Kavanagh Health Care Limited

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Inspection report

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Date of inspection visit:
09 May 2016

Date of publication:
09 June 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced inspection was conducted on 9 May 2016.

Situated in North Liverpool and located close to public transport links, leisure and shopping facilities, Kavanagh Place is registered to provide accommodation for up to 40 people with personal and nursing care needs. At the time of the inspection 38 people were living at the home. The location is a two storey property with a passenger lift between the floors. It has four separate units that provide care for people with specialist nursing needs. Each bedroom has its own en-suite facilities.

A registered manager was in post. 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 registered manager was not available on the day of the inspection.

Each of the three people that we spoke with told us that they felt safe living at Kavanagh Place. Staff had received training in safeguarding and were able to explain what they would do if they suspected that someone was being mistreated.

People living at the home had detailed care plans which included an assessment of risk. These were subject to regular review and contained sufficient detail to inform staff of risk factors and appropriate responses.

Accidents and incidents were accurately recorded and were subject to assessment to identify patterns and triggers. Records were detailed and included reference to actions taken following accidents and incidents. Reference was also made to behaviours, observations and other issues that may have led to an accident or incident.

Staffing numbers were adequate to meet the needs of people living at the home. The provider based staffing allocation on the completion of a dependency tool. We were provided with evidence that this information was reviewed following incidents where new behaviours were observed which might increase or change people's dependency level.

People's medication was stored and administered in accordance with good practice. We spot-checked medicines administration records and stock levels. We saw that records were complete and that stock levels were accurate.

Staff were suitably trained and skilled to meet the needs of people living at the home. The staff we spoke with confirmed that they felt equipped for their role. The training matrix and staff certificates showed that the majority of training was in date.

The records that we saw showed that the home was operating in accordance with the principles of the MCA. Capacity assessments were not generic and were focused on the needs of each individual. Applications to deprive people of their liberty had been submitted appropriately.

Food was produced using fresh ingredients to a high standard and offered good choice. People could choose to eat in dining rooms or other areas of the home. Drinks were provided at regular intervals and on request.

People were supported to maintain their health through regular contact with healthcare professionals.

Throughout the inspection we saw staff engaging with people in a positive and caring manner. Staff spoke to people in a respectful way and used language, pace and tone that was appropriate to the individual.

Each of the people living at the home that we spoke with said that they were encouraged and supported to be independent. Throughout the inspection we saw people moving around the building independently and engaging in activities of their own choosing.

Staff spoke with people before providing care to explain what they were doing and asked their permission. Where people didn't respond staff repeated or re-worded the question to ensure that the person understood.

Staff were attentive to people's appearance and supported them to wipe their hands, face and clothing when they had finished their meal. When we spoke with staff they demonstrated that they understood people's right to privacy and the need to maintain dignity in the provision of care.

People's preferences and personalities were reflected in the décor and personal items present in their rooms. Important items and photographs were prominently displayed. However we saw that the personalisation of rooms was limited in some cases.

People and their relatives were involved in care planning and review on a regular basis.

The home employed activities coordinators but we also saw staff actively involved in organising activities and motivating people to take part. The home displayed an activities board which detailed a varied programme of activities. However, we noted that activities were generic and personal hobbies and interests were not regularly considered.

Information regarding compliments and complaints was clearly displayed and the provider showed us evidence of addressing complaints in a systematic manner. All of the people that we spoke with said that they knew what to do if they wanted to make a complaint.

People living at the home spoke very positively about the quality of the care provided and the management of the home.

Staff were motivated to provide good quality care and supported to question practice. Staff told us that they felt confident in speaking to the registered manager or reporting outside of the home if necessary.

The provider had systems in place to monitor safety and quality and to drive improvements. We saw evidence of a quality assurance programme which detailed requirements and themes for each month. We also saw evidence of regular audits and detailed reports relating to; health and safety, fire safety, water

temperatures and maintenance of buildings and equipment. The records that we saw indicated that all audits had been completed in accordance with the provider's schedule.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People living at the home had detailed care plans which included an assessment of risk. These were subject to regular review and contained sufficient detail to inform staff of risk factors and appropriate responses.

