

Kavanagh Health Care Limited

# Kavanagh Health Care Limited

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

Kavanagh Health Care Limited is owned by Exemplar Health Care and is situated in the Kirkdale area of Liverpool. It is a modern, purpose built two storey building, divided into four wings and provides care for people with mental health needs including early onset dementia, neurological disorders and complex physical care needs for up to 40 people.

This was an unannounced inspection which took place on 14 and 16 June 2017. The service was last inspected in May 2016 and at that time was given a quality rating of 'good'.

There were 38 people accommodated at the time of our inspection.

There was a registered manager 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.

We reviewed the way people's medication was managed. We saw there were systems in place to monitor medication. Some medicines given such as external medicines [creams] and prescribed thickeners (used for thickening fluids for people with swallowing difficulties) were not being recorded appropriately. We found some omissions on records which indicated some diet supplements had not been given as prescribed.

The registered manager was able to evidence a series of quality assurance processes and audits carried out internally and externally by staff and from the provider's visiting senior managers. We found these were developed to help ensure effective monitoring and development of the service as well as helping to ensure standards were continually maintained. We found however, that audits for medicines management had not identified the concerns we found on inspection.

The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed on a regular basis where obvious hazards were identified.

Planned development / maintenance was assessed and planned well so that people were living in a comfortable environment. We found some examples where access to facilities could be improved for people. The development of environmental cues for people living with dementia would help orientate people with their surroundings to promote their wellbeing.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained. Most people were satisfied with living in the home and felt the care offered met their care needs. People we spoke with said they were consulted about their care and we saw some examples in care planning

documentation which showed evidence of people's input.

We saw written care plans were formulated and care reviews were ongoing. Care was organised so any risks were assessed and plans put in place to maximise people's independence whilst help ensure people's safety.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made and decisions made in the person's best interest.

The registered manager had made referrals to the local authority applying for authorisations to support people who may be deprived of their liberty under the Deprivation of Liberty Safeguards (DoLS). DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found the applications were completed and were being monitored by the registered manager.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We saw checks had been made so that staff employed were 'fit' to work with vulnerable people.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report any concerns they had.

We observed staff interacting with the people they supported. We saw how staff communicated and supported people. Staff were able to explain each person's care needs and how they communicated these needs. People we spoke with and their relatives told us that staff had the skills and approach needed to ensure people were receiving the right care.

We saw people's dietary needs were managed with reference to individual preferences and choice.

People we spoke with said they were happy living at the home. They spoke about the nursing and care staff positively. When we observed staff interacting with people living in the home they showed a caring nature with appropriate interventions to support people.

We discussed the use of advocacy for people. There was information available in the home regarding local advocacy services if people required these.

Activities were organised in the home and these were appreciated by the people living at the home. We saw an activities programme. The staff member who organised these was motivated to provide meaningful and stimulating activities.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We saw that a record was made of any complaints and these had been responded to.

You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

We found medicine administration needed improvement to ensure effective on-going management as the provider's arrangements to manage medicines were not consistently followed.

Prescribed thickeners (used for thickening fluids for people with swallowing difficulties) were not being safely monitored.

We found that people had had risks to their health monitored. Assessments and care plans contained necessary detail to help ensure consistent outcomes for people's health.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

There were enough staff on duty to help ensure people's care needs were met. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

There was good monitoring of the environment to ensure it was safe and well maintained. We found that people were protected because any environmental hazards had been assessed and effective action to reduce any risk had been taken.

**Requires Improvement** 

### Is the service effective?

The service was effective.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made and care and treatment planned in their best interest.

The home supported people to provide effective outcomes for their health and wellbeing.

**Good** 

We saw people's dietary needs were managed with reference to individual preferences and choice.

Staff said they were supported through induction, appraisal and the home's training programme.

The therapeutic environment in the home was the subject of on-going development. We discussed further developments in line with best practice in dementia care.

### **Is the service caring?**

**Good** ●

The service was caring.

