Barchester Healthcare Homes Limited

Kenwyn

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced focused inspection took place on 22 January 2018. The last inspection took place on 3 and 9 October 2017 when the service was not meeting the legal requirements. There were two breaches of the regulations. This was because the arrangements in place for the administration and management of medicines at the service were not robust. Three medicine errors had been reported since the last inspection of 03 and 09 October 2017, two for similar concerns and which took place close together. This meant effective action had not been taken following the first event, in order to prevent a second event occurring. People did not always receive their medicines as prescribed due to a lack of stock held at the service. Medicine audits were not effectively identifying when errors or omissions took place. We were concerned that nurses did not always follow the service's policies and procedures when events took place. Information held by the service regarding the number of Deprivation of Liberty Safeguards authorisations was not accurate. People did not always receive care that was personalised and responsive to their changing needs. Concerns found at previous inspections were not always effectively addressed. Breaches of the regulations continued to remain despite the service providing CQC with action plans laying out the actions they were to take to address issues.

The service was rated as Requires Improvement at that time. Following this inspection the service remains Requires Improvement. Following the last inspection the service sent us an action plan stating the actions it was taking to meet the legal requirements of the regulations. This focused inspection was carried out to check they had followed their action plan and to confirm they now met the legal requirements. This report only covers our findings in relation to the Safe and Well led domains. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kenwyn on our website at www.cqc.org.uk

People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Kenwyn is a care home which offers nursing care and support for up to 109 predominantly older people. At the time of the inspection there were 80 people living at the service. Some people were living with physical disabilities, long term physical health and mental health conditions including dementia. The service occupies a large detached building over two floors. The service is divided in to four units providing different levels of care to people according to their needs.

The service had reported two further medicine errors since the last inspection. A third took place days before this inspection. The nurse did not follow the service policy to seek medical advice or contact the person's family following the error. There were systems in place for the management and administration of medicines. Recently implemented weekly and monthly medicines audits were being carried out on all areas of medicines administration and management and these were effectively identifying when errors occurred. Audits looked at areas such as daily stock tallies, stock balances carried forward, self-administration assessments and the signatures on medicine records. The most recent medicine error was identified by the next shift, after the error occurred, due to nurses counting medicines at every medicine round.

Risks in relation to people's daily lives were identified, assessed and planned to minimise the risk of harm whilst helping people to be as independent as possible. However, some guidance was not always sufficient to guide staff to reduce risks effectively.

Lessons were not always being learnt by the service following events that took place. One person had been identified as having behaviour that challenged staff, agreed actions had not been implemented to address the concern. Staff were being injured on a daily basis. One member of staff had been reported as having responded inappropriately to being injured by this person. This matter was being investigated at the time of this inspection by external agencies. The service had not taken adequate internal action to advise staff on how to support the person and record incidents each time staff were injured. One person had conflicting information in their care plan and room charts regarding when staff should re-position them.

One person was not having their specific needs met by staff who did not have sufficient knowledge and skills to meet their needs. Staff recognised this but no specific action had been carried out to try to improve things for the person. Records did not evidence that this person was receiving the agreed individual support commissioned.

Another person had discussed and agreed their specific dietary requirements with the staff and chef at the service. However, during this inspection this person was offered inappropriate foods. This meant people did not always receive person centred care.

Records about the assessment of a person's mental capacity were not clear. One assessment stated they did not have capacity for a decision about having bed rails. A second assessment was delayed having recognised the person understood but could not, at that time, make their own decision. The treatment escalation plan (TEP) stated they had capacity. Later in their care plan it stated this person had a Deprivation of Liberty Safeguards authorisation in place when this was incorrect. No authorisation was in place. An application had been made to the supervisory body (Local authority) for this to be assessed. This meant staff were not being provided with accurate information to guide their care practice.

The service had identified the minimum numbers of staff required to meet people's needs and these were being met. The service had staff vacancies at the time of this inspection which were being actively recruited for. Agency staff were being used to cover vacant posts and were often the same staff working regularly at the service. This meant they were familiar with people living at the service and their needs.

At the last inspection people were not supported to leave the service and go out in to the local area as staff were not trained to use the service's vehicle. At this inspection staff had been provided with the necessary training and people were supported by staff to go out, to visit the local area.

The registered manager had resigned two weeks prior to this inspection. An acting manager was in place at the time of this inspection. The manager was supported by a deputy manager and a clinical lead. The provider was also supporting this service with regular visits.