Staff were recruited following a robust process and deployed in sufficient numbers to meet the needs of people living at the home.

Medicines were stored and administered in accordance with best-practice guidelines.

Is the service effective?

Good

The service was effective.

Staff were trained in topics which were relevant to the specific needs of the people living at the home and were supported through regular supervision.

The provider applied the principles of the Mental Capacity Act (2005) meaning people were not subject to undue control or restriction. Applications to deprive people of their liberty had been made appropriately.

People were provided with a balanced diet and had ready access to food and drinks. Staff supported people to maintain their health by engaging with external healthcare professionals.

Is the service caring?

Good

The service was caring.

We saw that people were treated with respect and compassion throughout the inspection.

Staff knew each person and their needs and acted in accordance with those needs in a timely manner. People's privacy and dignity were protected by the manner in which care was

delivered.

People were involved in their own care and were supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People living at the home and their relatives were involved in the planning and review of care.

People's preferences for the provision of care were recorded and reviewed on a regular basis.

Procedures for the receipt and management of complaints were robust.

Is the service well-led?

Good

The service was well-led.

The registered manager was not available during this inspection but systems and processes were well-established meaning that the home operated effectively in their absence.

The provider had systems in place to monitor safety and quality and to drive improvements. They completed regular audits which included information to feedback to the staff team.

The home maintained records of notifications to the Care Quality Commission and safeguarding referrals to the local authority. Each record was detailed and recorded outcomes where appropriate.

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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 inspection took place on 9 May 2016 and was unannounced.

The inspection team consisted of an adult social care inspector, a specialist advisor in nursing care and an expert by experience in residential and dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the local authorities who commission services at the home. We used all of this information to plan how the inspection should be conducted.

We observed care and support and spoke with people living at the home and the staff. 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 also spent time looking at records, including six care records, four staff files, medication administration record (MAR) sheets, staff training plans, complaints and other records relating to the management of the service. We contacted social care professionals who had involvement with the service to ask for their views.

On the day of the inspection we spoke with three people living at the home. We also spoke with three relatives. We spoke with the operations manager, two nurses, six other staff, two visiting healthcare

professionals and an independent advocate.

Good

Is the service safe?

Our findings

Each of the three people that we spoke with told us that they felt safe living at Kavanagh Place. One person said, "They [staff] look after you properly." Other people told us that staff checked on their wellbeing regularly.

We saw that people were kept safe because staff were vigilant in monitoring behaviours and indicators of abuse. Staff had received training in safeguarding and were able to explain what they would do if they suspected that someone was being mistreated. The home displayed information regarding safeguarding and whistle-blowing in the main reception area.

We asked people living at the home what they would do if they were being treated unfairly or unkindly. They each said that they would complain to the manager or the senior staff. Relatives also told us that they would speak to senior members of staff or the manager if they had any concerns. All of the staff spoken with gave a good description of how they would respond if they suspected that one of the people living at the home was at risk of abuse or harm.

People living at the home had detailed care plans which included an assessment of risk. These were subject to regular review and contained sufficient detail to inform staff of risk factors and appropriate responses. In the care records that we looked at risk had been reviewed regularly. We saw that risk assessments had also been reviewed and care plans amended following incidents. The provider sought advice from other healthcare professionals to help manage behaviours and reduce risk. A visiting healthcare professional told us, "All care plans have been followed."

Accidents and incidents were accurately recorded and were subject to assessment to identify patterns and triggers. Records were detailed and included reference to actions taken following accidents and incidents. Reference was also made to behaviours, observations and other issues that may have led to an accident or incident.

The home had produced a personal emergency evacuation plan (PEEP) for each person living at the home and had conducted regular fire drills and testing of fire alarms and other emergency equipment. We also saw evidence of regular checks and detailed reports relating to; health and safety, fire safety, water temperatures and maintenance of buildings and equipment.