When interacting with people staff showed a caring nature with appropriate interventions to support people. Staff had time to spend with people and engage with them.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

There were opportunities for people to provide feedback and get involved in their care and the running of the home.

### **Is the service responsive?**

**Good** ●

The service was responsive.

Care was planned with regard to people's individual preferences. We saw written care plans were formulated and regularly reviewed.

There were activities planned and agreed for people living in the home.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain. Complaints made had been addressed.

### **Is the service well-led?**

**Requires Improvement** ●

The service was not fully well led.

There were a series of on-going audits and checks to ensure standards were being monitored effectively; medication audits had not recently been carried out and issues identified on the inspection had not been identified.

There was a registered manager in post who provided a lead for

the home.

We found the management structure had clear lines of accountability and responsibility which helped promote good service development.

The Care Quality Commission had been notified of reportable incidents in the home.

There was a system in place to get feedback from people so that the service could be developed with respect to their needs and wishes. These included meetings and other formal processes.

# Kavanagh Health Care Limited

## **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.

This was an unannounced inspection which took place on 14 and 16 June 2017. The inspection was undertaken by two adult social care inspectors and a professional advisor who was a nurse.

We were able to access and review the Provider Information Return (PIR) as the manager sent this to us as part of the inspection. The PIR 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 also reviewed other information we held about the service.

During the visit we were able to meet and speak with two of the people who were living at the home. We spoke with two visiting family members. As part of the inspection we received feedback from two health care professionals who visit the home and who were able to give us some information regarding how the service supported people.

We spoke with 14 of the staff working at Kavanagh Health including nursing staff, care/support staff, kitchen staff, the registered manager and operational manager.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records for six of the people staying at the home including medication records, two staff recruitment files and other records relevant to the quality monitoring of the service. These included

safety audits and quality audits including feedback from people living at the home and relatives. We undertook general observations and looked round the home, including people's bedrooms, bathrooms and the dining/lounge areas.



# Is the service safe?

## Our findings

We reviewed the storage and handling of medicines on two of the units. We looked at a sample of Medication Administration Records (MARs), stock checks and other records for people living in the home. We found medicines were not always managed safely.

Medicines were stored in a locked trolley which was kept in a locked clinical room. The temperature of medicines stored must be checked and recorded. If medicines are not stored at the correct temperature, it can affect how they work. On one unit the temperature of the clinical room and the medicine fridge were not being monitored each day. The temperature of the drug fridge had not recorded from 3 June 2017 till 12 June 2017. The temperature of the clinical room had not been recorded since 31 May 2017.

Quantities of medicines received into the home must be checked to provide an accurate stock check. When looking at medicine administration records (MARs), we found quantities of medicines received had not always been checked and recorded. For example, for a handwritten entry on a MAR, there was no date when the entry was made or record of the quantity of medicine received. The MAR had also not been signed by two staff members to ensure accuracy of the information recorded which is in accordance with good practice.

We saw dietary supplements/ high protein drinks were prescribed for people who had a poor intake. We looked at the current MARs. For one person their MAR started on 5 June 2017 and staff had not signed to say they had given the person their once a day nutritional supplement/high protein drink which commenced on 8 May 2017. For another person they had been prescribed a dietary supplement/high protein drink to be given four times a day. The MAR which started on 5 June 2017 only recorded a staff signature three times a day; there was no staff signature to evidence the fourth dose prescribed for night time.

Some of the people living at the home were prescribed 'thickening' powder to thicken their drinks. This is to aid people who may have swallowing difficulties to accept fluids and reduce the risk of choking. The 'thickening' powder is a prescribed treatment which needs to be stored safely. The tins of 'thickening' agents appeared to be stored safely in a cupboard. However, on one unit we found a person had been prescribed a different thickening agent but six tins of the previous agent, some not empty, had not been removed. Staff were seen to remove these but disposed of them inappropriately in a general refuse bin in the dining room; the risk being this was accessible to people on the unit and not in accordance with the safe disposal of medicines. We alerted the nurse in charge to this.

