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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 17 and 18 August 2016. Breaches of legal requirements were found and enforcement action was taken. This was because the provider did not have effective systems in place to assess and monitor accidents and incidents and medicines management. Action was also required to ensure people who had their medicines covertly administered (hidden in their food or drink) were being correctly supported in line with the Mental Capacity Act 2005 (MCA). Staff had also not received training in restraint, despite being in situations where it may be required.

After the comprehensive inspection the provider submitted an action plan to tell us what they would do to meet the legal requirements in relation to the breaches.

Prior to our inspection we received information of concern from the local authority safeguarding team about people's call bells not being answered, the competency of nursing staff and staff's understanding of safeguarding processes. We undertook this focused inspection on 11 November 2016 to check improvements had been made and to look into the concerns which had been raised by the local authority.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kernow House on our website at www.cqc.org.uk.

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 the inspection there were 70 people living at the service.

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

People told us they felt safe living at the service. Staff were confident and understood what action they should take if they were concerned someone was being abused, mistreated or neglected. People's call bells were observed to be answered promptly. People's medicines were managed safely, and when people's medicines were administered covertly the Mental Capacity Act 2005 (MCA) had been implemented to ensure people's human rights were protected.

People whose care needs meant they may require a restriction of their freedom of movement, were supported by staff who had received relevant training. However, not all staff had undertaken this training,

so an action plan was in place to ensure all staff completed the training by March 2017.

People who had an accident or incident had care records in place to help support them and minimise ongoing risks. However, some people's risk assessments and care plans had not been updated, which meant they may not receive the correct support to keep them safe. Action was being taken to educate staff on the importance of completing documentation.

Nursing staff received continuous clinical training to advance their knowledge and spoke confidently about their understanding of the safe management of people's medicines, Huntington's Disease, the Mental Capacity Act 2005 (MCA) and the reporting of accidents and incidents. Staff told us they received training to meet people's individual needs and felt supported by the registered manager and deputy manager. The registered manager told us she felt more supported since the introduction of a new line manager. New quality monitoring systems had been put into place to enable a clearer overview of accidents and incidents and medicines, prompting action and improvement when necessary.

The Commission had not been informed of significant events in line with their legal obligations. However, immediate action was taken to submit the outstanding statutory notifications. The divisional director told us they would be implementing new processes within the service and across the organisation to ensure this did not happen again.

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

Aspects of the service were safe.

Action had been taken to make improvements. This meant the provider was now meeting the legal requirements.

People who had an accident or incident had care records in place to help support them and minimise ongoing risks. However, some people's risk assessments and care plans had not been updated, which meant they may not receive the correct support to keep them safe.

People told us they felt safe.

People were protected from abuse because staff understood what action to take if they suspected some was being abused, mistreated or neglected.

People who received covert medicines were supported in line with the Mental Capacity Act 2005 (MCA) to ensure their human rights were protected.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for 'safe' at the next comprehensive inspection.

Is the service effective?

Requires Improvement

Aspects of the service were effective.

Action had been taken to make improvements. This meant the provider was now meeting the legal requirements.

People whose care needs meant they may require a restriction of their freedom or movement were supported by staff who had received relevant training. However, not all staff were trained so an action plan was in place to ensure all staff received this training by March 2017.

People received care from staff who undertook training to ensure their ongoing competence.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for 'effective' at the next comprehensive inspection.

Is the service well-led?

Requires Improvement

Aspects of the service were well led.

Action had been taken to make improvements. This meant the provider was now meeting the legal requirements.

The Commission had not been informed of significant events in line with their legal obligations. However, immediate action was taken to submit the outstanding statutory notifications.

Staff told us they felt supported by the registered manager and deputy manager.

The registered manager received support from a line manager who had knowledge and understanding of the service.

Quality monitoring systems had been put into place to enable a clearer overview of accidents and incidents and medicines management, prompting action and improvement when necessary.

There was a positive learning culture; the registered manager and deputy manager had been working hard to make changes to improve the quality of the service.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for 'well led' at the next comprehensive inspection.

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 was 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.

We visited the home unannounced on 11 November 2016. This inspection was carried out to check that improvements to meet legal requirements after our comprehensive inspection on 17 and 18 August 2016 had been made. We inspected the service against three of the five questions we ask about services: is the service safe; is the service effective; is the service well led? This is because the previous breaches were in relation to these three questions.

The inspection team consisted of two inspectors; a specialist advisor for older people's clinical nursing care and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed the information we held about the home. We reviewed notifications of incidents that the provider had sent to us since our last inspection. A notification is information about important events, which the service is required to send us by law.

During our inspection, we spoke with six people living at the home, three relatives, five members of staff, six nurses, the maintenance person, the receptionist/administrator, a housekeeper, the deputy manager, the registered manager and a divisional director.

After the inspection we contacted the local authority service improvement team to obtain their views about the service and shared inspection feedback with the local authority safeguarding team and commissioners.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 17 and 18 August 2016 people who had their medicines covertly administered (hidden in their food or drink) were not being correctly supported in line with the Mental Capacity Act 2005 (MCA). We also found, documentation in relation to accidents and incidents was not being completed in sufficient detail, to help mitigate risks to people. At this inspection, we found action had been taken to address these concerns. The provider also had plans in place to ensure new practices were being embedded and sustained by staff.