Staffing numbers were adequate to meet the needs of people living at the home. The provider based staffing allocation on the completion of a dependency tool. We were provided with evidence that this information was reviewed following incidents where new behaviours were observed which might increase or change people's dependency level. We observed staff providing care and saw that there were sufficient numbers of staff available to keep people safe and respond to their needs.

The home recruited staff following a robust procedure. Staff files contained a minimum of two references which were obtained and verified for each person. There were Disclosure and Barring Service (DBS) numbers

and proof of identification and address on each file. DBS checks are completed to ensure that new staff are suited to working with vulnerable adults.

People's medication was stored and administered in accordance with good practice. We spot-checked medicines administration records and stock levels. We saw that records were complete and that stock levels were accurate. We were told that nobody currently living at the home required covert medicines. These are medicines which are hidden in food or drink and are administered in the person's best interest with the agreement of the prescriber. Controlled drugs were stored safely and associated records were completed correctly. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation. We saw evidence of good PRN (as required) protocols and records. PRN medications are those which are only administered when needed for example for pain relief. We saw that the provider used body charts to indicate where topical medicines (creams) should be applied. Records relating to the administration of medicines were detailed and complete. A full audit of medicines and records was completed regularly. Issues had been identified during previous audits and addressed in a timely manner.

Good

Is the service effective?

Our findings

Staff were suitably trained and skilled to meet the needs of people living at the home. The staff we spoke with confirmed that they felt equipped for their role. The training matrix and staff certificates showed that the majority of training was in date. The average completion rate for training the provider required staff to complete was recorded as over 90%. Staff were given additional training which related to the specialist needs of people living at the home. For example, training was provided to help staff recognise indications of anxiety and to reduce the risk of behaviours escalating. The people living at the home that we spoke with told us they thought that the staff were suitably skilled. A relative told us that they thought staff were, "Well trained and knew the needs of [their family member]."

New staff were trained and inducted in accordance with the principles of the care certificate. The care certificate requires new staff to undertake a programme of learning before being observed and assessed as competent by a senior colleague. All staff that we spoke with confirmed that they had been given regular supervision. We saw that this was recorded in staff records. One member of staff described supervision as, "A positive experience and not just a tick-box exercise." Nurses were given access to training in support of their professional development. For example, one nurse had recently attended training on palliative care.

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).

The records that we saw showed that the home was operating in accordance with the principles of the MCA. Capacity assessments were decision specific and were focused on the needs of each individual. Applications to deprive people of their liberty had been submitted appropriately. However, some applications had not yet been processed by the local authority. The home maintained a record of DoLS applications and their status. At the time of the inspection 34 people were subject to restrictions on their liberty.

We sat with people and sampled a meal at lunchtime in three of the four units. Some tables were laid out with table cloths, crockery and cutlery. Staff were busy but attentive in serving and monitoring people. Staff wore personal protective equipment (PPE) in-line with good practice for food hygiene. The food was prepared from fresh ingredients, well presented and nutritionally balanced. People's preferences, allergies and health needs were recorded and used in the preparation of meals, snacks and drinks. For example, one person expressed a strong preference for 'cheesy mash' which was provided as an alternative to the standard menu. Alternatives were available to each main meal however the menu was not prominently displayed and did not make effective use of images to aid understanding. We spoke with the operations

manager about this. They agreed to ensure that choice was better promoted. People spoke positively about the quality of food. Comments included, "The food's okay. There's always enough" and "I like the food." People told us that they were offered plenty of drinks throughout the day. We saw staff offering drinks at lunchtime and throughout the inspection.

The people that we spoke with did not have a good understanding of their healthcare needs and were not always able to contribute to care planning in this area. For those people who did not understand the provider had identified a named relative to communicate with. We asked people if they could see health professionals when necessary. We were told that they saw doctors, chiropodists, opticians and other healthcare professionals when they needed. We saw records of these visits on care files. A visiting healthcare professional told us, "[In relation to my specialism] care is effective." Another said, "I have always found the staff to be most professional and caring." The home also employed a full-time physiotherapist who had access to a range of resources to promote people's physical wellbeing and independence.