For three people we saw the number of scoops of thickening agent needed for Stage 1 was not recorded on their fluid chart though talking with staff confirmed their knowledge of how many scoops to add in accordance with the dietician's instruction. There were supporting care plans in people's care files but these were not immediately accessible for care staff to refer to for the required information. The registered manager informed us there should be a chart in the storage cupboard for thickeners with details of people's requirements to act as a prompt for staff; this was not the case on at least one unit.

We checked how external preparations [creams] were administered. We found creams for three people had been supplied. We were told these were administered daily by care staff and we saw these were on the MAR. We asked whether the creams had been applied and we were told they had been applied that day. Staff told us the only place creams were recorded was on the MAR which stated 'carers administer'. There was no record maintained of which individual care staff had administered the creams. This was not in keeping with good practice or the providers own policy which stated: 'Once the topical medication has been administered to the individual the care should sign the Topical Application Record'. The registered manager concurred this as the policy. We were assured the creams would have been applied but we were concerned about the lack of accurate records to evidence this.

We asked what auditing mechanisms were in place to check if medication was being administered safely. Medicine audit for May 2017 had not been completed. Previous medicine audits did contain reference to checking of creams but there was no checks made regarding the administration of thickening agents for fluid and dietary supplements in any of the audits we saw. We questioned the effectiveness of this as the anomalies we saw had not been identified. The registered manager advised us the audits would be reviewed to capture these issues.

These findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

MARs we viewed contained photographs of people to assist with accurate identification, as well as information regarding any allergies that people had.

We checked a number of stock balances for medicines which had been dispensed from blister packs and found the stock balances to be correct.

Controlled medicines were stored in a separate locked cupboard in line with legislation. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation. We were informed no one was receiving controlled medication at the time of our inspection.

We saw evidence of PRN (as required) protocols and records in place. PRN medicines are those which are only administered when needed for example for pain relief. Guidance regarding administration of people's medicines recorded within people's care plans; this included the administration of PRN medicines.

We saw information around the use of covert medication. Covert medicines are medicines given without the persons consent or knowledge in their 'best interest. We saw a care plan to support this practice along with a record from the person's GP to continue with administering the medicines covertly; this practice had been initiated prior to the person taking up residency at the home. There was no record from pharmacy regarding the medicine to be given covertly. This was raised with a staff member who agreed to action this to improve these records.

Care records we saw confirmed that people were reviewed regularly by visiting GP's and this included medication reviews.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as, falls, nutrition, mobility, pressure relief and the use of bed rails. These assessments were reviewed regularly to help ensure any change in people's needs was assessed to allow appropriate measures to be put in place. For example, one person had particular risks associated with their mobility and they had been assessed as a high risk of falls due to unsteady gait. We

saw the person had one to one observations during the day and every 15 minutes at night to help reduce any risk of falls. There was a detailed moving & handling assessment in place and a 'falls prevention' care plan which was very specific about the person's unsteady movements in relation to their medical condition.

Another person had specific behaviour that meant they were a risk to other people. We saw these had been assessed and measures put in place to reduce any risk of harm. The care plan was detailed so that care staff could provide a consistent approach. We saw staff approaching the person confidently in line with the assessments and care plan. The PIR submitted by the registered manager prior to our inspection stated: "The staff team are experienced in managing volatile and unpredictable behaviour, applying de-escalation techniques to prevent further escalation of behaviour." We looked at management audits to see how any examples of 'restraint' were followed through and we saw good systems for ensuring they were reviewed appropriately.

When we visited the home we checked to see if there was sufficient staff to carry out care in a timely and effective manner. We looked at the staffing rota on one of the units we visited. There were two nurses on duty with five care staff. On nights there was one nurse with three care staff; this for 10 people on the unit. Some of these people were being supported on a one to one basis. We saw some flexibility of staffing to cover periods of higher need. For example, sometimes one of the care staff would be working until midnight (twilight shift) to assist with supporting people with supper, personal hygiene and going to bed.

