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

Summary of findings

Overall summary

This responsive comprehensive inspection took place on 3 and 9 October 2017. The first visit was unannounced, the second visit was announced. Concerns were received by the Care Quality Commission and Cornwall Council safeguarding unit from the service about medicine errors which had occurred at the service. There had also been concerns raised by the public and healthcare professionals that some people had not always had their care needs met and their concerns had not always been resolved to their satisfaction.

The last inspection took place on 4 and 10 October 2016. There were two breaches of the regulations found at this inspection. We were concerned that medicines management was not always safe and that regular medicine audits and checks had not identified the concerns found at the inspection. We found that care plans were not always updated to take account of people's changing needs. The registered manager had not appropriately recorded an investigation into a medicine error. This meant it was not possible to establish the details of all decisions made to help ensure a re-occurrence of such events did not take place in the future.

Following the inspection in October 2016 the provider sent the Care Quality Commission an action plan outlining how they would address the identified breaches. We carried out this inspection in response to concerns raised and to check on the actions taken by the service to meet the requirements of the regulations.

Kenwyn is a nursing home which offers care and support for up to 109 people. At the time of the inspection there were 96 people living at the service. Some people were living with physical disabilities, long term physical health and mental health conditions including dementia. The service is made up of a large detached building over two floors. The service was divided in to four units.

We walked around the service which appeared clean, comfortable and found that there were no incontinence odours. People's rooms were personalised to reflect people's individual tastes. People's choices were respected.

Systems for the management and administration of medicines were not robust. Three medicine errors had been identified by the service since the last inspection. Two errors, which occurred a week apart, involved two people not having their prescribed pain relief given to them. This was because the service did not have sufficient stock.

We found during this inspection further concerns regarding the safe management and administration of people's medicines. Three people were found to have not received their medicines as prescribed.

Regular medicines audits and 'resident of the day' checks were not consistently identifying when errors and

omissions occurred. 'Resident of the day' was a system when a named person was chosen daily for a full review of all aspects of their care including their medicines. Recent support and training provided to all the nurses had not been effective in addressing the medicine concerns found at this inspection.

Nursing staff did not always follow the service's policies. For example, the specific action to take when a person choked. The registered manager was investigating an incident where a person had choked and did not receive the care and treatment from a nurse as set out in the service policy.

Staff were supported by a system of induction training, supervision and appraisals. People were supported by staff who knew how to recognise abuse and how to respond to concerns. Risks in relation to people's care and support needs were mostly assessed and planned for to minimise the risk of harm. These risks were regularly reviewed to take account of changes in people's care needs. One person's care plan did not contain required risk assessments to help protect them from the risk of abuse from another person.

Staff received training relevant for their role and there were good opportunities for on-going training and support and development. More specialised training specific to the needs of people using the service was being provided. For example, tracheostomy care. Staff meetings were held regularly for all teams of staff. There was a daily 'stand up' meeting held with each units nurse and team leads from throughout the service to discuss both people living at Kenwyn and the service's needs.These daily meetings allowed staff to air any concerns or suggestions they had regarding the running of the service and helped communication throughout the service. Staff told us they felt well supported by the management team.

The registered manager carried out dependency assessments for each person. These assessments identified the minimum numbers of staff required to meet people's needs. We found the staffing levels were above those dictated by the dependency assessment carried out by the service. People, families and staff felt there were sufficient staff to meet people's needs. However, some families and visiting healthcare professionals told us it was sometimes difficult to find staff when they visited.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005 (MCA). The principles of the Deprivation of Liberty Safeguards (DoLS) were understood. The registered manager was not clear how many DoLS authorisations were in place, we were told there were nine, when the DoLS team told us there were actually10. Eight DoLS authorisations had not been notified to the Care Quality Commission in line with legal requirements.

Meals were appetising and people were offered a choice in line with their dietary requirements and preferences. Where necessary, staff monitored what people ate to help ensure they stayed healthy. People had their weight monitored regularly. Referrals were made to healthcare professionals where necessary to seek guidance and support with people's changing needs.

The premises were well maintained. There were two resident maintenance staff who carried out repairs although we were concerned some works such as redecoration of one unit and repairing showers had been delayed. The dementia unit had been due to be re-decorated at the last inspection and this had not taken place. One unit had some pictorial signage to meet the needs of people living with dementia.

Care plans were well organised and contained information to guide and direct staff to meet people's needs. We found the 'Resident of the day' review system took place but was not always effective in identifying issues found at inspection.

Some care plans did not always contain accurate and up to date information. Care planning was reviewed

regularly and people's changing needs were mostly recorded. People, and where appropriate relatives, were invited to the reviews which took place, although care plans did not show any recorded evidence that people, or if appropriate families, had been shown and agreed to their own care plans.

