Glencare Homes Ltd

Penhellis Nursing Home

Inspection report

Cross Street
Helston
Cornwall
TR13 8NQ

Tel: 01326565840
Website: www.penhellis.com

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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 Penhellis on 14 August 2018. Penhellis is a care home which provides nursing care and support for up to 26 predominantly older people. At the time of this inspection there were 22 people living at 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.

The service is a detached historical house on two floors with access to the upper floor via stairs or a passenger lift. Some rooms have en-suite facilities and there are shared bathrooms, shower facilities and toilets. Shared living areas include a lounge on the ground floor and first floor, a first-floor reminiscence room and a dining room. The service stands in its own grounds with accessible mature garden areas as well as a central courtyard.

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 28 June 2017. In June 2017 we found people's medicines were not always managed safely. We found several errors which had occurred within the previous month, which did not appear to have been followed up or reported. The registered manager undertook an annual medication audit; however, this was too infrequent to address the errors and areas for improvement that it identified. The medicines room was small, warm and cramped. When nurses were preparing medicines, they needed to prop the door open as it quickly became too warm. The temperature of this room was not being monitored to ensure that the medicines were kept at a suitable temperature. Similarly, the temperature of the medicines fridge was not recorded daily. There was a lack of continuity of nursing care due to a high use of agency and bank nursing staff. This, in part had resulted in one person running out of their prescribed medicines.

At the inspection in June 2017 there was an inconsistent approach to the monitoring of some people's health conditions meaning it was not always possible to understand if their needs were being met and their treatment was appropriate. People's rights were not always protected as the principles of the Mental Capacity Act were not always followed. Some people's records indicated that they lacked capacity to make certain decisions, without saying what the specific decisions were. Nor did the records contain a capacity assessment. Audits to monitor the quality of the service had failed to identify or address the areas of concern identified during our previous inspection in relation to capacity and medication management.

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.

The registered manager had implemented a more robust review and medicines audit system to identify and address any errors more frequently. Medicine audits were being carried out twice weekly by a registered nurse and registered manager. Medicine administration records [MAR] were being checked at the end of every medicines round. When errors had occurred, there was an error log where it was recorded by the nurse, signed and dated. This information identified any particular trends or patterns. For example, it had been noted errors were being found during a specific staff shift pattern by agency staff. The registered manager was able to address this with the supplying agency as they were not part of the services staff team.

The medicines room remained as the previous inspection. A small compact room where staff could only work with the door propped open. There were proposals in place for it to be resited as part of a planned extension of the service. However, in the interim period a fan had been put in place and daily temperature checks were being made and recorded. The records showed the rooms temperature had been satisfactorily maintained. Daily fridge temperatures were now being monitored and were satisfactory.

The registered provider had recently installed a surveillance system in the medicines room. There was a policy statement telling people using the room about the purpose of collecting information here, how the information will be accessed and stored. Also, there was a sharing of information protocol. Staff told us they were made aware of this system as were people using the service or where they lacked capacity their legal representatives. There was signage in the room to alert people to this system.

The service was being staffed satisfactorily. There remained a reliance on agency staff, however the service had managed to increase its level of bank staff which meant there was generally a level of continuity. Nobody told us they were concerned about the consistency of staff or staffing levels. Staff said there were times that were particularly busy but that they worked as a team which meant they worked together to meet people's individual needs.

Care records were being reviewed and changes made to respond to risk. The records we viewed demonstrated the information was in good order and it was easy to find the relevant section within. There was a numerical Index at the front and each section that made it was easy for staff to navigate and find the information they needed.

Where people lacked metal capacity there was evidence to demonstrate the service acted in accordance with the Mental Capacity Act [MCA]. In order to meet the breach from the inspection in June 2017 the service had introduced a revised assessment tool. This had been used to record people's capacity and identify any issues. Best interest meetings were taking place and applications sent to the local authority where necessary for the authorisation of restrictive care plans.