The staff were happy working at the service and recognised positive changes in the service over the past few weeks. They felt well supported and able to seek advice and guidance at any time. There was a significant amount of work in progress and it was too soon for us to judge the impact of these changes at the time of this inspection. We will review the service again with a comprehensive inspection in the future.

We found a breach/breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports

after any representations and appeals have been concluded.

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. Three medicine errors had been reported since the last inspection. The last error took place two days prior to this inspection. Nursing staff did not seek medical advice or inform the person's family following this error. The service was not following its own procedure and policy.

There were sufficient numbers of suitably qualified staff to meet the needs of people who used the service.

Care plans recorded identified risks in relation to people's care and these were assessed. However, staff were being injured by one person's behaviour that challenged. Agreed action had not been taken to record such events, and specific guidance was not provided to staff to help reduce such events in the future.

Is the service well-led?

Requires Improvement

The service was not entirely well-led. Records were not always clear about directing staff to meet people's needs. Records were not always providing accurate information for staff. Commissioned support was not always clearly recorded as having been provided.

Lessons were not always learnt when things did not work well. One person's specific needs were not being met by knowledgeable and skilled staff. Effective action had not been taken to help reduce injuries to staff sustained in the care and support of a person.

Best interest processes were not always recorded before restrictions were put in place or applied for.

There were clear lines of responsibility and accountability at the service.

Staff felt supported and able to access advice and guidance when needed from the management team.

The new manager had only been in post for two weeks prior to this inspection. It was not possible to judge the impact of the changes being made at this time.

Kenwyn

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 inspection took place on 22 January 2018. The inspection was carried out by two adult social care inspectors.

Before this inspection we reviewed information we held about the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with six people living at the service. Not everyone we met who was living at Kenwyn was able to give us their verbal views of the care and support they received due to their health needs. We looked around the premises and observed care practices. We spoke with seven staff, the acting manager and the clinical lead. We spoke with two visitors.

We looked at care documentation for 12 people living at Kenwyn, medicines records for five people, and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

One person with specific support needs, had not been able to continue with community day care support and activity due to their service closing. The service had been commissioned to provide 12 hours a week of one to one support with activities. This had not been recorded since 11 January 2018. This meant this person was not having the activity levels provided as commissioned by the local authority. Staff had tried to carry out activities with this person but the person had either not been able to complete them, appeared disinterested, or had put activity items in their mouth. Staff did not have the skills and knowledge to meet this person's needs. Staff did not know what the person used to enjoy when at the day centre and had not received any specific training for this person's needs and told us they had "Tried to work things out ourselves." This meant the person was not having their specific needs met.

Another person had met with kitchen and care staff to discuss their specific dietary requirements. During this inspection the person was offered inappropriate foods that they could not eat or did not like. This meant the person was not being cared for in a person centred manner.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the last inspection the arrangements in place for the administration and management of medicines at the service were not robust. Three medicine errors had been reported since our last inspection in October 2017. Two for similar concerns which took place close together. Two people did not receive their pain relieving patch as prescribed. This meant effective action had not been taken following the first event, in order to prevent a second event occurring. Some people did not always receive their medicines as prescribed due to a lack of stock held at the service. Medicine audits were not effectively identifying when errors or omissions took place. We were concerned that nurses did not always follow the service's policies and procedures when events took place.

Since the last inspection in October 2017, three further medicine errors have taken place. Four days after the last inspection a person was given too much of a medicine that requires stricter controls. A week later another person did not receive their prescribed pain relieving patch and this was delayed for 24 hours until the error was recognised. The acting manager had held a meeting with nurses the week prior to this inspection. At this meeting medicines management issues were discussed, with the manager highlighting the need to ensure people received their prescribed medicines in a timely and safe manner. Two days prior to this inspection, a person was given too much of a prescribed medicine. The nurse was distracted during the medicine round. The nurse did not seek medical advice and did not inform the person's family. No action was taken until three days later when the deputy manager was given the incident report. This meant the nurse did not follow the service's policy and procedure and the concerns found at the last inspection have continued to take place. This is the third inspection at which we have had concerns regarding medicines administration.

This is a repeated breach of Regulation 12 of the Health and Social Care Act (Regulated Activities)

Regulations 2014.

In the months since the last inspection the service had implemented detailed weekly and monthly medicine audits. Also nurses were counting medicines at every medicine round to ensure any errors were identified. The error reported on the 19 January 2018 was identified by the nurse on the next shift due to these newly implemented checks. Stock balances were being regularly carried forward to ensure people's medicines were always available as prescribed.