People had access to planned activities. An activity team was in post, providing 90 hours of activities each week throughout the service. They arranged regular events for people. These included, craft, music, exercise, dancing and housework tasks. People were not able to access the local community in the service's mini bus, as it had not been possible to have a member of staff assessed as competent to drive the bus and support people travelling in it safely. We were assured by the registered manager this was being addressed.

The registered manager was supported by a deputy manager, a team of nurses, carers and activity staff. The registered manager received regular support from the regional director for the provider.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 related to poor medicines management, ineffective audits and systems in place to identify the concerns found at this inspection and ineffective resolution to some people's concerns.

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 safe. Systems for the management of medicines were not robust. People did not always receive their medicines as prescribed.

Staff knew how to recognise and report the signs of abuse. They knew the correct procedures to follow if they thought someone was being abused.

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

Care plans recorded risks that had been identified in relation to people's care and these were appropriately managed.

Is the service effective?

Requires Improvement

The service was generally effective. Staff were well trained and supported with regular supervision and appraisals.

People had access to a varied and nutritious diet.

The management had a clear understanding of the Mental Capacity Act 2005 and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. However, the service did not have complete information on all 10 DoLS authorisations in place at Kenwyn at the time of this inspection.

Is the service caring?

Good

The service was caring. People who used the service and their relatives were positive about the way staff treated the people they supported.

Staff were kind.

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

Is the service responsive?

Requires Improvement

The service was not entirely responsive. People did not always receive personalised care and support which was responsive to their changing needs.

Care plans were regularly reviewed and contained information for staff to meet people's needs. However, we found some care plans did not accurately reflect people's background and current care needs.

People knew how to make a complaint.

People were consulted and involved in the running of the service. However, some people's wishes to take part in activities outside of the service were currently not able to do this due to a lack of appropriately trained staff to do this safely.

Is the service well-led?

Requires Improvement

The service was not entirely well-led. Audits and checks carried out at the service did not identify concerns found at this inspection relating to medicines management. Actions taken to address the breaches of the regulations found at the last inspection had not been effective in meeting the requirements of the regulations.

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

Quality assurance systems were robust and people were asked for their views on the service. However, some people's wishes had not always been supported. Such as requests to have specific activities outside the service.

Staff were supported by the management team.

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 checked 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 3 and 9 October 2017. The inspection was carried out by three adult social care inspectors, a specialist nurse advisor, 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.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other 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.

Prior to the inspection we spoke with six visiting health and social care professionals.

During the inspection visits we spoke with 12 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 14 members of staff, and the registered manager. We also spoke with 10 visitors.

We looked at care documentation for 16 people living at Kenwyn. Medicines records for 29 people, staff files, training records and other records relating to the management of the service.

Following the inspection we spoke with two further health and social care professionals.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of this service in October 2016 we were concerned that people living at the service had not always had their prescribed medicines managed and administered in a safe manner. There were concerns with the recording processes used by staff when receiving, recording and administering medicines. We found prescribed creams in use in people's rooms which had not been dated upon opening. This meant staff were not aware of when to dispose of the item as no longer safe to use. Staff were not always following the protocols in place for administration of 'as required' (PRN) medicines. These protocols should have informed nurses when and how to administer the medicine safely, and in the way specific to each person.

Since the last inspection the service had reported three medicine errors.Two very similar events occurred one week apart and involved two people not having their prescribed pain relief given to them as the service did not have sufficient stock held.

At this inspection we found that all handwritten entries on to the Medicine Administration Record (MAR) had been countersigned by a second person and prescribed creams were recorded when opened and applied. However, we identified further concerns with people not receiving their prescribed medicines in a timely manner. Some information relating to people's MAR were unavailable to inspectors at the first inspection visit.The registered manager sent further information to CQC relating to specific medicine administration concerns raised at feedback at the end of the inspection, two days after the first inspection visit.

Three people had not received their prescribed medicines in a timely manner. One person had been prescribed a medicine which was to be administered once every three months. According to the MAR chart for 14 August 2017 to 10 September 2017 it stated the item was due on 8 September. The MAR chart from 11 September 2017did not state when the next dose was due. The August MAR stated that they had one ampoule of this medicine in stock,but the September MAR stated that they had two. Staff failed to give the dose that was due on 8 September 2017 and had not recognised this omission. The medicine had been administered in June 2017 but no record had been made of when the next dose was due. The nurse rang the person's GP to check it was still needed and it was confirmed that it was. The person received their medicine during the first inspection visit, nearly four weeks after it was due. This concern had not been identified prior to this inspection.