Throughout the inspection we observed staff providing support with respect and kindness. People generally told us they felt safe and comfortable living at Penhellis. Comments included, "Life is very calm and predictable, everything is spotlessly clean and the staff are always discretely on hand to help me." and "I'm so glad I chose to live here. It's just a lovely place to be." Two people told us they had experienced staff members speak with them in a way they found disrespectful. They had reported these issues to the registered manager and they had not reoccurred. Staff records showed these issues had been addressed with staff through personal supervision.

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, general practitioners (GP) and speech and language therapists (SALT). In addition, people could choose complimentary therapies including Reiki, Indian Head Massage, acupuncture and herbal medicine. These additional services incurred additional charges which were displayed in the welcome pack.

Staff were sufficiently skilled to meet people's needs. Necessary pre-employment checks had been completed and there were systems in place to provide new staff with appropriate induction training. Existing staff received regular training, supervision and annual performance appraisals.

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 manager used effective systems to record and report on, accidents and incidents and take action when required.

The service was suitably maintained. It was clean and hygienic and a safe place for people to live. We found equipment had been serviced and maintained as required.

Staff wore protective clothing such as gloves and aprons when needed and there were appropriate procedure in place to manage infection control risks.

Meals were appetising and people were offered a choice in line with their dietary requirements and preferences. Where necessary staff monitored what people ate to help ensure they stayed healthy.

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 safe. Staff knew how to recognise any potential abuse to keep people safe.

Potential risks to people were identified and measures were in place to minimise them.

People received their medicines as prescribed. Staff received training and support to administer medicines safely.

There were sufficient numbers of staff to care for people in a safe way. Recruitment processes included checks so that only suitable staff were employed.

The service was clean and working practices were in place to minimise the spread of any infection.

Is the service effective?

Good

The service was effective. People's health care needs were assessed and monitored and advice was sought from healthcare professionals when required.

People's dietary needs were met. The range of food options promoted their health and wellbeing.

People were supported by staff who had been appropriately trained to understand their needs.

Is the service caring?

Good

The service was caring. Staff communicated effectively with people and treated them with kindness, compassion and respect.

People's privacy and dignity was respected by staff.

Staff showed concern for people's well-being in a caring and meaningful way and responded appropriately to their needs

Is the service responsive?

Good

The service was responsive. People received personalised care and support which was responsive to their changing needs. Care plans gave clear direction and guidance for staff to follow to meet people's needs and wishes.

Staff supported people to take part in social activities of their choice and access the local community.

People and their families told us if they had a complaint they would be happy to speak with the management and were confident they would be listened to.

Is the service well-led?

Good

The service was well led. The quality of the service was monitored through regular audits were effective in highlighting areas requiring further improvement.

The registered manager had systems in place to develop and take forward systems to improve people's quality of care.

People's and relative's views about the service were sought and acted on.

Penhellis Nursing Home

Detailed findings

Background to this inspection

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

The inspection was carried out by two 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.

We spoke with a range of people about the service; this included eight people who lived at Penhellis. During and following the inspection we spoke with eleven staff members, the registered manager and nurse on duty. We contacted five professionals whose contact details were provided prior to the inspection. There was one response.

We looked at care records of four people who lived at the service and training and recruitment records of three staff members. We also looked at records relating to the management of the service. In addition, we checked the building to ensure it was clean, hygienic and a safe place for people to live.

During our inspection, we used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

At the last inspection we found medicines were not being managed safely. We found a number of errors. These mostly related to missing signatures on Medicine Administration records (MAR). These errors did not appear to have been followed up or reported. Audits were not taking place regularly to identify medicines errors and to take timely action. We found that the medicines room was small, warm and cramped. When nurses were preparing medicines, they needed to prop the door open as it quickly became too warm. The temperature of this room was not being monitored to ensure that the medicines were kept at a suitable temperature. Similarly, the temperature of the medicines fridge was not recorded daily. We looked at these areas which resulted in a breach of regulation as part of this inspection. The registered manager had taken action to review the medicines system. This was a breach of the regulations.