At the last inspection we were concerned that medicines that were required to be given occasionally (PRN) did not always have sufficient guidance for staff about when to give the medicine. At this inspection the manager had taken action to ensure all medicines that were to be given PRN had protocols provided for staff on when to give such medicines.

At the last inspection some people who had medicines prescribed for specific times in a month, or year, did not always have recorded evidence that these had been given appropriately. There were not always records when the next dose was due. At this inspection we checked the records for people who had prescribed medicines at specific times, such as three monthly medicines. These medicines were clearly documented and showed staff when the next dose was due.

At the last inspection we were concerned that one person who was required to have medical tests carried out, before their next prescription was ordered, did not always have this done. This led to delays in them having their prescribed medicines given. At this inspection we found the blood tests were being carried out appropriately by the service and the person was given their correct medicines consistently in a timely manner.

The service held an appropriate medicines management policy. There were medicine administration records (MAR) for each person. Staff completed these records at each dose given. We saw staff had transcribed medicines for people, on to the MAR following advice from medical staff. These handwritten entries were signed and had been witnessed by a second member of staff. This meant that the risk of potential errors was reduced and helped ensure people received their medicines safely. Some people had been prescribed creams and these had mostly been dated upon opening. This meant staff were aware of the expiration of the item when the cream should be disposed of.

Kenwyn were storing medicines that required cold storage, and there were medicine refrigerators at the service for this purpose. There were records that showed medicine refrigerator temperatures were monitored regularly to ensure the safe storage of these medicines could be assured. The service had ordering, storage and disposal arrangements for medicines. The regular audits were ensuring people did not run out of their prescribed medicines.

People were given the opportunity to self administer their own medicines if they wished. People had been assessed regularly to help ensure they were safe to take on this responsibility. Staff monitored their medicines in their rooms to ensure people took their medicines appropriately.

Risk assessments were in place for each person for a range of circumstances including moving and handling, nutritional needs and the risk of falls. Where a risk had been clearly identified there was guidance for staff on how to support people appropriately in order to minimise risk and keep people safe whilst maintaining as much independence as possible. For example, the equipment required and how many staff were needed to support a person safely. However, some guidance was not always sufficient to guide staff to reduce risks. For example, one person had been identified as having behaviour that challenged staff. There had been a

meeting on 16 January 2018 when it was agreed that specific records would be made of every incident of aggression that occurred, possible triggers and whether an approach was effective or not. This had not been implemented. Staff told us they were being injured on a daily basis. We saw visible scratches on many staff who reported such injuries were happening 'every day' whilst supporting this person. One member of staff was under investigation as having responded inappropriately to being injured by this person. This matter was being investigated at the time of this inspection by external agencies. The manager was not monitoring records made about staff injuries. The service had not taken effective action to protect staff after the event. Staff told us they had been told to 'leave and return later'. They told us it was not always possible to do this as the person often urgently needed personal care. This person had been referred to an external specialist but the service had not addressed the specific challenges experienced by staff on a daily basis.

This contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to and since the last inspection, the service and visiting healthcare professionals had raised their concerns to CQC about two people living on one unit at Kenwyn. One person was physically aggressive towards another person. Many incidents of aggression had been recorded. Safeguarding alerts had been made to the local authority. The service had been commissioned to provide one to one support for this person. While there had continued to be some incidents reported, these incidents had lessened considerably. The service was considering moving this person to another service in the group where the staff could more easily meet the person's needs. Staff at this other service, were provided with specialised training in how to carry out safe holds on a person. Staff at Kenwyn are not provided with restraint training and have a 'no holds' policy.

People and their families told us they felt it was safe at Kenwyn. The service held an appropriate safeguarding adults policy. Staff were aware of the safeguarding policies and procedures. Safeguarding was regularly discussed at staff meetings. Staff were confident of the action to take within the service, if they had any concerns or suspected abuse was taking place. Staff received training updates on Safeguarding Adults and were aware that the local authority were the lead organisation for investigating safeguarding concerns in the County. There were "Say no to abuse" leaflets displayed in the service containing the phone number for the safeguarding unit at Cornwall Council. This provided information to people, their visitors and staff on how to report any concerns they may have.

The service had a whistleblowing policy so if staff had concerns they could report these and be confident of their concerns being listened to. Where concerns had been expressed about the service, if complaints had been made, or if there had been safeguarding investigations the manager investigated these issues. This meant people were safeguarded from the risk of abuse.

The manager understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these as necessary. Staff told us if they had concerns management would listen and take suitable action. The manager said if they had concerns about people's welfare they liaised with external professionals as necessary, and had submitted safeguarding referrals when appropriate. Staff were clear about people's rights and ensured any necessary restrictions were the least restrictive.

