit so that activities suitable for each group were provided. For example, where people were more mobile or active a mini bus was available to access community activities. It was a hot day on the first day of inspection and one activity coordinator dressed up to take an ice cream trolley around each unit and offered ice cream to people. People were very engaged by this and it stimulated a lot of laughter and conversation. This was offered regularly. Where people were not able to engage or were asleep arrangements were in place for them to be offered ice cream later. Regular coffee mornings were held as well as bingo sessions, cake sales, singing, film shows, sensory sessions and pampering activities. Some people attended external activities including swimming. External entertainers and an aroma therapist were booked to visit regularly. The activities coordinators and staff also spent one-to-one time with people chatting and reading.

The service responded to people needs as they were entering the final stages of their life. Supporting people and their families through end of life was an essential and continuing part of care by the service. The service had arranged for medicines to be used if necessary to keep people comfortable. The registered manager and staff gathered as much information during the assessment and review process to record information that would support the person and their family when entering the final stage of their life. For example, informing people who were significant in the person's life if that was their choice.

The service had a complaints procedure which was available to people. Contact details for external organisations including social services and CQC had been provided should people wish to refer their concerns to those organisations. A staff member told us, "If I wanted to complain I could but I've never needed to. If one of my team complained I would give them all the support I could, but it shouldn't come to that. Most things are easy to sort out once you know about them, so we are encouraged to say something early rather than leave it and worry."

Good

Is the service well-led?

Our findings

During the previous inspection we identified staff morale was low and that organisational changes had not been effectively communicated. During this inspection we found staff morale had generally improved. Staff told us the registered manager was visible in the service and they felt confident they could speak with managers at any time. Comments included, "Yes there were changes and it was difficult but on the whole it's much better" and "I am a lot happier than I have been anywhere else." Some staff told us there were times when shifts were difficult but that communication from the management team had improved. This was through regular meetings, including daily 'stand up' meetings designed to respond to any immediate operational issues, for example utilising staff where they were needed.

There were clear lines of accountability and responsibility within the service. Monthly visits were made by an area manager to support the registered manager and to carry out audits and reviews of operational issues. Any operational or organisational changes were communicated to the services registered manager through regular organisational engagement meetings. The management team consisted of a registered manager, deputy manager and senior nurses. Each had responsibility for specific care and clinical audits.

The organisation promoted equality and inclusion within its workforce. Staff were protected from discrimination and harassment and told us they had not experienced any discrimination. Systems were in place to ensure staff were protected from discrimination at work as set out in the Equality Act. For example, making reasonable adjustments to support staff through return to work programmes.

As part of the provider's internal quality assurance checks they invited people who used the service, relatives, staff, representatives and professionals to complete an annual survey about the service. The most recent recorded comments included, "I find the staff welcoming and friendly to visitors. Kind and understanding with my relative," and "In general the home is an excellent place to live." Some comments mentioned people were generally satisfied with the service but they had noticed more agency staff. We shared this with the registered manager who confirmed they had taken the comments into account and were now using an adapted Barchester staffing tool which reflected the more complex needs of people living at Kernow House.

People using the service received regular newsletters to inform them of things going on at Kernow House and other Barchester services. People had the opportunity to make comments through a care home website in order to share their experiences.

Staff meetings were regularly held which were an opportunity to discuss quality issues and make further improvements to the service. The registered manager was required to feed information on the performance of the home such as incidents, complaints and safeguarding into a central governance system for the organisation to ensure the provider was aware of how the service was performing and provided a mechanism by which performance and risk could be scrutinised.

There were audits taking place to review and manage the operation of the service regularly. This included

incidents/ accidents analysis and the environment.

The registered manager worked in partnership with other organisations to make sure they were following current practice, providing a quality service and the people in their care were safe. These included social services, healthcare professionals including General Practitioners and district nurses. The service also worked closely with Independent Mental Capacity Advocates (IMCAs). IMCAs represent people subject to a DoLS authorisation where there is no one independent of the service, such as a family member or friend to represent them.

People's care records were kept securely and confidentially, in line with the legal requirements. Services are required to notify CQC of various events and incidents to allow us to monitor the service. The registered manager had ensured that notifications of such events had been submitted to CQC appropriately. The service had the latest CQC rating on display where people could see it.