Another person was prescribed a specific medicine, when the supply was finished the staff had not recognised this was a special item (liquid form needed) and there was a delay in obtaining the medicine in tablet form. The person did not receive this medicine for five days. Following the inspection the service told us the delay in obtaining this medicine was due to the pharmacy not being able to provide this medicine in a liquid form. This information was not in the person's records.

One person was admitted to Kenwyn on a prescription of a specific medicine which could only be obtained from a specific source. It was not clear to staff that a blood test was required before a new supply of this medicine could be provided. Lack of guidance for staff on the specific ordering processes and lack of effective communication with external agencies led to delays in obtaining supplies and the person was not

able to take their medicines as prescribed on two separate occasions, 10 September and 25 September 2017. A care plan for this medicine was not created until five weeks after this person was admitted and did not contain sufficient information for staff about all side effects and clear action for staff to take in the event of one of the side effects being observed.

On one unit in the service care plans for medicines that were to be given 'as required' were not available for some medicines; therefore there was insufficient information for staff to give these medicines in a consistent manner .

Nurses had been provided with recent training regarding a choking event. The weekend prior to the first inspection visit a person choked during their meal. Despite recent training the nurse did not follow the choking protocol held by the service. The person was not provided with the recommended care and treatment. The registered manager had informed the safeguarding unit of Cornwall Council of this event and was investigating the matter at the time of this inspection.

Prior to this inspection healthcare professionals and the service had raised concerns to CQC about two people living on one unit at Kenwyn. One person was physically aggressive towards another person. An incident of this nature was recorded on 13 August 2017. It had been reported that one person had been pulled out of their chair by the other person. The person had been placed on hourly observations to help ensure they were kept safe. On 13 September 2017 a visiting healthcare specialist advised the service to put a care plan in place to help protect the person from the risks associated with physical aggression from the other person. A best interest meeting was held to review this concern. It was agreed that a contingency plan would be put in place to inform and guide staff what to do when any physical aggression was observed. On 27 September 2017 the service reported to Cornwall Council safeguarding unit that this person had again suffered physical aggression by the same person. On 2 October 2017 a further report by staff was made of this person suffering physical aggression by the same person. At this incident it was recorded that staff withdrew from the room leaving the two people together in the room alone. We reviewed this person's care file. No care plan or contingency, as recommended by the best interest meeting, was in place to inform and guide staff on how to respond to these events of aggression. There was no risk assessment in the person's care file, related to the risk of physical aggression from another person, to inform staff. This meant staff were not provided with adequate information and direction to ensure staff were always consistent in their approach in order to reduce risks and to ensure the person was always kept safe.

This is a breach of Regulation 12 of the Health and Social Care act 2008 (Regulated Activities) 2014.

Medicines were stored securely at Kenwyn. Medicines that required cold storage were kept safely in medicine refrigerators on each unit. There were daily records of the temperatures of these refrigerators and also of the storage room temperature to ensure that medicines were kept at the correct temperature and therefore fit for use. Medicines that had a reduced expiry date once opened were dated on the day of opening to ensure that they were fit for use. There were suitable arrangements for storing medicines which required extra security. Regular checks had been made for these medicines and they had not identified any issues. When staff made handwritten entries or amendments to MARs they were signed by a second member of staff to show that they had been checked for accuracy.

Staff had completed Mental Capacity Act and Best Interest medicine documentation for people who lacked the mental capacity to make decisions about their medicines. A pharmacist had checked to make sure that the medicines were safe and effective when administered covertly (crushed and mixed with food and drink.) Nurses had completed electronic on-line training for the use of medicines and had also received training from their local pharmacy. People told us they received their medicines on time

People we spoke with told us, "I feel very safe here," "They (staff) always make sure my safety straps are one when I am in my wheelchair" and "They (staff) always use the hoist when moving me." Two people were unable to use a call bell due to their healthcare needs. Technology had been considered to address this issue. One person had been provided with a listening device which was also held by the nurse on the unit. The other person was in the process of trialling other electronic devices to assist them to call staff for assistance.

Since the last inspection in October 2016 safeguarding concerns for 10 people had been raised to the safeguarding unit either by the service themselves, health and social care professionals or the public. These had all been investigated and closed by the local authority who were satisfied with the response from the service.

Staff training records showed all staff who supported people with medicines had received appropriate training. Staff were aware of the need to report any incidents, errors or concerns and felt that their concerns would be listened to and action would be taken.