We observed other units had similar levels of staff. When we spoke with staff they gave varying levels of feedback regarding staffing numbers. Some felt the staffing was insufficient at times and also felt that staff 'are moved from unit to unit a lot to cover' [deficiencies in numbers]. This meant consistency of care could suffer; although staff could not give specific examples apart from this might affect 'going out' [for example, social trips]. A relative we spoke with also confirmed this.

Most staff, however, felt staffing was adequate overall with enough staff to ensure people's safe care. One staff commented, "I have no concerns, most staff are long standing and know the [people] well. The twilight shift is a big help." The registered manager felt the policy of moving staff to cover on different units was a necessity and it meant that staff experienced looking after all of the people in the home. A relative commented, "My [relative] gets very good care; there's always plenty of staff around. It's very safe here."

There were ancillary staff such as, an administrator, kitchen staff (all day), and domestic cover. When we looked at the duty rota we saw these staffing figures were reflected for the week of our inspection and for the two weeks before this.

The observations we made evidenced staff were available. We observed staff attending to people and supporting them to eat and drink as well as assisting with aspects of personal care. During the SOFI observations we conducted on a unit caring primarily of people living with dementia, we saw the care was carried out at an appropriate pace with staff having plenty of time to carry out care such as, supporting people with their meals.

We looked at how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at two staff files and asked for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people. The recruitment process included notes of staff interviews which included questions asked to prospective employees in many areas of safe care including recognition and reporting of abuse.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the local contact numbers for the local authority safeguarding team were available to staff.

We reviewed some more recent safeguarding concerns that the registered manager had reported through safeguarding procedures. Two of these involved one person, who we saw was being well monitored and their care and support was subject to on-going review by community mental health professionals. The other incident involved a staff member who allegedly failed to provide necessary support for a person. All incidents had been followed through with the safeguarding team from social services. It was clear the home had worked well liaising with the safeguarding team to ensure issues were followed up and any lessons learnt. A visiting health care professional told us the staff "Raised concerns about visitors that were suspected of taking advantage of a vulnerable client and the team ensured the safety of the client."

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed on a regular basis where obvious hazards were identified. Any repairs that were discovered were reported for maintenance and the area needing repair made as safe as possible. We saw the general environment was safe.

We saw how accidents and incidents were monitored in the home. All accidents were recorded and sent for review by senior managers up to board level. Statistics for accidents and incidents were easy to access and were analysed for any trends.

A 'fire risk assessment' had been carried out and updated yearly by the health and safety manager for the provider. We saw a health and safety audit carried out in January 2017 which highlighted some work regarding fire safety [signage] and this was documented as completed. We saw personal emergency evacuation plans [PEEP's] were available for the people resident in the home to help ensure effective evacuation of the home in case of an emergency. We spot checked other safety certificates for electrical safety, gas safety and kitchen hygiene and these were up to date. This showed good attention with regards to ensuring safety in the home and on-going maintenance. A health and safety committee met quarterly to co-ordinate outstanding health and safety issues.

# Is the service effective?

## Our findings

We looked to see if the home was working within the legal framework of the Mental Capacity Act (2005) [MCA]. 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 so that they can 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.

We found requirements were being met and people who lacked capacity to make certain decisions were assessed appropriately.

For example, we looked at one person who had a medical condition that called into question their ability to consent to care and treatment. We saw that care had been taken to assess the person mental capacity with respect to certain decisions and that the person had been assisted to make decisions in some instances. Regarding the implementation of a DNACPR [do not attempt cardio pulmonary resuscitation] decision which had been made, we could see the person had been consulted regarding this.

Another person had a 'best interest' decision made regarding the use of a chair with a restraining belt in situ to protect the person for the risk of a fall from the chair. An assessment had been made, using a standard assessment tool, which showed the person was unable consent to this because of limited mental capacity.