We looked at the physical environment to see how it was adapted to meet people's needs. The home did not make effective use of signage and colour especially in the unit that specialised in dementia (Strawberry Fields). Corridors were bright, but bland. We spoke with the operations manager about this. They confirmed that the registered manager had recently completed a programme of learning regarding the dementia environment and their views would be incorporated into plans for a refurbishment of the unit.

Good

Is the service caring?

Our findings

Throughout the inspection we saw staff engaging with people in a positive and caring manner. Staff spoke to people in a respectful way and used language, pace and tone that was appropriate to the individual. One relative commented, "The staff are always checking people are okay, seeing if they need anything." Staff took time to listen to people and responded to comments and requests. We saw staff providing appropriate physical contact and re-assurance where required. Staff at all levels demonstrated that they knew the people living at the home and accommodated their needs in the provision of care. A visiting healthcare professional said, "The nurses are good. It's a nice place to come and it makes my job easier." The people living at the home we spoke with said that staff listened to them.

Staff spoke with people before providing care to explain what they were doing and asked their permission. Where people didn't respond staff repeated or re-worded the question to ensure that the person understood. For example, we heard a carer attending to the needs of one person during lunch. The staff member was very re-assuring and took time to ensure that the person was satisfied with the meal provided. We saw that people declined care at some points during the inspection and that staff respected their views.

People's privacy and dignity were respected throughout the inspection. For example, one person was displaying behaviours that might have compromised their privacy and dignity. Staff took time to gently encourage the person to access their room until the behaviour reduced. We also saw that staff were attentive to people's need regarding personal care. People living at the home had access to their own room with en-suite facilities for the provision of personal care if required. Staff were attentive to people's appearance and supported them to wipe their hands, face and clothing when they had finished their meal. When we spoke with staff they demonstrated that they understood people's right to privacy and the need to maintain dignity in the provision of care. We saw that staff knocked on people's doors and explained why they were there before entering rooms.

Each of the people living at the home that we spoke with said that they were encouraged and supported to be independent. Throughout the inspection we saw people moving around the building independently and engaging in activities of their own choosing.

Confidential information was securely stored. Care records and daily notes were respectfully worded and used language which was person-centred. The home was in the process of transitioning from one style of care record to another. We saw that the older care records were more clinical in their language. The operations manager confirmed that the need to evidence a more person-centred approach was one of the reasons that the new records were being introduced.

We spoke with visiting relatives throughout the inspection. They told us that they were free to visit at any time. Relatives made use of the communal areas, but could also access people's bedrooms and a visitor's room for greater privacy.

The service displayed information promoting independent advocacy services. We spoke with a

representative of one advocacy service. We were told that the home worked effectively with the advocacy service and had a positive relationship. Each of the people living at the home was able to represent themselves or had a nominated relative or advocate to act on their behalf.

Good

Is the service responsive?

Our findings

All of the people living at the home told us they received care that was personalised to their needs. One person said, "Yes, the staff know me very well." We saw that staff delivered care in a different way to each person. For example, some people required close observation to ensure their safety while others preferred a higher level of independence. Staff were able to tell us which approach was best suited to which person and why. This information was reflected in care records.

People's preferences and personalities were reflected in the décor and personal items present in their rooms. Important items and photographs were prominently displayed. However we saw that the personalisation of rooms was limited in some cases. We discussed this with the operations manager who assured us that people were free to choose colours and wall-papers for their rooms as well as bringing in personal belongings.