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. They were aware of the whistleblowing and safeguarding policies and procedures which were held at the service. Staff had received recent 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. People were asked for their views about if they felt safe at the service. If people were involved in safeguarding enquires or investigations they were offered an advocate if appropriate or required. Any concerns raised were fully investigated and reported as appropriate to the local safeguarding unit for external investigation. This helped ensure people were safeguarded from the risk of abuse.

Accidents and incidents that took place in the service were recorded by staff in people's records. Such events were audited by the registered manager. This meant that any patterns or trends would be recognised, addressed and the risk of re-occurrence was reduced.

Apart from one care plan in which risks were not clearly recorded for one person, risks were identified, assessed and reviewed regularly to take account of any changes in peoples needs. We have detailed our concerns about one care plan earlier in this section of this report. Staff were clear about people's rights and ensured any necessary restrictions were the least restrictive. Care plans contained risk assessments for a range of circumstances including moving and handling, supporting people when they became anxious or distressed and the likelihood of falls. Where a risk had been clearly identified there was guidance for staff on how to support people appropriately. This helped to minimise risk and keep people safe whilst maintaining as much independence as possible. For example, one person had requested bed rails to assist them in feeling secure when in bed. A specific risk assessment for this person and the rails on their bed was in place.

Some people were at risk of becoming distressed or confused which could lead to behaviour which might challenge staff and cause anxiety to other residents. Care records contained information for staff on how to avoid this occurring and what to do when incidents occurred. For example one care plan gave clear guidance to staff on what to do when one person became distressed. It stated staff should try to divert their attention, offer them a drink or attempt to joke with them as they have responded well to this in the past.

Care records contained detailed information on each persons' needs which was easy to find. They were

securely stored on each unit, but were accessible to staff and visiting professionals when required. The staff shared information with other agencies when necessary. For example, when a person was admitted to hospital a copy of their care plan/medicine records was sent with them.

We looked around the building and found the environment was clean and there were no unpleasant odours. Hand gel dispensers were available throughout the building. Personal protective equipment (PPE) such as aprons and gloves were available for staff and were used appropriately to reduce cross infection risks.

Equipment used in the service for moving and handling , wheelchairs, stand aids, passenger lifts etc was regularly checked and serviced by professionals to ensure they were always safe to use. The premises were regularly checked to ensure it was safe for people to live in. All necessary safety checks and tests had been completed by appropriately skilled contractors. All firefighting equipment had been regularly serviced. Fire safety drills had been regularly completed by staff who were familiar with the emergency procedure at the service.

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 drills were carried out regularly. People told us, "I think they have them (fire drills) twice per week – one at night, the other during the day" and "They (fire alarms) are always going off, they are."

Recruitment systems were robust and new employees underwent the relevant pre-employment checks before starting work. This included Disclosure and Barring System (DBS) checks and obtaining two references. The service carried out regular DBS checks of long standing staff to ensure they remained safe to work with vulnerable people.

The registered manager assessed the dependency levels for all people living at the service. This helped ensure there were sufficient staff on duty to meet their needs. The staffing levels recorded on the rotas showed the service had staff numbers above those which were identified by the dependency score. People, families and staff felt there were sufficient numbers of staff to meet people's needs. However, some visiting healthcare professionals and families had reported difficulty finding staff when they visited on some occasions. The service was not using any agency staff at the time of this inspection. 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. Staff were happy working at Kenwyn and told us they felt they worked well together. Comments included, "You don't see them (staff) hanging around doing nothing," "Usually they come very quickly," Amazing staff, come very quickly, unless there is an emergency on" and "Oh they come quickly."

Requires Improvement

Is the service effective?

Our findings

People's needs and choices were assessed prior to people moving in to Kenwyn. This helped ensure people's needs and expectations could be met by the service. This assessment was used to write the person's care plan over their first weeks at the service.

Some people living at Kenwyn were unable to use a call bell due to their healthcare needs. The service used technology to support the effective delivery of care and support. For example, one person was provided with a voice activated listening device which was also held by the nurse on duty. This meant they could summon assistance when needed.

People told us they felt the staff were well trained. Comments included, "The staff seem well trained particularly so with the handling aspects of my husband's personal care" and "The staff are excellent and all seem to be well trained." Staff told us the training they received was good. Training records showed staff were provided with all required training updates as required by law. Staff had also undertaken a variety of further training related to people's specific care needs such as trachyostomy care, which is about the care of a person who uses a hole in their throat to breathe. The registered manager monitored staff training needs regularly and updated the company's training records on a regular basis.

In care files we saw there was specific guidance provided for staff. For example, detailed information on specific medical conditions. This meant staff had easy access to relevant information that supported best practice in the care of individual's needs. People told us, "You can see the doctor if you want on his twice weekly visits by arrangement and immediately if it is an emergency." One relative commented, "If they need the GP he visits the home twice weekly and is on hand out of hours if required. This gives me confidence."

