Barchester Healthcare Homes Limited

Kernow House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this unannounced inspection of Kernow House on 17 and 19 May 2017. At the last comprehensive inspection in August 2016 we asked the provider to take action to make improvements and the service was rated as Requires Improvement. At the focused inspection in November, while we found the necessary improvements had been made, we did not review the rating of the service which remained as Requires Improvement.

Kernow House is part of the Barchester Healthcare group of homes. It provides personal and nursing care to a maximum of 98 people within five specialist units. 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 70 people living at the service.

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 and associated Regulations about how the service is run.

Before this inspection we received concerns about staffing levels at night. We found these concerns related to one unit where the level of night staff had been reduced. However, the reason for the reduction in staffing was because the needs of the people living in that unit were lower. Also night staff were shared between this unit and an adjoining unit because the two units had joined together.

A recent review of staffing numbers, across all the units, had resulted in staffing levels being reduced, although the review also took into account that fewer people were living at the service. A dependency tool was used to determine the staff numbers in each unit, which assessed each person across a range of different needs. While we found the numbers of staff on duty in each unit were in line with the recorded assessments of people's needs there were delays in people's needs being met. For example, on the first day of the inspection all of the units were busy and lunch time took over two hours to complete. In one unit staff finished serving breakfast only 45 minutes before lunch started.

A review of how staff were deployed between the five units had also taken place. This meant staff were sometimes moved from their usual unit to work in another unit where the needs of people's were the highest. Staff told us they did not always feel confident to support people in units they didn't normally work in as they were not familiar with their needs.

From our observations and feedback from people and staff we judged that the dependency tool used had not sufficiently taken into account the level of staffing needed to meet some people's needs. In addition we found staffing levels were not adjusted as people's needs fluctuated or to take into account staff who may

be new to the unit and therefore not so familiar with people's needs. For example, on the first day of the inspection people's needs were not being met in a timely manner. However, on the second day, with the same number of staff, people's needs were being responded to more promptly.

Staff supported people to maintain a balanced diet in line with their dietary needs and preferences. During the inspection staff told us people no longer had access to snacks such as crisps, chocolate and frizzy drinks and some people enjoyed these snacks. We found while these items of food were not stored in the kitchens in each unit they were still available for staff to access from the main kitchen. The management told us a decision had been taken across the service to encourage people to eat healthier snacks, such as yoghurts and fruit. However, this decision had not been effectively communicated to staff as they were not accessing these snacks from the main kitchen. There was also no evidence that people had been consulted about the decision the service had taken to encourage people to eat healthier snacks.

We found staff morale in the service was very low. Staff's perception of the recent changes to staffing levels, how staff were deployed and the decision to reduce the availability of certain snacks were extremely negative. Every member of staff we spoke with expressed their concerns about the changes. Comments from staff included, "There is no continuity moving around the units and it's unsafe", "They've cut staff. I have been sent home four times because they have changed the rota on my day off and not told me", "They have taken crisps and chocolate away and people can only have one glass of juice in the morning" and "Nine times out of 10 there are not enough staff and we can't take people out." We judged that there had been poor communication and support for staff around the organisational changes.

Most people living at the service were unable to tell us their views of the staffing levels. One person did tell us, "The place hasn't got enough staff."

Management and staff applied the principles of the Mental Capacity Act 2005 (MCA) in the way they cared for people. Although, we found records did not clearly state on what legal authority staff were providing care for one person. Where people's liberty was restricted in their best interests, authorisation for these restrictions had been sought from the local authority. For some people conditions had been applied to their Deprivation of Liberty Safeguards (DoLS) authorisation. Records to show that these conditions had been complied with were not being kept.

People's care files included risk assessments which identified risks and the control measures in place to minimise risk. However, we found insufficient action had been taken to mitigate the risk of harm for one person because a long lead used to operate the bed in their room had not been removed. Once we alerted the registered manager to this omission the lead was immediately taken away.

Care records were personalised to the individual and detailed how people wished to be supported. They provided clear information to enable staff to provide appropriate and effective care and support. Any changes to people's needs were recorded as part of the monthly review process. However, for some people these changes had not been updated in their main care plan which meant information about some people's current needs was not easily available for staff to follow. We have made a recommendation about the recording of people's care needs.