Following our previous inspection, the registered manager had implemented a more thorough review and audit system to identify and address any medicines errors. Audits were being carried out twice weekly by both the registered nurse and registered manager. Medicine administration records [MAR] were being checked at the end of every medicines round. When errors had occurred, there was an error log where it would be recorded by the nurse, signed and dated. This information identified any particular trends or patterns. For example, it had been noted errors were being found during a specific staff shift pattern. The registered manager had addressed this with the supplying agency as they were not part of the services staff team.

Since the previous inspection the site and size of the medicines room remained unchanged. There were proposals in place for it to be re-sited following planned building work, to extend the service. However, in the interim period a fan had been put in place and daily temperature checks were being made and recorded. The records showed the room temperature had been satisfactorily maintained. Daily fridge temperatures were now being taken, recorded and were satisfactory.

We found the service was now meeting the requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who lived at Penhellis if they felt safe living and receiving care there. One person told us, "I certainly feel safe and the staff and my family keep an eye out for everything. I have a call bell in my bedroom which I would use if I needed help at night and I keep a call button in my pocket during the day. If I use it, day or night, someone always comes to help me and asks what I need." During the previous inspection we found some people did not have call bels close to them to summon support when they needed it. We did not find this was the case during this inspection.

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, nutrition and hydration, and personal care. Where a risk had been identified, for example a pressure risk, the assessment had looked at factors such the person's mobility and skin condition as well as nutrition. The service referred such risks to the person's GP, Tissue Viability Nurse and ensured the necessary

equipment was made available. For example, pressure mattresses. Staff could tell us about people's individual risks and how they were being managed. Records were up to date and showed what action had been taken in response to changes in level of risk. For example, a person's mobility had deteriorated with more falls occurring. Staff had responded to the changes by making the necessary referrals to ensure suitable equipment was in place to safely support the person.

Incidents and accidents were recorded in the service. We looked at records of these and found appropriate action had been taken and where necessary changes made to learn from the events. Audits were in place to identify any patterns or trends which could be addressed, and subsequently mitigate the risks.

We observed the service was being staffed in numbers which met people's individual needs. The staffing rota showed there was a skills mix on each shift so that senior staff worked alongside care, domestic housekeeping and catering staff. A staff member told us, "We work really well as a team. Where there are gaps we try to fill them with our own staff. We do have agency staff though especially nurses." There was a nurse on duty on each shift. However, we were informed that it could become very busy for nurses especially in a morning when there was a lot to be done. We shared this information with the registered manager who told us they were aware of times when nurses were busy but that it was sporadic and was constantly monitored.

Some people preferred to stay in their rooms for most or part of the day. Staff were observed to frequently check on people's welfare in their own rooms. Staff were attentive to people's needs and when they required assistance. We observed call bells were responded to quickly throughout the inspection.

Staff had completed a thorough recruitment process to ensure they had the appropriate skills and knowledge required to meet people's care needs. Staff recruitment files contained all the relevant recruitment checks to show staff were suitable and safe to work in a care environment, including Disclosure and Barring Service (DBS) checks.

Staff said they felt confident that people were always treated well and that they did everything to ensure their safety and wellbeing. Staff understood what abuse meant and what action they should take if they suspected it. Staff had received training updates on safeguarding adults and were aware that the local authority were the lead organisation for investigating safeguarding concerns. Contact details were visible on the service's notice board so people could refer to the safeguarding team independently.

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.

Firefighting equipment had been regularly serviced. Fire safety drills had been regularly completed by staff who were clear about the procedures to be followed in the event of people needing to be evacuated from the building.

Equipment had been serviced and maintained as required. Records were available confirming gas; electric and fire systems were being maintained and were safe to use. Equipment including moving and handling equipment (hoist and slings) were safe for use and were being regularly serviced. We observed they were clean and stored appropriately so people were safe when moving around the premises.