Staff received regular supervision and appraisals. They told us they felt well supported by the registered manager and were able to ask for additional support if they needed it. The registered manager received regular supervision and support from the regional director of the provider.

Newly employed staff were required to complete an induction before starting work. This included training identified as necessary for the service and familiarisation with the organisation's policies and procedures. The induction was in line with the Care Certificate. The Care Certificate is designed to help ensure care staff that are new to working in care have initial training that gives them an adequate understanding of good working practice within the care sector. We saw staff were mostly completing this in a timely manner. There was also a period of working alongside more experienced staff until such a time as the worker felt confident to work alone. Staff told us they had completed or were working towards completing the care certificate and had shadowed other workers before they started to work on their own.

People had a choice of where they ate their meals. Some people were cared for in bed at all times so were supported to eat in their bedrooms. Other people ate in dining areas on each unit. People had a choice of what they would like to eat. There were menus which also described each meal to help people make choices. We saw other food was provided to people as they wished. We observed the lunch time period in

one of the dining rooms. The food looked appetising. People told us, "The food is very good and plentiful with good choice, I have put on weight and now have what I call "Kenwyn tummy!" and "It is like a three star hotel here, the food is beautiful, they (staff) treat you like a hotel guest. There is a fair amount of choice with hot and cold sweets and large portions."

Staff were knowledgeable about people's individual needs and likes and dislikes. Care staff had access to the kitchen so people were able to have snacks at any time of the day even if the kitchen was not staffed. People confirmed they could have tea and snacks whenever they wished. Care plans indicated when people needed additional support to maintain an adequate diet. Food and fluid charts were kept when this had been deemed necessary for people's well-being. For example one person who was having very little to drink was having all their drinks recorded. These records showed what amount each day should be taken by the person. Each day their intake was added up and recorded. People's weight was recorded regularly.

Kenwyn worked with many external healthcare professionals to support people's care and support needs. We spoke with three professionals who visited regularly. We spoke with one GP who was very positive about the knowledgeable care and support provided to people on one unit. Comments from healthcare professionals were mixed and included, "I think they (staff) are wonderful, I could not care for those people without them," "Sometimes I have asked for specific monitoring to be done and it is not always passed on," "Sometimes it is difficult to find a member of staff to help you" and "I have needed to prompt them (staff and management) to ensure specific issues are recorded in the person's care records, but it does get done eventually."

People had access to their GP. A list of people who needed visits was sent in advance to the GP so that they knew who they were coming to see at each visit.

The premises appeared clean and odour free. Spacious corridors supported people who used wheelchairs to move around easily. Some people had pictures on their own bedroom doors to help identify their rooms. People were able to furnish their bedrooms with their own personal possessions. There was some pictorial signage, to assist people to find their way around in the dementia unit, but very little elsewhere in the service. The dementia unit was in need of refurbishment. At the last inspection in 2016 we were told this unit was soon due to be refurbished, in line with the rest of the service having been refurbished, but we found this had not happened. The rest of the service was in good condition. At this inspection we were again told it was due to start soon. There were outside secure areas for people to enjoy if they chose.

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. Some people had capacity assessments in their files.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had applied for authorisations appropriately. We were told by the registered manager that nine authorisations were in place at the time of this inspection. Any conditions relating to these authorisations were being complied with and monitored. The external DoLS team based at the local authority, stated there were 10 authorisations at Kenwyn. Following the first inspection visit the registered manager was asked about this. They identified one person who had all the assessments on their file

indicating that an assessment had taken place but no authorisation had been sent to them. This meant the service was not aware of any conditions which may have been put in place on this authorisation that had been in place since May 2017. The registered manager told us this would be addressed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff were provided with training for the MCA and DoLS and were aware of how to protect people's rights. The service held an appropriate MCA/DoLS policy for staff to refer to.

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

Good

Is the service caring?

Our findings

People told us,"The staff are very good, there has always seen kindness," "The staff are excellent and they had a very good attitude," "They (staff) always knock before entering my room and then ask to come in. When I first came here they asked if I wanted only female staff for personal care. I prefer female carers but the men are very good" and "They (staff) give me hugs all the time but also they know when to leave me alone, they really know me."

People told us staff had time to sit with them and support them. Where appropriate people were provided with advocates to support them in decision making. An advocate is a person who represents people to ensure their interests and wishes are protected where this is appropriate.

People told us their privacy and dignity was respected. Comments included, "They (staff) always close the curtains and shut the door when caring for me" "The staff, apart from being friendly and very helpful respect my dignity. I don't feel degraded, for example when I have to go to the toilet they always ask me if I want the door shut."