Accidents and incidents that took place in the service were recorded by staff in people's records. Such events were audited by the manager and the provider. This meant that any patterns or trends were recognised, addressed and the risk of re-occurrence was reduced. Records showed actions taken to help reduce risk in the future such as referrals to external healthcare professionals for advice were made.

Care records were stored securely but accessible to staff and visiting professionals when required. They were accurate, complete, legible and contained details of people's current needs and wishes.

The staff shared information with other agencies when necessary. For example, when a person was admitted to hospital a copy of their care plan and medicine records was sent with them.

We looked around the building and found the environment was clean and there were no unpleasant odours. The service had arrangements in place to ensure the service was kept clean. The service had an infection control policy and lead staff who monitored infection control audits. The manager understood who they needed to contact if they need advice or assistance with infection control issues. Staff received suitable training about infection control, and records showed all staff had received this. Staff understood the need to wear protective clothing (PPE) such as aprons and gloves, where this was necessary. We saw staff were able to access aprons, hand gel and gloves and these were used appropriately throughout the inspection visits.

Each person had information held at the service which identified the action to be taken for each person in the event of an emergency evacuation of the premises. Fire fighting equipment had been regularly serviced. Fire safety drills had been regularly completed by staff who were familiar with the emergency procedure at the service.

The manager reviewed people's needs regularly. This helped ensure there were sufficient staff planned to be on duty to meet people's needs. The staff team had an appropriate mix of skills and experience to meet people's needs. During the inspection we saw people's needs were usually met quickly. We heard bells ringing during the inspection and these were responded to effectively.

The manager was open and transparent and always available for staff, people, relatives, staff and healthcare professionals to approach them at any time. The manager understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these as necessary

Requires Improvement

Is the service well-led?

Our findings

The service is required to have 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. The service did not have a registered manager in post. The registered manager had resigned two weeks prior to this inspection. The provider had arranged for an acting manager to work in the service to cover this role whilst they recruited a new registered manager. The new manager had been in post for two weeks prior to this inspection. Whilst they had begun to make changes and implement new ways of working it was not possible to judge what the impact of these changes would be at the time of this inspection.

A warning notice was issued against the provider following the last inspection. We were concerned that appropriate action was not always taken by the manager following events that took place at the service, such as investigating concerns about staff actions and the service provided. Where action was taken it was not always effective in addressing the risk of re-occurrence, such as medicine errors. Concerns from people, their families and healthcare professionals having been raised with the service, about the quality of care and support provided, had not been effectively addressed and they had lost confidence in the service. We were also concerned that the action plan sent to CQC following the previous inspection, had not been effectively put in to place or monitored and omissions and errors continued to occur. Some people's care was not always clearly recorded, and changes to care were not always clearly documented. This meant it was not easy for families and professionals to evidence that required care and support was provided. Records relating to Deprivation of Liberty Safeguards (part of the Mental Capacity Act 2005) authorisations held at the service were not accurate. The service had not notified CQC of all the authorisations in place as they are legally required to do.

Since the last inspection all nurses had been re-assessed for their competency in administering medicines and had been asked to sign to evidence they had been re-issued with a copy of Barchester's medicines policy. The new manager had held a meeting with nurses the week prior to this inspection, to raise the importance of safe medicine administration. A new clinical lead had been appointed to support the manager. Two medicine errors had been reported to CQC since the last inspection. At this inspection we identified continuing concerns with medicine errors. A further error had occurred during the weekend prior to this inspection. Immediately following the identification of this error, the nurse concerned did not follow the policy and procedure held by the service following this event. We have had previous concerns about nurses not always following the service's policies and procedures.

One person was cared for in bed and had been assessed as being at risk from skin damage due to pressure, they required re-positioning regularly. The care plan stated staff should re-position this person every two hours but the room charts stated every four hours. This meant staff were not provided with clear direction and guidance on when to care for this person.

A member of staff had responded inappropriately to being injured by a person who acted aggressively

towards them in December 2017. The matter was being investigated by an external agency. A safeguarding alert had been raised by a healthcare professional about injuries seen to this person, who was acting aggressively towards staff. Whilst risk assessments were in place, we did not see any internal action taken to investigate how these injuries could have occurred. However, whilst some of these events had taken place prior to the new manager taking up their post, there was no information provided to inspectors that related to any internal investigation or action taken to address these events. A meeting was held on the 16 January 2018 where it was agreed detailed records were to be completed about when this person had an aggressive episode. This had not been carried out. Staff were continuing to be injured on a daily basis and had visible injuries at the time of this inspection. This meant that effective action had not been taken to protect staff and support the person safely.

