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?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 10, 12 and 16 November 2015 and was unannounced.

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 units. On the day of the inspection 75 people were using the service.

There had been no registered manager in post since October 2015. An interim manager had been appointed but had recently left. 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. At the time of the inspection, the service was being overseen by the clinical lead and the divisional manager. Each unit had a head of unit in place to oversee its day to day management.

Staff exhibited a kind and compassionate attitude towards people and relatives told us they were happy with the care people received. Comments included, "The care given by the care team.....is deserving of several gold stars."

People told us they felt safe. Comments from relatives included, "[....] has been here six years now and he feels really safe," All staff had undertaken training on

Summary of findings

safeguarding vulnerable adults from abuse, they displayed good knowledge on how to report any concerns and described what action they would take to protect people against harm.

People were protected by the service's safe recruitment practices. Staff underwent the necessary checks which determined they were suitable to work with vulnerable adults, before they started their employment.

Staff told us they felt staffing levels were safe but didn't allow people's social needs to be met. People had the opportunity to join in some group activities at Kernow House but there were few opportunities to go out due to insufficient numbers of staff. Relatives commented, "It would be nice if they went out on the bus more. They don't seem to go out very often." and "Staff no longer have time to sit with [...] or hold her hand and read her a story." Staff also told us they did not always have the necessary skills or experience to provide meaningful activities to support people's interests.

People's care plans were detailed in relation to their physical care needs and sometimes contained personalised information about people's social care needs; but did not always specify how these needs were to be met. This meant there was a risk people's needs were not met how they wanted them to be. Due to the needs of people living at Kernow House, it was not always possible to involve people in their care plans however, this was not always recorded. People's care plans were not always legible which meant staff may not always be able to read or understand them. Incident forms were completed, however senior staff told us they were aware they needed to improve their analysis of and learning from incidents to ensure the service continually improved.

People's medicines were managed safely. Records were not always clear meaning people may not receive their medicines consistently as prescribed however, the staff member responsible for medicines took immediate action to ensure records were clear. External health professionals told us they were contacted appropriately, when required.

People's confidential and personal information was not always stored securely meaning other people could access it. People's privacy and dignity was mostly respected, however, observation windows on some people's doors (that could be covered for privacy) were often uncovered meaning people did not always have privacy. The use of these windows had not been considered in line with people's needs or wishes.

Relatives and friends were made to feel welcome and people were supported to maintain relationships with those who mattered to them. People and those who mattered to them knew how to raise concerns and make complaints. Complaints had not all been recorded properly but those that had, had been dealt with to the satisfaction of the complainant.

Staff talked positively about their jobs but did not always feel supported in their work. Team meetings were held to discuss practice but staff were not receiving one to one meetings, as set out in the provider's policy, to develop and improve their practice. Staff received training and had the correct skills to carry out their roles effectively within the unit they normally worked in. Some staff told us they did not consider themselves to have the correct skills when asked to work in different units.

Staff understood their role with regards to the Mental Capacity Act (2005) and the associated Deprivation of Liberty Safeguards. Applications were made and advice was sought to help safeguard people and respect their human rights.Quality monitoring systems were not effective. Many of the concerns we observed had not previously been identified and concerns which had been identified were not all being acted upon.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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

Some aspects of the service were not safe.

Medicines were managed, stored and disposed of safely.

Incidents were not always analysed meaning learning and improvements to the service could be missed.

Safe recruitment practices were followed and there were sufficient numbers of skilled and experienced staff to meet people's basic needs.

Staff had a good understanding of how to recognise and report any signs of abuse and staff acted appropriately to protect people.

Is the service effective?

Requires improvement

Some aspects of the service were not effective.

Staff were not receiving one to one supervision in line with the policy.

Staff completed core training required by the service as well as training to meet people's specific needs.

Staff had received training in the Mental Capacity Act and the associated Deprivation of Liberty Safeguards. Staff displayed a good understanding of the requirements of the act, which had been followed in practice.

Is the service caring?

Requires improvement

The service was not always caring.

People's confidentiality, privacy and dignity were not always respected.