We spent time in all the lounge and dining areas of the service during our inspection. Throughout the inspection people were comfortable in their surroundings with little signs of agitation or stress. Staff were kind, respectful and spoke with people considerately. We saw relationships between people were relaxed and friendly and there were easy conversations and laughter heard throughout the service. Staff responded effectively when they saw someone was in distress or discomfort. For example, people, who were living with dementia, were seen feeling unsure and confused and staff comforted them in a caring manner.

Staff were seen providing care in an un rushed way, providing explanations to people before providing them with support and ensuring they were calm throughout.

Some people's life histories were documented in their care plans. This is important as it helps care staff gain an understanding of what has made the person who they are today. Staff were able to tell us about people's backgrounds and past lives. They spoke about people respectfully and fondly. Staff told us how they cared for people in line with their preferences and choices.

Care files and information related to people who used the service was stored securely and accessible by staff when needed. This meant people's confidential information was protected appropriately in accordance with data protection guidelines.

Bedrooms were decorated and furnished to reflect people's personal tastes. One room had been completely decorated by the person. The service encouraged people to have their own belongings and things that were particularly important to them around them. This helped give rooms a familiar feel.

Visitors told us they visited regularly at different times and were always greeted by staff who were able to speak with them about their family member knowledgeably. They told us, "I am made to feel very welcome; I

help feed (the person) and the staff recognise me as part of the team" and "The staff always wave at me when I am in the room and at the same time they are checking on my husband" and "Everyone is so friendly and easy to talk to." People were well cared for. Some women wore jewellery and make up and had their nails painted. Some men wore ties according to their choice. One relative told us of the kind and thoughtful acts of staff. One male member of staff had bought in a special preparation for one man's beard and left it in their room for them to use. The person loved football and was able to watch World Cup matches in the middle of the night with family members. They also told us that their family member loved Indian food and that staff bought this in for them. Staff read poetry to them, which they greatly enjoyed.

Families told us they knew about the care plans of their family members and they were invited to attend the 'Resident of the day' care plan review meeting if they wished.

We saw the service sought the views and experiences of people who used the service, their families and friends. The service had held resident and families meetings.

Requires Improvement

Is the service responsive?

Our findings

Information held for staff, regarding guidance related to specific medicines and the plan for people to receive these medicines did not always contain sufficient detail. One medicine care plan had not been created until some weeks after the person had been living at the service. It stated the main side effects of a specific medicine, but did not state the symptoms of these and what staff should be aware of. It also did not state further side effects which may be serious, for example effects on the heart, and what staff should do if the person appeared unwell. This meant staff were not provided with sufficient information to ensure any symptoms would be noticed and acted upon in a timely manner.

Staff told us one person was doubly incontinent and needed the assistance of staff to be washed regularly. This was not clear from the information held in their file. Another care plan stated a person could not have children. But later in the same file it spoke about their daughter being involved in their care. This meant some care plans contained inaccurate and incomplete information which could mislead staff.

Some people had been assessed as needing to be re-positioned regularly when cared for in bed. One person was receiving end of life care and was not conscious at the time of this inspection. The care plan stated in one place they were to be re-positioned every two hours, elsewhere it stated 2-4 hours. This did not provide staff with clear guidance. There were six gaps in their re-positioning records between 30 September and 2 October 2017. These were of up to eight and a half hours. However, we did not evidence any impact on this person due to these apparent long periods of time without being re-positioned and judged that staff had omitted to record care that had been provided.

This contributed to the breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activity) 2014.

Each person had a care plan. Care plans were generally detailed and informative with guidance for staff on how to support people. The files contained information on a range of aspects of people's support needs including mobility, communication, nutrition and hydration and health. The information was well organised and easy for staff to find. The care plans were regularly reviewed. People and where appropriate family members were invited to attend care plan reviews. However, there was no evidence of people, or if appropriate their families, having been given the opportunity to sign in agreement with the content of their care plans.

Monitoring records were kept in people's rooms so staff were able to access them easily at the point when care was delivered. The records were positioned discreetly in order to protect people's privacy and confidential information.

Daily notes were consistently completed and enabled staff coming on duty to get a quick overview of any changes in people's needs and their general well-being. People had their health monitored to help ensure staff would be quickly aware if there was any decline in people's health which might necessitate a change in

how their care was delivered. For example, nurses checked people's observations such as blood pressure and people's weight regularly.

Some people required specialist equipment to protect them from the risk of developing pressure damage to their skin. This was provided and staff monitored this equipment to ensure it was set according to people's individual needs.