The environment was clean, tidy and maintained. One staff member said, "We take a pride in making sure the home is always clean." There were designated staff for the cleaning of the premises. Infection control

procedures were in place and regular checks were made to ensure cleaning schedules were completed. During the day of inspection, we observed staff making appropriate use of personal protective clothing such as disposable gloves and aprons.

Good

Is the service effective?

Our findings

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. 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).

At the previous inspection we found the principles of the Mental Capacity Act 2005 [MCA] had not been followed resulting in a breach of regulations. People's capacity to make specific decisions had not been properly assessed. Where people lacked capacity, there was a lack of evidence to demonstrate decisions to introduce restrictions had been made in the person's best interest.

At this inspection we found where people lacked capacity or their capacity was limited the service had followed the principles of MCA. People's capacity to make specific decisions had been documented and best interest meetings held to make decisions where people were unable to do this for themselves. Where people lacked capacity and best interest decisions had been made to introduce restrictive care plan, these had been referred to the local authority for authorisation under DoLS.

In June 2017 relatives had signed documents to consent to elements of people's care and treatment without the correct legal authority. Nobody can consent to care on behalf of an adult without the correct legal authority to do so, such as a Lasting Power of Attorney (LPA). Records seen at this inspection demonstrated consent had only been recorded by relatives if they had the legal authority to do so. The service had also introduced a system to record people's consent to be shared in line with the requirements of the General Data Protection Record [GDPR].

We found the service was now meeting the requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable about the people living at the service and had the skills to meet people's needs. People using the service and a relative told us they were confident that staff knew them well and understood how to meet their needs. One person told us, "I do trust the staff. They all know what they are doing and they know how I like things done."

People's healthcare needs had been monitored and discussed with the person or relatives as part of the care planning process. Two people told us the staff frequently asked about their wellbeing and when they reported they did not feel well staff contacted a relevant health professional. Care records showed visits from health professionals including General Practitioners (GP's) and district nurses were taking place as required. Other professionals were involved with people when necessary including physiotherapists and occupational therapists.

Staff told us they received formal supervision and appraisal to support them in their role. Nurses had previously received clinical supervision from the clinical lead. However, there was no current clinical lead working in the home. We were informed by the registered manager a new appointment had been made and so these supervisions would commence again. Arrangements had been made with the new clinical lead with appropriate supervision once appointed. There were daily shift handovers attended and delivered by nursing staff with information and updates given to the next staff team. This made sure staff coming on duty had current details for the people they would be supporting and caring for.

Newly employed staff were required to complete an induction before providing support independently. This included training identified as necessary for the service and familiarisation with the organisation's policies and procedures. The induction programme covered orientation to the premises and included fire procedures, staff handbook, safer working practice, safeguarding, infection prevention and control, moving and handling, practical skills, medicines and record keeping. The induction was in line with the Care Certificate which is designed to help ensure care staff that are new to working in care have initial training that gives them an adequate understanding of good working practice within the care sector.

Training records showed staff received regular training updates the provider considered mandatory such as moving and handling, safeguarding and infection control. Staff had also undertaken a variety of further training related to people's specific care needs including, care of the dying pressure care and consent. People and relatives told us they felt the staff were well trained, competent and knowledgeable.

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

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.

People told us they enjoyed the meals at Penhellis. Comments included, "There is always choice but if I really don't want something they can always find an alternative. Cook knows what we like; good farm food like I had at home when I was young, but we do eat well here," "The food is good and there's plenty of it" and "The menu is pretty standard but it's the type of food I'd cook for myself if I could."

The lunch meal was mainly served in the dining room, although some people chose to eat their meals in their own room and this was respected. It was a social occasion with people gathering together for their meal and sharing conversation. Staff engaged throughout and people's choices were respected. Drinks were served throughout the meal. Snacks and drinks were always available to people outside of mealtimes.

The service assessed people's dietary needs on admission and through regular review. Necessary referrals had been made where people required specialist dietary support. The chef was made aware of all special dietary needs. People were offered options at each meal.