While most people were unable to tell us about their experiences we observed they were relaxed and at ease with staff. People had good and meaningful relationships with staff and staff interacted with people in a caring and respectful manner. People who were able to tell us about their experiences said, "It's nice here. I'd rather be here than out in the rain" and "Everything's OK. It's tickety boo." A relative told us, "Staff are responsive to my requests and don't skive off when I want my son moved from chair to bed."

People received their medicines on time. Medicines administration records were kept appropriately and medicines were stored and managed to a good standard.

The service worked closely with healthcare professionals such as dementia liaison nurses, psychiatrists, speech and language therapists and GPs to help ensure people's individual needs were met. Incidents and accidents were recorded in each unit. An overview for the whole service was collated and analysed by the registered manager.

Staff had received training in how to recognise and report abuse. Staff told us if they had any concerns they would report them to management and were confident they would be followed up appropriately.

Staff completed a thorough recruitment process to ensure they had the appropriate skills and knowledge. Staff received appropriate training and supervision. New employees completed a thorough induction which incorporated the care certificate, which is an industry recognised induction that replaced the Common Induction Standards in April 2015.

People and their families were given information about how to complain. There were effective quality assurance systems in place to make sure that any areas for improvement were identified and addressed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see the action we have told the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not entirely safe. While the number of staff on duty was in line with how people's needs had been assessed some people did not receive their care in a timely manner.

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.

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

Is the service effective?

Requires Improvement

The service was not entirely effective. 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 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.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate and treated people with dignity and respect.

People and their families were involved in their care and were asked about their preferences and choices.

Staff respected people's wishes and provided care and support in line with those wishes.

Is the service responsive?

Good

The service was responsive. People received personalised care and support which was responsive to their changing needs. We

have recommended that care plans are updated to accurately reflect the care provided for people.

Staff supported people to take part in social activities of their choice.

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?

Requires Improvement

The service was not entirely well-led. 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.

The service sought people's views about the running of the service but had not consulted people about changes to the type of snacks available.

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

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 17 and 19 May 2017 and was carried out on both days by two adult social care inspectors. On the first day two specialist nurse advisors were part of the inspection team. The specialist advisors had a background in providing nursing care for older people and dementia care services.

Before the inspection we reviewed the information we held about the service and notifications of incidents we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with eleven people who were able to express their views of living at the service. Not everyone was able to verbally communicate with us due to their health care needs. We looked around the premises and observed care practices on both days of the inspection. 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.

During the course of the two days we spoke with the registered manager, the deputy manager, 15 care staff, six nurses, the chef, the activity co-ordinator and the administrator. On the first day we spoke with a visiting manager from another Barchester service and on the second day we spoke with the regional director. We also spoke with a visiting relative and visiting healthcare professional. We looked at 20 records relating to the care of individuals, four staff recruitment files, staff duty rosters, staff training records and records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

Before this inspection we received concerns about staffing levels at night. We found these concerns related to one unit where the number of staff on duty had been reduced from two night care workers to one. At the time of the inspection there were seven people living in this unit and usually no one needed any support from staff during the night. As a result of this a connecting corridor had been opened so this unit and the adjoining unit could operate as one. This meant the one night care worker had the support of five night care workers and one nurse from the adjoining unit.

A recent review of staffing numbers had resulted in staffing levels being reduced, although the review also took into account that fewer people were living at the service. A dependency tool was used to determine the staff numbers in each unit, which assessed each person across a range of different needs. While we found the numbers of staff on duty in each unit were in line with the recorded assessments of people's needs there were delays in people's needs being met.

On the morning of the first day of the inspection two care workers had called in sick and a number of staff were booked to attend training. This meant there were less staff available to cover the sickness and some staff had been redeployed around the service to support the units where people's needs were the highest. Although we observed staff providing good and appropriate care for people we also found staff had to prioritise who they supported which meant some people had to wait for help from staff. On the first day of the inspection all of the units were busy, particularly during meals times. In one unit, because many people needed help from staff to eat their meals, breakfast did not finish until 11.45am and lunch was served at 12.30pm. In another unit lunch took two hours to complete. This was because staff had to leave the people they were helping with their meal to support one person who was at risk of falling if left unattended.

In all the units, where people had been assessed as needing to be 'in line of sight' because they were at high risks of falls, we found staff were vigilant in monitoring their movements. However, particularly on the first day of the inspection, staff frequently had to leave the person they were supporting to help the person who was at risk to prevent them from falling. On the second day of the inspection the service was less busy than the first day.