Another person was being administered their medications 'covertly'. This meant without their knowledge. We saw that the person had been carefully assessed using the appropriate assessment tool regarding their capacity to consent to their medication administration and assessments had also included input from professionals. It was felt the person needed the medicine in their 'best interest' to ensure their health was maintained. This process showed a good understanding of the principles of the MCA and how they should be applied to ensure people's rights are protected.

The registered manager had made applications to the local authority for people who lacked the capacity to make a decision to stay in the home. We reviewed the applications for two people and saw the application had been made appropriately with the rationale described. We saw the assessment by the local authority was delayed on these applications and the registered manager said they would ensure the issue was followed up.

We observed staff provide support at key times and the interactions we saw showed how staff

communicated and supported people and asked their consent to care. When we spoke with staff they were able to explain each person's care needs and how they communicated these needs.

We received feedback from a health and social care professionals during the inspection who were involved in the support of people at the home. A specialist nurse told us "I always find the information I need when I visit and don't have any concern; they appear to manage our complex patients very well." Another professional commented, "The level of documentation has vastly improved and care is now personalised. The clients that I reviewed were complex and the staff were able to care and treat them [accordingly]." Both professionals told us the home work well with supporting professionals "to gain the best for their clients."

We reviewed the care of five people in detail on our inspection as well as asking about aspects of other people's health care and how effective this was. Each person's care file included evidence of input by a full range of health care professionals. If people had specific medical needs we saw these were well documented and followed through. Care records had been regularly reviewed and updated with reference to any external health support needed.

People we spoke with and relatives told us that staff had the skills and approach needed to ensure people were receiving the right care with respect to maintaining their health. We looked at the training and support in place for staff.

The Provider Information Return (PIR) told us: 'A full eight day induction programme that covers all mandatory training prior to [staff] having any direct contact with service users. All new staff complete practical observations, to ensure they are safe and competent in using equipment'.

We were supplied a copy of a staff training calendar and records for training undertaken and planned. We saw training had been carried out for staff in 'statutory' subjects such as health and safety, safeguarding, infection control and fire awareness. We saw a recent audit undertaken which included training statistics for staff. High percentage figures for staff attending training were recorded, although the registered manager informed us this should be higher and more training had been planned to meet the provider's own performance targets. For example, it had been identified that staff required training in 'end of life care' and we were told this was being facilitated. Staff raised this with us as they said they would like to attend this training.

All of the staff we spoke with said the provider was very supportive of training initiatives and staff were regularly reminded to attend courses to update themselves.

The registered manager informed us that many care staff had a qualification in care such as QCF (Qualifications Credits Framework) and confirmed that 56% of staff had attained a qualification. There were also 17 staff who had completed induction standard training for the Care Certificate.

Staff spoken with said they felt supported by the managers and the training provided. They told us that they had had appraisals and there were support systems in place such as supervision sessions. We asked about staff meetings and we were told that issues were discussed at daily handover as well as formal staff meetings arranged on a regular basis.

We observed the breakfast and lunch time provision in the lounge and the dining room on the different units. On one unit we saw staff supporting people to eat and drink. Staff supported people with their meals patiently and in a respectful way. Meal times were well paced and relaxed.

Most people we spoke with and visiting relatives told us that the meals were good and we saw lunch was a

sociable occasion.

Planned development of the home's environment was on-going. We found some examples where access to facilities could be improved for people and these were discussed with the registered manager; for example, access to a bathroom facility on one unit [Abby Road]. For people living with dementia [Strawberry Fields], we saw this unit had been recently decorated but there was an absence of environmental cues for people living with dementia such as, signage to aid orientation. The registered manager stated developments were on-going.

## Is the service caring?

### Our findings

The registered manager told us four staff had recently been appointed the role of dignity champion to monitor standards around dignity and respect. This was however a relatively new appointment and staff we spoke with were unsure about staff assigned to this role and what this role entailed. Staff we spoke with were keen to develop this further and were positive about how it could develop standards of privacy and dignity within the home.