Where people required monitoring of their food and drink intake records showed they were accurate and up to date. Nurses reviewed them daily and staff were informed of any adjustments. For example, "[Person's name] Please make sure fluids are encouraged." Staff monitored people's weight regularly as part of monitoring their general health.

The environment was meeting the needs of people who lived at Penhellis. This was an historic house with

features and furnishings relating to the period. Most people's rooms were large enough for them to bring their own items of furniture and personal items. One person told us, "It's been important to have some of my own things with me." Each room had a call system to help people to request support if needed. Aids and hoists were in place which were capable of meeting the assessed needs of people with mobility problems. There was no signage to support people living with dementia. This had the potential to pose constraints for people who may become disorientated in the homes environment. We discussed this with the registered manager who told us that this was in-keeping with the desire of people and their families that the service should look and feel as non-institutional and homely as possible. We did not observe there to by any negative impact for the people using the service at the time of the inspection.

There was a reminiscence room designed and decorated to include items from a previous period of time, which most people using the service could relate to. There was no evidence to show how this was used other than being told it was mainly used for meetings with families and other professionals. There was a first-floor lounge which again was not used by people using the service regularly. Staff told us it was used mainly for people to meet with their relatives or for professional meetings. Seating in this room would not support people who required lounge chairs or specialist seating.

Penhellis was surrounded by well-maintained garden areas and there was a central courtyard which was safe for people to use independently.

Good

Is the service caring?

Our findings

People who lived at Penhellis told us they were happy and felt the care provided for them was very good. People told us, "I carry my call button on me and I can press it to get someone's attention, which I sometimes do and they always come quite quickly," "The staff know what they are doing, and they make sure I have everything I need so I just trust them to get on with it." A relative told us, "Everyone knows everyone else here, at least to say hello to, there is such a happy atmosphere. Although some people are quiet and prefer their own company. [My relative] likes the staff and they seem to do their very best to be helpful and caring."

We used the Short Observational Framework for Inspection (SOFI). This is a way of observing care to help us understand the experience of people living there. This helped 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 Penhellis. We observed staff continuously engaging with people. For example, some people chose to sit alone or did not engage with those around them. Staff always took time to stop and speak with the person to ask if they were comfortable or wanted something. We observed two members of staff having positive communication with two people. They were talking about lunch, asking if they had enjoyed it. Did they want anything else, or had they had enough? The staff were offering the person a choice of ice cream or other pudding. They were also discussing the person's clothes particularly a waistcoat they had found in their wardrobe. It generated a lot of laughter and it was clear the staff team knew the person well. In all instances we found staff positively engaged with people. People were observed to respond well with staff and looked comfortable in the presence of staff members

Throughout the inspection visit we observed staff responded to people's needs in a caring manner and treated people with dignity. They were polite and attentive and quick to respond to people who required their assistance. 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.

Some people told us they were involved in their care planning and decisions about how they wanted to receive support. However, some people were very frail and consultation could only occur with people's representatives such as their relatives or advocates. People told us staff always asked them if it was alright with them before providing any care and support.

People were encouraged to make decisions about their care. For example, what they wished to wear, what they wanted to eat and how they wanted to spend their time. A senior staff member identified people who were not necessarily at risk at night but whose sleep patterns were being disturbed due to regular welfare checks. Where people had the capacity to consent and there were no other risk factors, they now had the opportunity to not be disturbed by staff. This mean their sleep was not disturbed for a significant period.

The service held resident's meetings which provided people with an opportunity to raise any ideas or concerns they may have. We saw the minutes of one of these meetings. It had discussed plans for a

gardening club, welcomed a new resident and talking about activity ideas in the community. For example, supporting people on a local walk and visiting a museum. This demonstrated the service sought the views and experiences of people who used the service, their families and friends.

There was a welcome pack for people moving into the service. It provided people with all the information they needed about living at Penhellis. This included terms and conditions, complimentary therapies as well as a price list for additional services. It talked about the history of the building, the range of communal lounges and meals and meal options.