Some people had been assessed as needing individual time with staff to alleviate their anxieties and help to minimise any behaviour that might be challenging for staff to manage. Additional external funding had been sourced to allow the service to provide individual support for some people. However, there were other people who had also been assessed as needing to spend individual time with staff. External funding was not available for these people because they did not meet the criteria for externally funded individual support. The registered manager explained that some extra hours were added to the overall dependency assessment to allow for additional staffing hours for people with high needs. However, the assessment tool did not specifically allocate hours for staff to spend time with individual people in line with their assessed needs.

A review of how staff were deployed between the five units had taken place. Before the review each unit was staffed separately and the units had made their own arrangements to cover for staff sickness and absence.

Since the review staff were often moved from their usual unit to work in another unit where the needs of people's were the highest. Management told us this had reduced the need to use agency staff and enabled staff to gain knowledge about people living in different units to where they normally worked. However, staff told us they did not always feel confident to support people in units they didn't normally work in as they were not familiar with their needs.

During the inspection we observed staff who were new to working on that particularly unit. We saw that, especially at the start of their shift, they were hesitant in helping people as they were unsure how to respond and communicate with people. This meant that the numbers of staff on duty, when a less confident member of staff was working, might need to be adjusted to take this into account. For example, on the first day of the inspection people's needs were not being met in a timely manner. However, on the second day, with the same number of staff, people's needs were being responded to more promptly.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care files included risk assessments which identified risks and the control measures in place to minimise risk. For example, risk assessments were completed to identify the level of risk when using equipment, bed rails, nutrition and the risk of developing pressure sores. These assessments were specific to the needs of the person. We found risk assessments were reviewed monthly or as required, should there be a change of risk level.

However, we found insufficient action had been taken to mitigate the risk of harm for one person. This person had moved into the service for a period of assessment and was known to be at a high risk of self-harm. Their care records stated, "Ensure items such as cutlery, belts and string are not available." However, we found a long lead used to operate the bed in their room had not been removed. Once we alerted the registered manager to this omission the lead was immediately taken away.

Medicines were managed safely at Kernow House. All medicines were stored appropriately and Medicines Administration Record (MAR) charts were completed. Medicines which required stricter controls by law were stored correctly and records kept in line with relevant legislation. A lockable medicine refrigerator was available for medicines which needed to be stored at a low temperature. Records demonstrated room and medicine storage temperatures were consistently monitored. This showed medicines were stored correctly and were safe and effective for the people they were prescribed for.

Staff were competent in giving people their medicines. They explained to people what their medicines were for and ensured each person had taken them before signing the medication record. Regular audits of people's medicines were carried out by a clinical lead.

Incidents and accidents were recorded in each unit. An overview for the whole service was collated and analysed by the registered manager. This helped to identify any patterns or trends which could be addressed, and subsequently reduce any apparent risks.

People were kept safe by a clean and hygienic environment. The home was visibly clean, with hand sanitising gel, gloves and aprons throughout the building which we saw staff using throughout the inspection.

The premises and equipment were maintained. Records showed that manual handling equipment, such as hoists and bath seats had been serviced. There were two hoists that were not working, one was a bath hoist

and another was a hoist used to weigh people. In the unit where the bath hoist had broken there was another assisted bathroom for people to use. In the unit where the weighing hoist had broken staff were able to use a hoist from another unit. While we judged that this had not had an impact on the safety of how people received their care both hoists had been reported as needing an engineer visit two months ago.

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.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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 whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

There were a range of very detailed, specific mental capacity assessments in people's records. These related to a number of decisions about care and treatment such as dental treatment, capacity to consent to immunisations. There were also assessments for decisions such as where the person wanted to live and agreement with their care plan. The mental capacity assessments asked if "all reasonable steps taken to maximise the person's capacity to make the decision.

However, for one person their 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. The initial assessment of their care needs and other records indicated they had capacity and they would sometimes make unwise decisions about their daily living. The person was often not compliant with their care and would refuse to take their medicines. They liked to spend time outside in the garden and they were not always dressed appropriately for the weather conditions. However, some of the instructions for staff, or order to keep the person safe, were actions that would only be appropriate to take if the person did not have mental capacity. For example, using MAPA (Management of Actual or Potential Aggression) to bring them in from the garden, in adverse weather conditions, if they could not be encouraged to come inside voluntarily. While there was no evidence to show that these methods had been used, because the service had not assessed the person's capacity there was no legal basis for the decision to use MAPA.