We asked people if they had been involved in their care planning and if they were able to make decisions about their care. Some of the people that we spoke with confirmed that they had been involved in their own care planning. They also confirmed that relatives were invited to contribute to care planning. One relative said, "We are fully involved in [relative's] care and decisions." Other people had difficulty understanding the question. We saw evidence in care records that people and their relatives had been involved in the review of care. However this evidence was not clear in all care records. A visiting healthcare professional said, "I came last week. I was impressed that care plans were updated and staff knew [about the changes]."

We observed that care was not provided routinely or according to a strict timetable. Staff were able to respond to people's needs and provided care as it was required. For example, we saw one person who displayed signs of distress. A member of staff stopped what they were doing and worked with a colleague until the person's anxiety levels had reduced. In another example one person asked for an alcoholic drink with their lunch. A member of staff was briefly diverted from serving lunches and provided the drink. A relative told us, "They [staff] bend over backwards for you."

We asked people living at the home if they had a choice about who provides their care. None of the people that we spoke with expressed concern about their choice of carers. We saw evidence that people's preferences for the gender of care staff was recorded in care records.

The home employed activities coordinators but we also saw staff actively involved in organising activities and motivating people to take part. The home displayed an activities board which detailed a varied programme of activities. However, we noted that activities were generic and personal hobbies and interests were not regularly considered. On the day of the inspection we saw staff discussing a trip to the city centre. Other people sat in small groups and chatted with each other and staff or watched television.

Information regarding compliments and complaints was clearly displayed and the provider showed us evidence of addressing complaints in a systematic manner. All of the people that we spoke with said that they knew what to do if they wanted to make a complaint. The staff that we spoke with knew who to contact

if they received a complaint. Compliments and complaints had been recorded and analysed.

The home completed satisfaction surveys on a regular basis. The results were analysed and shared with people living at the home and their families. In one case we saw that the home had produced an easy to read version of the results to aid understanding. The majority of views expressed about the home were positive.

Good

Is the service well-led?

Our findings

Staff were able to access regular team meetings where important topics were discussed. We saw evidence that discussions regarding care profiles, medication and best-interest decisions had taken place. Clear actions and expectations were identified in the records of these meetings including completion dates where appropriate.

People living at the home spoke very positively about the quality of the care provided and the management of the home. Comments included, "The staff have little chats with you about how things are" and "Yes, staff are caring to me and help with my problems." Relatives supported the views expressed by their family members and spoke of the running of the home in a positive manner. One relative said, "It's very well managed"

Staff were supported to question practice. One member of staff told us, "If I saw another staff do something wrong to a resident and I didn't like it I'd tell them myself and go straight to the manager." Staff told us that they felt confident in speaking to the registered manager or reporting outside of the home if necessary. Comments included, "I'd have no problem whistleblowing if I saw something wrong and nothing was done about it." However staff told us they were concerned that temperatures in some rooms could not be controlled because the thermostats had been disabled. We saw that this was the case. They said that they had reported this as a concern to the registered manager but no action had been taken. We spoke with the operations manager about this and were advised that the heating system took a long time to heat-up and cool down. They said that the heating controls had been removed to ensure that temperatures throughout the building were managed appropriately. They agreed to review the situation. Some controls were enabled before the end of the inspection.

Staff were motivated to provide good quality care and were supported by the provider. One staff member said, "I've thoroughly enjoyed my time here, it's a good atmosphere and lots of support" Another member of staff said, "I really enjoy it but its hard work too." While a third person told us, "It's the most supportive organisation that I've worked for."

Each of the staff that we spoke with was able to explain the purpose of the home and its values. We saw that these values were reflected in the provision of care. The operations manager told us that the home existed to, "Enhance lives."

The provider had systems in place to monitor safety and quality and to drive improvements. We saw evidence of a quality assurance programme which detailed requirements and themes for each month. The registered manager and other senior managers completed a series of audits which included information that was fed-back to the staff team. Areas assessed during these audits included safeguarding and medication. The records that we saw indicated that all audits had been completed in accordance with the provider's schedule.

The home maintained records of notifications to the Care Quality Commission and safeguarding referrals to

the local authority. Each record was detailed and recorded outcomes where appropriate.