Staff had a good understanding of protecting and respecting people's human rights. For example, there were lounges and private spaces in which families could sit with their relatives for a private discussion as an alternative to bedrooms.

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

People who wished to move into the service had their needs assessed by the registered manager to ensure the service could meet those needs and expectations. Care plans were in place for people and were accurate and up to date to reflect current nursing and care needs. The care plans included information about people's nursing care needs as well as guidance on how their emotional and social support needs would be met. Where people required additional nursing care, for example with medical interventions, this was clearly documented within the care plan and shared with professionals to ensure these needs were met.

The ground floor lounge had a range of seating. People with their own mobility had chosen to sit alone or in small groups and were chatting with each other. Two people were positively engaging with each other in a meaningful way. One other person was knitting for a charity. They told us they enjoyed doing this as it was for a good cause. However, people using mobility aids including wheelchairs were positioned in a line in front of the television as they entered the lounge. It meant they had restrictions engaging in conversation with people at either side. Not everyone was watching the television. We observed some people were sleeping or staring around the room. Due to the number of chairs in the room, it restricted the choice of position for wheelchairs.

We recommend the service reviews the lounge design in order to maximise the seating options for people using the service.

Staff were regularly coming into the lounge and speaking with people when they did. They asked about people's welfare and if anybody wanted a drink. A staff member told us, "The morning can be busy, but we make sure

There was an activity coordinator however they were not working on the day of the inspection. There was also a lifestyle manager who had been in post for five weeks. The purpose of this was to talk through any worries or responding to questions and queries from people on a one to one basis. This person was not on duty to speak with. As this was a recent post people were not able to tell us how it had supported them. Staff told us there were various activities which took place mainly in the afternoon. These included, board games, quizzes and armchair exercises. External entertainers came in from time to time. The services web site was promoting activities in the coming months. This included a chef demonstration of local autumnal food, a herbal medicines presentation as well as a fire work display and BBQ for Guy Fawkes.

People had access to complimentary therapies as part of the 'hotel package' promoted in the welcome pack. This included massage, aromatherapy, massage and reflexology. Subject to availability people had access to one of the therapies of their choice for one hour per quarter. They could also use these therapies more often but at their own cost.

The service arranged for visits from a local child-minding group and a local Brownies group. The Brownie group had developed a specific badge to show they made visits to Penhellis to speak with people.

The service told us people enjoyed local events including Floral Day which was a traditional festival for Helston. A recent residents meeting reported a person had been supported to visit the local museum. However, some people told us they wished the staff could occasionally accompany them on trips into the local village. Some people said they missed being involved in the community and one person commented, "I was never a big church-goer. The services were not a big part of my life, except as a child going to Sunday School. But, I call myself a Christian and I enjoyed being part of wider parish life. When you move away from your home town and come to live in a care home, you have to give all of that up." While regular religious services were held at the service, visiting and being involved in the local parish church was important for some people. We shared this with the registered manager in order for them to ensure people living at the service, were aware that they would be supported to attend church or other events in the community.

There were end of life procedures in place to take account of people wishes wherever possible, as well as ensuring the service could access any specific medical needs for people at these times. This helped the service to contact and liaise with the end of life service ensuring peoples urgent care needs were supported. The service worked closely with the family and health professionals, reducing the need for avoidable hospital admissions and providing the right care at the right time.

People and their families were given information about how to complain and details of the complaints procedure were displayed in the service. People told us they knew how to raise a concern and they would be comfortable doing so. Two people told us they had experienced staff members speak with them in a way they found disrespectful. They said it had not occurred again and that the registered manager had been made aware of the issues. These were of a historic nature and we observed this had been addressed with a staff member through personal supervision. The other staff member no longer worked at the service.

Good

Is the service well-led?

Our findings

At the previous inspection we found the registered manager was not completing medicines audits in a timely way and had not identified issues for poor compliance with the Mental Capacity Act 2005 through care planning audits. This had resulted in in a breach of regulation. At this inspection we found the registered manager had taken steps to review and implement a more timely audit in both these areas as reported on in the safe and effective domains of this report.