Where people's liberty was restricted in their best interests, authorisation for these restrictions had been sought from the local authority. For some people conditions had been applied to their Deprivation of Liberty Safeguards (DoLS) authorisation. Three people had a condition of their DoLS authorisation that stated, "Any meaningful time spent with staff should be recorded in their notes. A separate record of activities is suggested." The registered manager told us care staff and the activities co-ordinator would spend one-to-one time with these people. However, records to show that staff were spending meaningful time with these three people had not been kept.

Another person had a condition of their DoLS authorisation that said, "Covert medicines policy to be reviewed monthly and justification for the continued need for the procedure recorded." Conversations with

staff confirmed that less restrictive options were considered before administrating their medicines covertly (disguised in food or drink). A member of care staff said, "Nine times out of 10 covert medicines are offered overtly first." However, there were no records to evidence that staff had asked the person if they wanted to take their medicines or if monthly reviews were taking place, in line with the DoLS condition.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We observed throughout the inspection that staff asked for people's consent before assisting them with any care or support. People made their own decisions about how they wanted to live their life and spend their time. For example, we observed staff always asked people before assisting them with any task and always knocked and waited to be invited into their room.

People had their nutritional and hydration needs met. Hot and cold drinks were available for people throughout the day. Each unit had a kitchen from which staff could provide drinks and snacks as people needed them. Some people were able to access the kitchen to make their own drinks. We observed the support people received during the lunch time period. Mealtime was unrushed and people were talking with each other and with staff. Tables were attractively laid with clean table clothes. People were offered a range of drinks with their meals and there were different meal options for people to choose. Where people might have difficulty in making decisions, for example people living with dementia, staff showed people the different meals so they could visually understand what was on offer. Staff provided people with individual assistance, such as help with eating their meal or cutting up food to enable people to eat independently. Staff were patient and encouraging when helping people to eat.

Regular nutritional meetings, between care and kitchen staff, were held to identify any changes or improvements that could be made to individual's diets, taking into account their weight and health needs. Referrals were made to SALT (speech and language therapists) or dieticians as required. Food and nutrition charts were completed and information was recorded in people's care plans and risk assessments as necessary. For example, one person was at risk of choking and their care plan stated that they should always eat in the dining room where staff could be alerted to an emergency.

During the inspection staff told us people no longer had access to snacks of crisps, chocolate and frizzy drinks and some people enjoyed these snacks. We found while these items of food were not stored in the kitchens in each unit they were still available for staff to access from the main kitchen. The management told us a decision had been taken across the service to encourage people to eat healthier snacks, such as yoghurts and fruit. However, this decision had clearly not been effectively communicated to staff as they were not accessing these snacks from the main kitchen.

People's individual health needs were well managed and staff had the skills to recognise when people may be a risk of their health deteriorating. Where people were assessed as being at risk of losing weight staff regularly checked their weight and took appropriate action to help them maintain a healthy weight. Care records confirmed people had access to health care professionals to meet their specific needs. This included staff arranging for opticians, dentists and chiropodists to visit the service as well as working closely with healthcare professionals such as dementia liaison nurses, psychiatrists and GPs.

Staff told us there were good opportunities for on-going training and for obtaining additional qualifications. There was a programme to make sure staff received relevant training and refresher training was kept up to date. Training was a mixture of on-line courses and external training days. The service had their own trainer who had recently started to provide refresher training days where all core subjects were refreshed in one day. Staff who had attended these sessions said they were very helpful and it was better to cover all these

areas in one day rather than attend lots of separate sessions. The service provided training specific to meet the needs of people living at the service such as dementia awareness, dysphasia, restraint, choking and food allergens.

Staff told us they felt supported by managers and they received six one-to-one supervision sessions per year as well as annual appraisals. This gave staff the opportunity to discuss working practices and identify any training or support needs. Staff also said there were regular staff meetings which gave them the chance to meet together as a staff team and discuss people's needs and any new developments for the service.

Newly employed staff were required to complete an induction which included training in areas identified as necessary for the service such as fire, infection control, health and safety and safeguarding. They also spent time familiarising themselves with the service's policies and procedures and working practices. The induction included a period of at least three days working alongside more experienced staff getting to know people's needs and how they wanted to be supported. The induction was in line with the Care Certificate which replaced the Common Induction Standards in April 2015. It 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.