Positive caring relationships had been formed between people and staff.

Visitors were made to feel welcome.

People were supported by staff that promoted independence.

Is the service responsive?

Requires improvement

The service was not always responsive.

Some activities were planned in line with people's interests but, due to lack of time and experience, staff found it difficult to provide meaningful activities for people.

Care records recorded people's health needs but did not always contain individualised information about people's social needs.

The service had a policy and procedure in place for dealing with any concerns or complaints and people were satisfied with the outcome of the complaints.

Summary of findings

Is the service well-led?

The service was not always well-led.

There was no registered manager in place and staff felt they lacked the support they needed.

Quality assurance systems were in place but had not identified or acted upon concerns found by the inspection.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred, in line with their legal obligations.

Requires improvement

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.

The unannounced inspection took place on 10, 12 and 16 November 2015. It was undertaken by two inspectors, a pharmacy inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service. This included previous inspection reports and notifications 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 nine people who lived at Kernow House, six relatives of people living at Kernow House, the divisional manager, clinical lead and 21 members of staff. We also spoke with three health and social care professionals who have contact with people living at Kernow House.

We looked around the premises and observed how staff interacted with people throughout 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.

We looked at nine records related to people's individual care needs and 20 people's records related to the administration of their medicines. We viewed five staff recruitment files, training records for all staff and records associated with the management of the service including quality audits.

Whilst carrying out our inspection we left 'Tell us about your care' comment forms at the reception desks of the home. Three staff members and two relatives completed our forms and commented on what they thought of the service.

Requires improvement

Is the service safe?

Our findings

Staff felt, during the inspection, there were enough staff on duty to keep people safe and meet their basic needs. They reported that in the weeks prior to the inspection, there had been times when staffing levels did not feel safe and did not allow them to meet people's needs. They told us staffing levels had improved and the service was not fully occupied which eased pressure. They did not feel confident, however, this level would be maintained in the future. Comments from staff included, "the basics are getting done but the extra, the human bits, are getting missed" and "I go home feeling I have not achieved what I should have done." A healthcare professional told us, "I've never been concerned about safety but see the staff are stretched now." Staff on one unit, where people had high support needs, reported not being able to get some people out of bed until lunch time telling us, "You want to give everything to your residents but we can't." A head of unit confirmed this was often the case.

Incidents were logged and care plans and risk assessments were mostly updated as a result. However, a senior staff member had recognised, whilst they responded to and took action concerning more significant events, they needed to spend more time reflecting on all events to highlight any improvements that could be made as a result. Some incidents were overseen by a senior Barchester member of staff to ensure they had been dealt with effectively.

Medicines were managed, stored, and disposed of safely but records were not always clear, meaning people may not always receive their medicines as prescribed. For example, one person was prescribed insulin and the dose was dictated by their blood sugar reading. There was information for staff about how to calculate this dose but the amount administered was not recorded. Information about when to give medicines prescribed 'when required' was not always clear and not always followed accurately. The staff member responsible for medicines told us they would put systems in place immediately to ensure these concerns were addressed. Staff were trained in, and confirmed they understood the importance of, safe administration and management of medicines. Medicines were locked away and, where refrigeration was required, temperatures had been logged and fell within the guidelines that ensured quality of the medicines was maintained.

People told us they felt safe. Comments from relatives included, "[....] has been here six years now and he feels really safe," "[.....] was quite unsettled before but feels safer now" and "It's all good. My worry for mum's safety has decreased a lot now she's living here."

People were protected by staff who had an awareness and understanding of signs of possible abuse. Staff felt reported signs of suspected abuse would be taken seriously and investigated thoroughly. One member of staff commented, "the organisation reinforces the importance of people reporting concerns." Staff were up to date with safeguarding training and knew who to contact externally if they felt their concerns had not been dealt with. For example, the local authority or the police.

People were supported by suitable staff. Robust recruitment practices were in place and records showed appropriate checks were undertaken to help ensure the right staff were employed to keep people safe. Records confirmed checks were applied for and obtained prior to staff commencing their employment with the service.