We found the service was now meeting the requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had recently installed a Close Circuit Television [CCTV] in the medicines room. The service had signage to alert staff this was in place on the front of a fridge in the medicine room. However, as the door was frequently open when staff were working in this room, it was possible people moving past in this corridor would be captured. The guidance for General Date Protection Regulation [GDPR] is that signage should be in place to alert people that CCTV was in use. At the time of the inspection there were no additional signs outside the medicines room notifying people CCTV was being used in the service. Since the inspection the registered provider has informed the commission that signage had been extended external to the medicines room. This now alerts people to it's presence.

The film footage was not being monitored in the home, but remotely via the mobile phone of the director of the company. Some staff commented about how they felt their professional integrity was being questioned by the registered provider. People we spoke with gave us their views. Some told us they were very concerned and felt devalued and not trusted. Others told us they didn't have a problem with the use of CCTV but knew some did. Comments included, "I feel it undermines my professional integrity," "We've got used to it now. Since the inspection the registered provider informed the commission the audio had been deactivated from the device to ensure privacy was upheld.

There was a CCTV information sheet in the medicines room. This reported on the purpose of collecting this information. It included, "To ensure conduct of staff and protect them from allegations. To protect staff from allegations of significant errors. To safeguard the company from theft and to safeguard the company from any false allegations where this can be proved from this information." The purpose of this information was focused on the monitoring of staff.

There were clear lines of accountability and responsibility both within the service and at provider level. The management structure consisted of a registered manager supported by a clinical lead and an administrator. A new clinical lead had been employed and was due to commence work at the service soon. People were informed of the management team and other heads of service in the welcome pack on a person's admission. People were also able to identify staff through the colour coding of their uniforms. For example, nurses wore a navy tunic with red trim. This helped people to identify with staff.

The registered manager told us of the importance of staff wellbeing and gave examples of how this was

promoted. A recent staff notice was placed in all wage slips giving advice on the benefits of a good night's sleep and how to achieve this. There were other therapeutic and motivational examples given to staff to maintain their health and wellbeing. Staff were encouraged to nominate each other for an 'Extra Miles Award'. Designed for staff to acknowledge where they have gone the 'extra mile' in their role. Its aim to boost morale and team spirit. Also, a Personal Achiever Award' which had resulted in a luxury spa day and a chartered aeroplane trip over Cornwall. The service had also been commended by paying all staff the Voluntary Living Wage rate. Some of these incentives were still being embedded and staff did not share with us the impact this had yet made.

There were systems in place to support staff. There was daily communication between the registered manager, nurse on duty and staff as well as staff meetings. These were an opportunity to keep staff informed of any operational changes. A staff member told us senior staff were delegated roles to support staff. For example, senior care were responsible for supervisory roles as well as holding staff meetings and feeding back information to the registered manager so they were aware of any issues and actions which needed to be taken.

There was evidence of people's views being considered through daily communication and through resident's meetings. There was a survey system in place to take account of people's views. A survey was being undertaken at the time of the inspection. The results from the previous survey were positive with comments suggesting the service was excellent or very good and nobody had reported any concerns. People reported they felt the staff were professional, knew them well and respected their wishes.

Relatives felt able to visit at any time and told us they were generally satisfied with the service. One person said, "The manager asks for feedback and listens to what they are told. If they can't do anything right away they don't forget about it, and they might still come back to it later. But if they can adapt things easily the manager tells us what they want to happen before things change then updates us when changes are planned."

We received some comments that the registered manager was not always visible in the service and spent most of the time in the office. The registered manager did delegate specific tasks to operational staff as reported above but had a good understanding of the day to day operation of the service.

The service worked in partnership with other organisations to make sure they were following current practice, providing a quality service and to ensure the people in their care were safe. These included working collaboratively with social services and healthcare professionals including general practitioners and district nurses.

The service was meeting the requirement of regulation by having the CQC rating from their last report on display in the reception area of their premises and on their website.