The design, layout and decoration of the building met people's individual needs. Corridors and doors were wide enough to allow for wheelchair users to move freely around the premises. There were ramps by external doors to provide wheelchair access to the garden. There were enclosed courtyards which provided a safe environment for people who wished to go outside independently.

In line with recognised research the units, where people were living with dementia, had toilets and bathroom doors painted yellow with blue toilet seats. This helped people orientate around the service and use toilet facilities independently. There were tactile pictures on the walls in all corridors and some people gained comfort from touching these pictures. Soft toys, small imitation household items and tools were placed on the shelving in the corridors for people to pick up and use should they want to.

Good

Is the service caring?

Our findings

On the day of our inspection there was a relaxed and friendly atmosphere at the service. People had good and meaningful relationships with staff and staff interacted with people in a caring and respectful manner. People appeared to be well cared for and spoke positively about the care they received. Comments from people and relatives included, "It's nice here. I'd rather be here than out in the rain", "Everything's OK. It's tickety boo" and "Staff are responsive to my requests and don't skive off when I want my son moved from chair to bed."

There was plenty of shared humour between people and staff. People, who were able to verbally communicate, engaged in friendly and respectful chatter with staff. Where people were unable to communicate verbally, their behaviour and body language showed that they were comfortable and happy when staff interacted with them.

The care we saw provided throughout the inspection was appropriate to people's needs and wishes. Staff were patient and discreet when providing care for people. They took the time to speak with people as they supported them and we observed many positive interactions that supported people's wellbeing and respected their dignity. For example, during the lunch time meal one person came into the dining room having removed some of their clothing. Staff responded quickly and calmly helped the person to dress more appropriately to respect their dignity. For another person, who would usually eat independently, staff realised they had not eaten their meal and it was cold. Rather than heating their meal in the microwave staff gave them a fresh meal and then spent time encouraging and supporting them eat the meal. Another example was where we saw staff assisting one person to move from an armchair into a wheelchair using a hoist. Staff were kind and gentle explaining what they were doing throughout the procedure to prevent the person from becoming anxious.

People were able to make choices about their daily lives. People's care plans recorded their choices and preferred routines. For example, what time they liked to get up in the morning and go to bed at night.

Some people living at Kernow House had a diagnosis of dementia or memory difficulties and their ability to make daily decisions could fluctuate. The service had worked with relatives to develop life histories to understand the choices people would have previously made about their daily lives. Care plans contained a "This is me" document detailing people's background, family and previous occupation as well as their known likes and dislikes. Staff had a good understanding of people's needs and used this knowledge to enable people to make their own decisions about their daily lives wherever possible.

People's privacy was respected. Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. Bedroom, bathroom and toilet doors were always kept closed when people were being supported with personal care. Staff always knocked on bedroom doors and waited for a response before entering.

Staff supported people to maintain contact with friends and family. Visitors told us they were always made

welcome and were able to visit at any time. People were able to see their visitors in one of the communal areas or in their own room.

Good

Is the service responsive?

Our findings

People received care and support that was responsive to their needs because staff were aware of the needs of people who lived at Kernow House. Staff spoke knowledgeably about how people liked to be supported and what was important to them.

Before moving into the service a manager or nurse visited people to carry out an assessment of their needs to check if the service could meet their needs and expectations. Copies of pre-admission assessments on people's files were comprehensive and helped staff to develop a care plan for the person.

Each person had a care plan and overall these were personalised to the individual person. Care plans contained appropriate assessments, for example, about the person's physical health, personal care needs, and moving and handling needs. Care plans gave direction and guidance for staff to follow to meet people's needs and wishes.

Any changes to people's needs were recorded as part of the monthly review process. However, for some people these changes had not been updated in their main care plan which meant information about some people's current needs was not easily available for staff to follow. For example, one person's needs had changed since returning from a stay in hospital after a fall in March 2017. On their immediate return to the service a new care plan was written to cover a two week recovery period when they needed to be cared for in bed. After this recovery period and in the weeks that followed their mobility improved and with support from staff, and the use of a walking frame, they were able to walk short distances. Daily notes indicated that the person walked with their frame for some parts of the day and at other times staff supported them in a wheelchair. However, their care plan had not been updated to state that they sometimes used a wheelchair or that they used a walking frame.

We recommend that the service ensures that people's care plans accurately reflect the care being provided for people.