People were supported by staff who understood and managed risk effectively. People moved freely around the unit they lived in and chose how and where they spent their time within the unit. Staff explained how people were encouraged to do as much as possible for themselves and saw themselves as "there to minimise the risk." They confirmed this was recorded in people's risk assessments. One risk assessment noted a person's wish to go out shopping on their own. This had been assessed as a risk to the individual. The staff managed this well and had put plans and strategies in place so they could respect the person's choice and help minimise the risk to their safety and that of others.

Staff were knowledgeable about people who had behaviour that may challenge others. We observed one person got distressed whilst sitting in the lounge area. Staff reacted promptly; they recognised the person had become anxious and sought help from a senior member of staff when they felt de-escalation techniques were not helping. The senior member of staff was successful in finding the cause of the person's anxiety. The quick response

Requires improvement

Is the service safe?

prevented the person from being at risk, ensured their needs were met and they became calm and settled. Staff who provided one to one support to people who needed it alternated with other staff so they remained alert to the person's needs. The physical environment was adapted to suit the needs of the people living at Kernow House. People were assessed by healthcare professionals to ensure they had the correct equipment to meet their needs; however, some people living with Huntington's disease, reported they did not feel the furniture was suitable for them. Chairs had tipped over whilst they were using them, making them feel unsafe. The head of unit escalated this as a health and safety concern to the senior management team.

Requires improvement

Is the service effective?

Our findings

People's relatives told us they felt people were supported by knowledgeable, skilled staff. They told us, "[Staff] are lovely; very, very kind and totally reliable," "The staff are brilliant," and "The care given by the care team in this and other units is deserving of several gold stars." An induction programme was in place which incorporated the care certificate. The care certificate is a national induction tool which providers are required to implement to ensure new staff work to expected standards within health and social care services. On-going training was planned to support staff member's continued learning and was updated when required. Staff told us they received "good training." Training courses included, Mi Skin (care of the skin), Footsteps (preventing falls) and infection control plus courses specific to people's individual needs, such as Huntington's and dementia training. A senior staff member told us care staff were given "all the tools to do the job" and a healthcare professional told us, "I do see a lot of training going on." However, some staff told us they would benefit from additional training relating to people's specific needs, when working in a different unit.

Formal one to one meetings with staff to ensure they were supported in their roles were not taking place as set out in the organisation's policy. Staff told us, "we used to have regular supervisions but this has lapsed recently," "The nurses are so busy they do not have time" and "I was just left to get on with the job after my induction." Senior staff confirmed they did not feel they had the time currently to carry out one to one meetings or review staff competence. Staff meetings were regularly held to discuss practice and keep staff informed of any changes. People when appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS provides legal protection for vulnerable people who are, or may become, deprived of their liberty. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Documentation showed appropriate applications had been made for people.

Staff showed a good understanding of the main principles of the MCA. Staff asked people's consent before providing care or support. They were also aware of how people who lacked capacity could be supported to make everyday decisions, for example, showing people pictures of food to help them choose what they would like to eat. Staff knew people well and understood their facial expressions and body language in response to the choices given. People's preferred communication methods were recorded in some care plans but not in all care plans meaning they may not be used in a consistent way with people.

People were involved in decisions about what they would like to eat and drink. People's records identified what food people disliked or enjoyed and listed what the staff could do to help each person maintain a healthy balanced diet. People were encouraged to say what foods they wanted to eat through informal feedback and through biannual surveys. The chef and deputy chef planned future menus according to the feedback received.

People's food choices were respected. We observed a staff member asking what someone wanted for breakfast and then repeating the answer to confirm they had understood correctly. People were relaxed at mealtimes and told us the meals were good. Comments included, "I had a pasty today and it was very nice. It was all crimpled round the edge, how I like it!" Staff interacted with people in a friendly way and sensitively supported people who needed assistance. Staff encouraged people to eat, praising them throughout, saying, for example, "Let's have one more mouthful," and "Careful, there's no rush."