During the inspection we observed staff spending time chatting easily with people. There was plenty of laughter and a relaxed atmosphere. We observed people's dignity and privacy being respected by staff during the inspection, such as, staff knocking on people's door before entering their rooms and waiting for a reply before they entered. People's preferred term of address was also respected. Staff's approach to people was genuine, caring, patient and considerate. People were not rushed when receiving support with daily tasks.

Staff we spoke to knew the people they were caring for well and told us they were kept up to date about any change in people's needs through daily handovers and reading people's care plans. A staff member said, the care plans were very informative and subject to regular review; this we saw and the reviews were comprehensive. We saw that care files containing people's private information were stored securely in order to maintain people's confidentiality.

Care plans were written in such a way as to promote people's independence. For example, they clearly reflected what people were able to do for themselves and what they required staff to assist them with. A staff member said, "We know the residents really well and know when and how they need help."

We saw that people had access to advocacy support if needed. For example, in one person's care file the use of an advocate was clearly recorded the under 'professional note' section. Advocacy details were displayed throughout the home so that people had contact details for this service.

We observed relatives/visitors visiting throughout both days of the inspection and a number of were also joining in with various social activities. The staff told us visitors were welcome at any time, encouraging relationships to be maintained. One relative we spoke with told us, "Staff are very good – the best - [person's] personal care is always very good, the staff pay very good attention to this."



## Is the service responsive?

### Our findings

We saw that care files contained a pre admission assessment completed prior to people moving into the home; this ensured the service was aware of people's needs and that they could be met effectively from the day they moved in.

We looked at how people were involved with their care planning. We saw evidence that people's plan of care and key decisions had been discussed with them and/or their relative and this was recorded in the care files we looked at.

People had a plan of care and these were specific to the individual person. A care plan provides direction on the type of care an individual may need following their needs assessment. The care plans we saw recorded information which included areas such as, personal care, health support, mobility, social support nutrition and communication. Care plans were detailed and were written in a way that painted a detailed portrait of the individual in respect of their health and social care needs, choices and preferences.

People were able to make choices and these were clearly recorded in a plan of care. In respect of medicines we saw how people liked to take their medicines, for example how much water they wanted or whether a spoon was used rather than a cup. For one person we saw a good example of how staff had made adaptations to the person's diet so they could have a food they would not normally be served because of a dietary restriction. For another person information was recorded around preference of bath time which was an important part of their morning routine. One person liked to eat the same foods at the same time each day. Staff we spoke with demonstrated a good knowledge of people's individual care, their needs, choices and preferences. It was evident the staff knew people well and staff respected their decisions. There was reference to social background and 'my life so far' to help the staff get to know people's life history before taking up residency in the home.

We looked at how social activities were organised and how people were encouraged to participate in their chosen social interests. Social activities appeared to be very well managed and the service had a full time senior activity co-ordinator who took overall charge of the social events along with a full time activity co-ordinator and two part time activity co-ordinators. The activity staff were on duty during the inspection and they were supporting a number of people with various social activities. This included music, games, and gardening. The majority of people were sat outside enjoying the sunshine with plenty of staff around to also support them. Everyone seemed to enjoy the time in the garden.

The senior activity co-ordinator advised us of the social calendar and we saw different events were arranged each day so that people benefited from a stimulating and varied programme. People could participate, for example, in singing, dancing, gardening, cookery, BBQs, quizzes, game, cinema trips, pub meals, massage, beauty sessions and visits to places of interest with the use of a minibus. In respect of supporting people with dementia, memory boxes were being introduced [but not yet available] with photographs and personal items which were meaningful to people to help reinforce memories. We saw raised garden beds and plans were in place to have a sensory garden. The activity coordinator also told us about the lunch club for wives

and husbands which was proving to be very popular and also choosing a different unit each Friday for deciding on the trips out. Social events were displayed on the units; a cupcake tea party had been arranged for the week of the inspection.