In October 2017 CQC were contacted by the local safeguarding unit to inform us that a healthcare professional had raised concerns to safeguarding about the support of a person living at Kenwyn. They were concerned that commissioned individual support was not being provided. This concern had been investigated by specialist healthcare professionals and remained in safeguarding at the time of this inspection, with a review due in March of this person's needs. At this inspection there were no records made by staff, since 11 January 2018, to evidence that this commissioned individual support was being provided. This had not been identified prior to this inspection. Safeguarding concerns were not always being robustly monitored. Lessons were not being learned by events at the service.

Whilst the specific concerns in the warning notice from the last inspection had been met by the service continued concerns remained. The service remains in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for the third time.

At this inspection we spoke with some of the people who had previously raised concerns with us about the management and investigation of issues raised with the manager. They told us that the clinical lead, or the new manager, had met with them and discussed their concerns. They felt their concerns had been resolved at the time of this inspection. Healthcare professionals also confirmed that they felt any matters raised with the new manager, deputy or clinical lead, were now being addressed effectively. The new manager had put in place a process where all visiting healthcare professionals were met in reception by a member of the management team. This was improving communication and allowed for direct feedback to be given to the service by visiting professionals.

A person was of concern to us at the last inspection. Several safeguarding alerts had been raised about this person. This person was being aggressive towards the other person on a regular basis. The service had been commissioned to provide individual support for this person to help distract them away from any aggression. This was being provided and whilst incidents were still taking place the number of events was greatly decreased. This person was being assessed with a view to being moved to another service.

The new manager had implemented new recording charts to help staff to document all care and support provided in one place. This meant it was easier for monitoring purposes. We saw these charts in place and they were well completed by staff. Where staff were monitoring people's care these records were regularly checked by senior staff to ensure they were completed appropriately. However, we found one person's care records guidance did not match the guidance provided in the person's room records. We were assured this would be addressed immediately following the feedback provided to the service at the end of this inspection.

The complaints procedure was displayed in the front entrance of the service. This was to help ensure people were informed how to raise any concerns they may have and what to do if they felt their concerns were not

resolved to their satisfaction. No further concerns have been received by CQC since the new manager had taken up their post. Any outstanding concerns that the new manager was aware of prior to them taking up their post, had been addressed by meeting with the person and discussing their complaint and taking steps to effectively resolve them.

The action plan sent by the provider to CQC following the warning notice and the breaches of the regulations at the last inspection, had been carried out and its implementation was being monitored on a regular basis by the management team and the provider.

At this inspection the new manager had carried out a specific audit of all the people living at Kenwyn who met the criteria for a DoLS application to be made. New applications had been made to the local authority for assessment of potentially restrictive care plans. The service had accurate records of all the assessed authorisations in place and details of these were held in people's care plans.

An independent audit carried out on the medicines management of the service had been carried out regularly over the past three months and showed clear improvements in specific areas of the management of medicines. Errors were being identified effectively and addressed.

People, relatives, staff and healthcare professionals told us the new manager was approachable, visible and accessible. Whilst staff had not yet had a formal staff meeting with the new manager they were confident they could access any support or guidance they needed.

The new manager spent time in the service and was aware of day to day issues. The manager believed it was important to make themselves available so staff could talk with them, and to be accessible to them. Staff met regularly with the registered manager, both informally and formally to discuss any problems and issues. There were handovers between shifts so information about people's care could be shared, and consistency of care practice could be maintained. Daily 'stand up' meetings continued to take place each day with the leads of each staff group attending. The provider visited the service regularly providing support to the management team and carrying out their own audits against agreed targets.

Services are required to notify CQC of various events and incidents to allow us to monitor the service. The service was notifying CQC of any incidents as required, for example expected and unexpected deaths. The previous rating issued by CQC was displayed. The new manager said they thought staff had a clear understanding of their roles and responsibilities.

There was a clear vision and strategy to deliver high quality care and support. There were clear lines of accountability and responsibility both within the service and at organisation level. There was a clear management structure. The manager was supported by a deputy manager, a clinical lead, a team of nurses, and care and ancillary staff.

People's care records were kept securely and confidentially, and in accordance with the legislative requirements. Staff and visiting healthcare professionals had access to people's care records to help ensure the care plans were kept up to date with changing situations.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The care and treatment of some service users was not appropriate, did not meet their needs and did not reflect their preferences.