People's records highlighted where risks with eating and drinking had been identified. For example, one person's record contained incident forms concerning excessive coughing whilst eating. Staff sought advice and regularly liaised with a speech and language therapist (SLT) to ensure they were supporting the person safely. Recommendations had been made to minimise the risk to the person, which were followed in practice and regularly reviewed.

Requires improvement

Is the service caring?

Our findings

Confidentiality was not always respected. Offices which contained people's records were left unlocked. We told the clinical lead about this who immediately locked one of the offices that contained people's personal information. People's names and personal information about them were recorded in communal records such as communication books and over the three days of the inspection, people's confidential records in one unit were left unattended in the kitchen or lounge areas. This meant that people's confidential information could be read by others. At the time of the inspection, there was no plan in place to rectify this.

People's personal information was not maintained securely. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's privacy and dignity were respected by staff most of the time. Doors were always closed when people were receiving personal care and staff discussed personal matters discreetly with people. People's doors, on one unit, however, contained clear observation windows. These could be uncovered so people could see into the room or left covered for privacy. There was no record in people's care plans saying they had been consulted about this, nor guidance for staff about when they should be covered or uncovered. This meant people's privacy was not always respected. The clinical lead said people would be consulted and the information added to people's care plans.

People felt well cared for, they and their relatives spoke highly of the staff and the care they received. Comments included, "They are all very kind," "[....] is well looked after and I know he's ok because he smiles," "They are very good at caring for [...]" and "Staff always smile at mum or talk to her even as they are just walking by." Staff talked to people in a caring way, examples included, "You've got a lovely smile," and "Well done, you're a super man!"

Staff showed concern for people's wellbeing in a meaningful way. We saw staff interact with people in a caring, supportive manner and took practical action to relieve people's distress. For example, one person showed signs of distress whilst walking through the lounge. A staff member joined them as they walked, spoke with the person in a kind manner and rubbed their back. They continued to walk and comfort them until they were settled.Staff knew the people they cared for and were able to tell us about individuals' likes and dislikes, commenting "We try to spend time with people to get to know them." However, relatives and staff raised concerns that there was often not enough time for staff to spend with people, beyond meeting people's basic care needs. Staff told us, "it is difficult....it doesn't feel like we're here for the residents," and "We talk to people when we are doing our work but are not able to talk with people as much as we would like to. They're human beings, they need care."

People and their relatives told us staff listened to them and took appropriate action to respect their wishes. One relative told us "staff are aware of the importance to mum of looking smart so they help her put on her make-up and co-ordinate her clothes." We observed staff helping a person who was having difficulty using their phone and finding the correct number to dial. They reassured the person and stayed with them until they achieved what they were doing. The next day we saw them supporting the person with the same task with equal patience and understanding.

Friends and relatives were able to visit without unnecessary restriction. Visitors told us they were always made to feel welcome and could visit at any time. Staff said they worked hard to ensure people maintained contact with their family and friends. Feedback to the service from relatives included, "The staff were most obliging and helped to make our visit an extremely pleasurable experience" and "The family thank you all so much for the love, friendship and support you have shown them."

Requires improvement

Is the service responsive?

Our findings

People did not always receive personalised care. In order to provide personalised activities, an activities budget had recently been put in place for staff to use for individual activities for people. Staff did not feel they had the time or skills to be able to provide activities for people either in the home or in the community. Staff commented, "we used to be able to do what most people liked but we no longer have the staff to take people out." Relatives told us, "It would be nice if they went out on the bus more. They don't seem to go out very often," "Staff no longer have time to sit with [...] or hold her hand and read her a story. Having someone to talk to is different to just having the radio on. I've never had a concern, apart from the staffing levels. I think time to sit with people is vital." and "There now seems to be insufficient carers, who simply do not have time to give these vulnerable people the attention, the extra time to hold a hand or the conversation I believe they deserve."

Some group activities within the home still took place, such as sensory sessions, hymn singing and film afternoons however, on the first day of the inspection, a swimming trip for a group of people was cancelled due to lack of staffing. Senior managers agreed not enough activities were taking place. They felt this was due to staffing levels and the need for staff to gain the skills to provide meaningful, personalised activities.