Daily handovers provided staff with clear information about people's needs and kept staff informed as people's needs changed. Staff wrote daily records detailing the care and support provided each day and how people had spent their time. Staff told us handovers were informative and they felt they had all the information they needed to provide the right care for people. This helped ensure that people received consistent care and specific staff were available to respond to their needs.

There were management handover meetings each day called 'stand up' meetings. This was where the head of each unit and other departments such as maintenance and the kitchen met to handover over important information about people's needs across all departments. Items discussed included dependency and staffing levels in each unit and any concerns about specific people's needs. This meant that there was a management overview of people's needs, rather than just within each unit. The service could respond appropriately to meet people's needs by ensuring staffing and resources were in the right place.

The service employed a full-time activities coordinator who was committed to providing a programme of group and individual activities for people. There were weekly activities in the service such as coffee mornings, bingo, cake sales, singing, film shows, sensory sessions and pampering activities. Some people attended external activities including swimming and external entertainers and an aromatherapist were booked to visit regularly. The activities coordinator and staff spent one-to-one with people chatting and reading. The activities coordinator told us; "It's more about lifestyles than activities. We have some very lonely people and I spend one to one time with them."

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. When concerns had been raised these had been dealt with in a timely manner and plans had been put in place to make any necessary improvements.

Requires Improvement

Is the service well-led?

Our findings

At this inspection we had concerns about how recent organisational changes had been communicated to staff and how management had supported staff through these changes. Staff morale was very low. Staff's perception of the recent changes to staffing levels, how staff were deployed and the decision to reduce the availability of unhealthy snacks were extremely negative. Every member of staff we spoke with expressed their concerns about the changes. Comments from staff included, "There is no continuity moving around the units and it's unsafe", "They've cut staff. I have been sent home four times because they have changed the rota on my day off and not told me", "They have taken crisps and chocolate away and people can only have one glass of juice in the morning" and "Nine times out of 10 there are not enough staff and we can't take people out."

We found there had been changes to the senior management structure for the service. In September 2016 Kernow House became part of the complex care division within the Barchester Healthcare group and this resulted in the registered manager reporting to different senior management. As part of the process for the senior management to understand how this service operated a review of the staffing structure had taken place. This had resulted in some changes to how staff were deployed and lower staffing levels in the service. A review of food and nutrition meant the service had decided to encourage people to eat healthier snacks such as fruit and yoghurts. However, there was no evidence that people had been consulted about the decision the service had taken to encourage people to eat healthier snacks and limit access to unhealthy snacks.

As detailed in the safe section of the report we had concerns about how staffing levels were determined. The evidence of how people's needs were assessed to decide staffing levels did not match what we saw as there were delays in how quickly staff could provide support for people. It was not clear if the dependency tool sufficiently took into account people with high needs, particularly those at high risk of falls. When new staff worked on a unit, who were redeployed from their usual unit, there was no evidence that any adjustments to staffing numbers were made to take this into account. Most people living at the service were unable to tell us their views of the service. One person did tell us, "The place hasn't got enough staff."

We found there were areas where record keeping could be improved. As detailed in other sections of the report, we have made recommendations about record keeping in relation to care plans and complying with DoLS conditions re personalised activities and covert medicines.

Overall we found the service was managed efficiently and there were many examples of positive outcomes for people living at the service. Staff provided good care for people and showed a genuine commitment to the people they supported. Staff told us they felt supported by the registered and deputy managers. Most staff were not clear about the senior management structure and therefore did not feel as supported by senior management.

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

and addressed. The registered manager operated a cycle of quality assurance. Questionnaires were sent to people and relatives annually in order to gain their feedback on the service and to make changes if required. There were regular relatives' meetings and staff meetings. At the most recent relatives' meeting, one relative said of the food on the Petherwin unit, "It really is excellent."

There were audits in place such as medicines, accidents, falls, pressure mattresses and wheelchairs. There had been a recent external pharmacy audit which confirmed there were no actions to complete. The service operated a "resident of the day" scheme on each unit. This was a system of checks for a person who was chosen at random each day. The checks included a thorough file audit, a spring clean of their room, physical health checks and a visit from the chef to look at their nutritional needs.

There were a range of up to date policies which were accessible to staff and provided guidance and important information. These were reviewed and updated annually by the registered manager with the oversight of senior staff.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked mental capacity the provider had not acted in accordance with the requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of suitably qualified, skilled and experienced staff on duty to meet people's needs. Regulation 18 (1)