People were kept safe. People's falls, accidents and incidents were discussed on a daily basis at a meeting attended by head of departments. Ideas about how to minimise risks such as de-escalation techniques were openly discussed helping to effectively support people and to keep them safe. For example, one person had been walking into other people's bedrooms, and was becoming disorientated. Discussions took place about how they could best signpost the person to their bedroom door, by personalising it.

People who had an accident or incident had care records in place to help support them and minimise ongoing risks. Care plans, risk assessments and body charts were in place to help ensure a clear audit trail of decision making. Staff commented, "I have completed incident forms recently and I am confident completing them. This unit is very good at incident forms…we had document training the other day about how to make sure everything is completed correctly" and "We record the time, place, what happened and the reason".

People's relatives were informed when necessary, and learning had recently taken place following a delay in not informing a family of an incident quickly enough. As a result of this, the accident and incident report had been adapted to help ensure this did not occur again.

People told us they felt safe, commenting "This is a nice home with nice people (staff) looking after me", "I feel safe because the staff work so hard looking after me", and "I feel safe because there is always somebody around to make sure I am ok". A relative also told us, "I know my relative feels safe because she knows she can ask them to do anything for her". People's call bells were observed to be answered promptly. One member of staff told us, "If someone rings their call bell, we always go to check what it is they need".

People were protected from harm and abuse because staff understood and were confident about what action to take if they suspected someone was being abused, mistreated or neglected. Staff told us, "If I felt nothing was being done, I would call the whistleblowing helpline. They give you leaflets in your training so I have the information of where I could go externally. All our policies are here for us to look at too. They're always somewhere that is easy for us to get to. There are leaflets about safeguarding in the staff room too. I feel confident I could raise concerns with the head of unit or manager" and "I would look in the policies or for information in the office if I needed to contact anyone else…all staff have access to the policies and procedures".

People who received covert medicines were supported in line with the Mental Capacity Act 2005 (MCA) to ensure their human rights were protected. Nursing staff had a good understanding of what was expected and risk assessments and care plans in place demonstrated procedures were being correctly followed. There were monitoring checks in place to ensure people received their medicines safely and that procedures were being followed correctly.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 17 and 18 August 2016 staff had not received training in restraint, despite being in situations where it may have been required. At this inspection, we found action had been taken to address this concern. The provider also had plans in place to ensure staff who were yet to complete the required training were due to complete it within the next three months.

People whose care needs meant they may require a restriction of their freedom or movement were supported by staff who had received related training; and when restraint was used documentation was in place to record the incident and show an audit trail of actions taken. Staff told us, "We try to diffuse the situation by offering choice or leaving them alone to calm down" and "I'm reluctant to restrain anyone...prevention is always better…If we find anything that works or aggravates (…) we record it and the nurses bring the specifics to everyone's attention... all of them have pretty up to date care plans". However, not all staff were trained so an action plan was in place to ensure all staff received this training by March 2017.

People told us they thought the staff who supported then had relevant training and skills. Staff received training to meet people's individual needs, commenting "I have had Huntington's disease training and got lots of paperwork too to keep and I can review it. The senior staff are very knowledgeable. There is information in the office but senior staff are good at giving advice about specific circumstances", and "There's loads of information in the office and the nurses and staff are very knowledgeable about Huntington's disease…handovers are very informative too…whatever questions I've asked, someone has known the answer.

Nursing staff undertook training to ensure their ongoing competence, and explained that they had recently received training in respect of documentation, Huntington's Disease, Mental Capacity Act 2005 (MCA) and restraint.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 17 and 18 August 2016 the provider did not have effective systems in place to assess and monitor accidents and incidents and the safe management of people's medicines. At this inspection, we found action had been taken to address this shortfall.

Quality monitoring systems had been put into place to enable a clearer overview of accidents and incidents and medicines management, prompting action and improvement when necessary.

There was a monthly audit of people's accidents and incidents which took place within the service as well as at an organisational level. The divisional director explained, "There is a new system for collating and analysing accident and incident forms. This has given a better overview and is easier to identify themes". However, as a result of this analysis some people's risk assessments and care plans had not been updated, meaning people may have been at risk of not being supported correctly. The registered manager and deputy manager acknowledged there were some gaps and emphasised the systems were new and that they continued to support staff to ensure their ongoing understanding of the new documentation. Medicines audits were in place to assess and monitor the quality and safety of the service, which included covert management arrangements.

There was a positive learning culture; the registered manager and deputy manager had been working hard to make changes to improve the quality of the service and had been adapting systems to ensure they were effective in highlighting when improvements were needed. For example, at the daily head of department meeting any complaints or compliments received were discussed openly.

The Commission had not been informed of significant events in line with their legal obligations. However, the organisation took immediate action to submit the outstanding statutory notifications. The divisional director told us they would be implementing new processes within the service and across the organisation to ensure this did not happen again.

Staff told us the service was managed well and that they felt supported by the registered manager and deputy manager, commenting "Yes, it's well led. It's easy to complain but there are 70 people living here and over 100 staff. The registered manager is only one person. She is doing very well and changes she's making, take time to filter down…the rotas are now unchangeable without the registered manager knowing. The deputy manager is good too and great as a supervisor. I feel I have been very supported personally and they have been flexible around me. These are good people", and "I find the manager and deputy approachable and could knock on their door and go and talk to them. That's worth a lot as an employee".

The registered manager told us she was pleased with the increased support she had received over the last month from her new line manager, telling us that there seemed to be a better understanding from the organisation about the complexities and uniqueness of the service. The registered manager's line manager visited twice a month and had a good knowledge and understanding of the service.