A senior staff member told us it was essential people were able to go out or take part in meaningful activities so they did not become anxious. They told us taking people out was often a successful de-escalation technique if someone was agitated, as trips out often calmed people.

People's social needs were not always being met because the staff were not deployed in sufficient numbers. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable about people's interests and what activities they enjoyed doing. Where people could not give information about themselves, staff used family members to learn about people's likes and dislikes. Staff talked about how people's interests had been used to provide meaningful activities; for example, one person enjoyed working on motorbikes and a motorbike had been bought so they could repair it with staff support. Staff also used their knowledge of people to support any rehabilitation needs. For example, one person who had found it difficult to start walking again in hospital, after an operation, was successfully supported by staff at Kernow House to walk again. Staff told us, "We give the best care we can, spending time with people, communicating with people and keeping people comfortable." A healthcare professional told us they were very impressed with the care provided by the staff.

Care records contained detailed information about people's physical care needs and some contained information about people's social, psychological and emotional needs, their likes, dislikes and preferences about how they wished to be supported. However, these details were not recorded about every person. Some people and, where appropriate, those who mattered to them were involved in reviewing their care plans. Due to the needs of some people living at Kernow House, it was not possible for them to be involved in their care plans but this was not recorded. Care plans were not always legible which meant staff may not always be able to read or understand them but we were told there was no facility for them to be typed.

The service had a policy and procedure in place for dealing with concerns or complaints. People and those who mattered to them knew who to contact if they needed to raise a concern or make a complaint. A relative told us they had raised a small concern and it had been dealt with quickly and professionally. Staff confirmed any concerns were dealt with without delay and any changes to people's care was communicated through staff meetings or at staff handover. For example, a family member had complained because their relative had not had a bath regularly. They had received a written response apologising and informing them what action would be taken. This had been followed by staff. The divisional manager confirmed all complaints they were aware of had been recorded, dealt with and the complainants were satisfied with the response.

Requires improvement

Is the service well-led?

Our findings

There had been no registered manager in post at Kernow House since October 2015 and an interim manager had recently left. The service was being overseen by the clinical lead and the divisional manager. Staff told us they did not feel the management structure or staff roles were clear and relatives told us they had not known who the registered manager was or that they no longer worked there. The divisional manager told us the company was in the process of recruiting a new manager.

Senior managers from Barchester regularly visited to audit different aspects of the service, for example health and safety and compliance with the five key questions looked at by CQC. These audits included actions and timescales within which to improve practice. However, their observations had failed to identify concerns including insufficient staffing to meet social needs, unsecured confidential information, lack of detail in some care plans and lack of clarity regarding certain medicines records. Actions had been allocated to the registered manager to complete but not re-allocated to another staff member when the registered manager left. The systems in place to monitor the quality of service people received were not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff felt supported by the nursing staff and the clinical lead saying, "All of the management team are easy to talk to," and one staff member described the clinical lead as, "absolutely fantastic." However, some staff told us they were concerned about the lack of support or feedback they received in their job and didn't feel part of the wider company. Comments included, "managers do not seem to acknowledge you," and "we don't get told what is happening or how it will affect us." Staff told us this had resulted in low staff morale and a reluctance to raise ideas or question practice as they did not feel listened to.

The provider sought feedback from people and those who mattered to them. Questionnaires had been distributed to gauge people's opinion of the service. Senior staff were unsure, however, if any specific ideas or concerns could be or had been raised through these. Meetings were held to encourage people and their relatives to raise ideas that could be implemented into practice. A recent meeting was used to ensure relatives felt confident raising any concerns or problems so they could be resolved swiftly. The lack of activities was also discussed. Relatives were told there was no activity time allocated at the moment but this should improve next year.

The service had an up to date whistle-blowers policy which supported staff to question practice. It clearly defined how staff who raised concerns would be protected and a whistleblowing helpline number was displayed around the home.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred, in line with their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were not sufficient numbers of staff suitably deployed to meet people's social needs.** Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems to assess, monitor and improve the quality and safety of the service provided were not operated effectively. Records relating to the care of service users were not kept securely.** Regulation 17 (1) (2) (a) (c)