The senior activity co-ordinator informed us that 'one to one' time was offered to people who wished to stay in their room or who were frail in health and needed to be nursed in bed. They told us that this was an area they wished to develop further as in the main they concentrated on social activities for people who did not remain in their room.

People had an activity care plan which provided lots of detail for preferred hobbies and pursuits. Social activity records were available however these were not all current to evidence people's participation and enjoyment. The senior activity co-ordinator said they would look at ways of recording this information in a timelier manner to improve this record.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. The PIR told us full details of three complaints over the past year and how these had been managed. We saw that one complaint was particularly difficult to manage but we saw communication with family members had been as positive as possible and there was on-going monitoring to try and resolve issues.

We reviewed another two, more recent complaints, and these had also been responded to appropriately and in line with the provider's complaint policy.

## Is the service well-led?

### Our findings

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. The managers were able to evidence a series of quality assurance processes and audits carried out internally and externally from senior managers, registered manager and clinical nurse managers. These processes have generated a series of developments over the recent years to improve the quality monitoring in the home and were being carried out on a regular basis. They included good checks and audits regarding health and safety and environmental standards in particular. Statistics collected around untoward incidents were also very well monitored and there was good analysis to help ensure any risks could be reduced. A health and safety committee comprising of key staff in the home met quarterly.

As part of the feedback to the registered manager and senior managers we identified improvements were needed with the management of medicines. We saw the auditing process regarding medication management had not identified the issues we found on the inspection. We looked at a number of medication audits which we were advised were carried out monthly. The audit for May 2017 had not been carried out as the registered manager explained that the clinical service manager, who would normally carry out this audit, had left employment that month. Audits we looked at did not include review of thickening agents. The medication audit carried out in February 2017 identified the recording of creams 'was not consistent' but there had been no effective action to address this. We discussed with the registered manager how the audit could be improved. In addition, more specialist audits developed to improve the living environment for people living with dementia could be employed in the home.

We would recommend that the governance systems are further developed with respect to audits for medication and environmental standards in line with best practice.

There was a registered manager who was supported by a regional manager and other senior managers who were part of the overall governance. Internally the home also had two clinical nurse managers but one post was vacant at the time of our inspection. There was a clear management structure with all levels of management supervising the home's quality assurance systems and processes.

The PIR for the home stated, 'The management structure within the home consists of a registered manager, two clinical nurse managers and six heads of department. Weekly heads of department meetings take place to review the service and drive actions. There is a six monthly meeting schedule in place that provides individuals with a forum to ask questions or provide feedback'.

We saw notes for a series of meetings held and a schedule for further meetings on each of the units over a six month period. The meetings included senior carer and also meetings with nursing staff. Nursing staff were supported to have 'reflective' exercises to review current issues and develop practice. We saw a senior carer meeting dated in January 2017 had been well attended and positive issues had been discussed.

There were some negative comments from staff regarding the support received by the management on a daily basis, mostly related to internal movement of staff. Most staff were positive, however, and found the

registered manager offered the right level of support and structure to the home. One staff commented, "[Registered manager] is very good and will meet with us – overall moral is good."

There were also forums for people living at the home and visitors to provide feedback. The registered manager reported it was difficult to get people involved at times but there had recently been a 'garden project' which had involved people living at the home and relatives in developing the garden at Kavanagh Health. We saw notes for a meeting held in April 2017 attended by 14 people and another in May 2017. The registered manager reported positive moves to get people involved in staff recruitment and reported one person living at the home had been involved in a staff appointment. In March 2017 surveys had been sent out to people and their relatives but full feedback had not yet been received from senior management.

The Care Quality Commission (CQC) had been notified of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding Kavanagh Health.

From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for the home was displayed for people to see.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	We found medicine administration needed improvement to ensure effective on-going management as the provider's arrangements to manage medicines and prescribed treatments were not consistently followed.