People told us, "This place has done wonders for me. The staff go as far as they can go to give me care, they support me to do whatever I like, with care and after risk assessments when needed" and "The manager does 'walk the patch' and is very approachable and responsive to requests."

People who wished to move into the service had their needs assessed to ensure the service was able to meet their needs and expectations. The registered manager was knowledgeable about people's needs.

There was a staff handover meeting at each shift change. There was also a daily 'stand up' meeting which we observed on the morning of one inspection visit. During this meeting staff represented each unit and team at the service. For example, catering, laundry, activities and maintenance staff were represented. At this meeting all staff including the registered manager shared information about changes to people's individual needs, any information provided by professionals and details of any service provision issues, such as catering and maintenance staff were present. A record was completed to enable staff to refer to this information later in the shift if necessary. This helped ensure there was good communication between all staff and management.

People had access to a range of activities at Kenwyn. Two activities co-ordinators were employed, four assistants and a volunteer who helped organise a full programme of events including craft, cooking, housework tasks, quizzes, coffee mornings, drinks parties and gentleman's club events. There were records which showed some people had requested specific activities outside of Kenwyn. There were no regular trips out in the mini bus at the time of this inspection. There had not been a trip out since 2 June 2017. This was due to staff not having been assessed as competent to drive the mini bus and ensure people's safety at all times. This meant people were not supported to go out in to the local community and follow their own interests. We were assured by the registered manager that this was being addressed. People had a personalised activities assessment to help ensure the activities met their needs. Sensory activities were provided for people with dementia. This was provided on a one to one basis or in small groups. On the day of the inspection there were activities being arranged and people were being invited throughout the service to join in. Individual activities were provided to people in their own bedrooms. We saw records of people being read to, chats about people's past lives and people's choice of music being played to them.

People had access to quiet areas and well maintained outside areas which were secure. Comments included, "They (people living at the service) don't seem to use the gardens much and yet they're lovely" and "I get involved in some of the activities but would like to see more for the younger people."

Some people chose not to take part in organised activities and therefore could be at risk of becoming isolated. During the inspection we saw some people either chose to remain in their rooms or were confined to bed because of their health needs. We saw staff checked on people regularly and responded promptly to any call bells.

People and families were provided with information on how to raise any concerns they may have. Details of the complaints procedure were contained in the pack provided when people first arrived at Kenwyn. There was an appropriate complaints policy and procedure held by the service. There had been complaints raised

to the registered manager. There were records of the investigation in to each concern and the feedback provided to people to try to resolve the matter. Although, we found this had not always been adequate to satisfy the complainant.

There were many compliments received by the service. One stated, "What a change Kenwyn made to (relative)'s life She had mental and physical stimulation and proper care. They had a life back and it was all due to the staff at Kenwyn Nursing home. They thoroughly enjoyed the social aspect and freedom suddenly available to her" and "Whether you are a nurse, carer, cook, cleaner, administration clerk, receptionist or handyman or fellow resident, you all played a part in making (the person) a new life. We cannot thank you enough for the care and attention and even the love that (the person) received over their time with you."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in October 2016 we had concerns that the registered manager had not effectively recorded the meetings held following the investigation into a medicine error. This meant it was not possible to establish the details of the discussions and decisions made to help ensure a re-occurrence of such events did not take place in the future. Audits and checks of medicines management had identified some issues that required action. However, these had not been addressed and we continued to find such concerns at the inspection.

At this inspection we found the registered manager had robustly recorded a recent disciplinary meeting relating to a medicine error with a member of staff and the subsequent written warning issued. However, we continued to find that medicines management was not satisfactory. Staff had received additional training and support, audits were being carried out and 'resident of the day' medicine checks were being carried out regularly for all people living at the service. However, medicine errors continued to occur. We found people did not always have their prescribed medicines available to them. Some people had not always had their medicines given as prescribed. This is detailed in the Safe section of this report and some of the errors we have reported had not been identified through audits and checks.

The action plan sent to CQC following the last inspection stated random daily and weekly records checks would be carried out. We found this action plan had not been effectively put in place or monitored and omissions continued to occur which were not identified by these audits and checks.

Three healthcare professionals told us they had requested additional assessments or information to be added to people's care plans and this had not always taken place in a timely manner. Two families had contacted the CQC before and since this inspection to tell us that they felt their concerns raised to and investigated by the registered manager, were not always resolved to their satisfaction.

Before this inspection we were contacted by one person's relative about their experiences of care provision at Kenwyn, and the response they received to their concerns from the registered manager. Their experience had led them to remove their family member to another service. One healthcare professional was not confident that specific concerns raised would not re-occur in the future as they felt the concerns had not been effectively acted upon. Concerns had been received by CQC in March 2017 from a family of a person living at Kenwyn relating to a person not always having their care needs provided for as directed in the care plan, such as regular continence pad changes. This matter was investigated by the safeguarding unit and the registered manager. The family and the healthcare professional were assured this person had received appropriate care and support but that it had not always been recorded for family to see. Staff were provided with specific training on the importance of robust documentation.

Following this inspection we were contacted again by the same healthcare professional stating that the concerns they raised in March 2017 were still of concern to the family. They were considering moving their family member to another service. We reviewed this person's care file and met with them. We found some re-positioning and pad changes had been recorded by staff on a bed rail assessment. This meant it was not

easy to establish when care and support had been provided. This person had been assessed by a speech and language therapist and assessed as needing to have their food 'pre-mashed'. This person's food charts now stated they were being given pureed meals. It was not clear from the records why this change had been made to how their food was prepared. The family had not been involved in the decision to change the consistency of their meals. Whilst we were unable to establish any impact on this person's well being, the family and the healthcare professional were unhappy at the way their concerns had been received by the registered manager.

Services are required to notify CQC of various events and incidents to allow us to monitor the service. The service was not notifying CQC of all events as required, for example all DoLS authorisations as we have detailed earlier in this report. The registered manager told us they would send the outstanding notifications immediately.

Although the registered manager had effectively addressed some of the concerns found at the previous inspection repeated concerns regarding medicines management and effective governance issues remained.

This is a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regular surveys were sent out to people to seek their views and experiences of the service provided. The feedback was sent to the provider to be rated out of 1000. The overall performance rating latest score in 2016 for 'your care rating' for Kenwyn was 836/1000. Barchester care homes average is 880/1000. Most relatives and staff we spoke with told us the registered manager was approachable and always available to speak with. Staff told us they felt well supported by the registered and deputy managers who would always provide support to them when needed. Comments from people included, "They (management) are there when you need them," "The manager has her finger on the pulse, she sorts things out," The manager is very thorough and caring," "I think the staff are well managed. I don't speak to the manager very much and there aren't many things I have to ask her, but she does get things done. She is lovely" and "The manager is very good with me, she gets things sorted out for me." Some people told us they did not see the registered manager and would refer to the unit nurse with any concerns or issues.

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 had a registered manager in post.

The registered manager was available to support staff, people and their families. There were clear lines of accountability and responsibility both within the service and at provider level. The registered manager was supported by a deputy manager and a team of nurses. The manager received supervision from the regional director of the provider.

Staff told us they felt well supported through supervision and regular staff meetings. Staff commented, "I am satisfied that the manager sorts out any complaints and if I had a complaint unresolved I would go to the service provider, Barchester, or failing that , the CQC," "I am happy here," "The managers will roll up their sleeves and help as needed" and "We get the support we need, we only have to ask."

There were systems in place to support all staff. Staff meetings took place regularly. These were an opportunity to keep staff informed of any operational changes. There was a daily 'stand up' which was

attended by the nurse from each unit and leads from each department throughout the service. This meant that staff and management had the process in place for effective communication on all aspects of the running of the service.

The registered manager worked in the service every day supporting staff, this meant they were aware of the culture of the service at all times. Daily staff handover provided each shift with a clear picture of each person at the service and encouraged two way communication between each shift. This helped ensure everyone who worked with people who lived at the service were aware of the current needs of each individual.

People's care records were kept securely and confidentially, and in accordance with the legislative requirements. All record systems relevant to the running of the service were well organised and reviewed regularly.

There were two maintenance people in post with responsibility for the maintenance, repair and auditing of the premises. Larger works needed authorisation from the provider and this had delayed some work such as replacing showers in people's en suite bathrooms that no longer worked. Equipment such as moving and handling aids and wheelchairs were regularly serviced to ensure they were safe to use. There were systems in place to monitor the quality of the service provided. Audits were carried out over a range of areas, for example, maintenance of the premises, fire systems, passenger lift, boilers, water systems. All bedrooms were systematically checked for any repairs needed. There had been some delay in repairing en suite showers in some rooms. We were told that the dementia unit was imminently due for re-furbishment at the last inspection but this had not taken place. We were assured this work would commence soon. The environment was clean and well maintained. People's rooms and bathrooms were kept clean.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. The registered person must assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks. The registered person must ensure the proper and safe management of medicines.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes must be established and operated effectively to ensure compliance with the requirements of the regulations. The registered person must seek and act on feedback from relevant persons and other persons on the services provided, for the purposes of continually evaluating and improving such services. Providers must ensure that their audit and governance systems remain effective.

The enforcement action we took:

warning notice issues