Mentfade Limited

Kynance Residential Home

Inspection report

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Date of inspection visit:
09 February 2017
10 February 2017

Date of publication:
09 March 2017

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

Summary of findings

Overall summary

This inspection took place on 9 and 10 February 2017 and was unannounced. Kynance is a care home that provides accommodation for up to 32 people, including people with dementia care needs. There were 31 people living at the home when we visited. The home is based on two floors connected by a passenger lift, in addition to a basement where the kitchen and laundry are located. There was a good choice of communal spaces where people were able to socialise, including a newly built conservatory that was used as the dining room. All bedrooms had en-suite facilities.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

At our last inspection, in February 2016, we identified breaches of two regulations. Decisions taken on behalf of people were not documented in accordance with legislation designed to protect people's rights; and people were not protected from the risk of being deprived of their liberty unlawfully. Following the inspection, the registered manager sent us an action plan detailing how they would become compliant with the regulations. At this inspection, we found action had been taken to address these issues, but concerns were identified in other areas.

The provider had not displayed their previous quality rating on the premises, although this was rectified during the inspection. The provider had also failed to ensure that information was provided in writing to relevant people after significant accidents and incidents occurred.

One person's safety was compromised as their drinks were not always thickened to the right consistency; this put them at risk of choking. Staff had received fire safety training, but not all senior staff were clear about evacuation procedures. However, other individual and environment risks were managed appropriately and protected people from harm.

Suitable arrangements were in place for the safe administration of medicines. However, checks showed that two people had not received all of their prescribed medicines and photographs of some people were not available to help staff ensure they gave the right medicines to the right people.

People with diabetes were not always supported to receive appropriate care or an appropriate diet in line with their individual needs and preferences. Their care plans did not provide sufficient information to enable staff to deliver diabetes care in a personalised way. However, other people's dietary needs were met; people praised the quality of the food and were supported appropriately to eat and drink enough.

People's other care needs, including support with personal care, were met. Care plans contained comprehensive information about the way each person wished to receive care and support. People were

empowered to make choices; staff were led by people's wishes and accommodated them wherever possible.

Staff had received safeguarding training and knew how to identify, prevent and report incidents of abuse. Robust recruitment procedures were followed to help ensure only suitable people were employed to support people.

Staff followed legislation designed to protect people's rights and freedom. They were suitably trained and were supported appropriately in their role.

People had access to healthcare services and were seen regularly by doctors, specialists and community nurses. People also had access to a range of activities to meet their welfare needs.

People were cared for with kindness and compassion. We observed positive interactions between people and staff. Staff knew people well, spoke about them warmly and showed consideration for their feelings.

People were supported to maintain and build relationships and their spiritual needs were met. People's privacy was protected. Staff encouraged people to be as independent as possible and involved them in decisions about their care.

The provider sought and acted on feedback from people. There was an appropriate complaints procedure in place and people had confidence that any concerns they raised would be addressed.

People were happy living at Kynance and felt the service was well run. There was an appropriate management structure in place. Staff were motivated, communicated effectively and worked well together.

The registered manager conducted a limited range of audits to monitor the quality and safety of the service, but was in the process of developing a more robust quality assurance system.

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

Requires Improvement

The service was not always safe.

The risk of a person choking on their food and drinks was not managed effectively and not all staff were clear about evacuation procedures in the event of a fire. However, other individual and environmental risks were managed appropriately.

Appropriate arrangements were in place for the safe administration of medicines, although records indicated that two people had not received some of their medicines in the previous week.

People felt safe at the home and staff knew how to identify, prevent and report abuse. There were enough staff to meet people's needs and the process used to recruit staff was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The care and dietary needs of people with diabetes were not always met in a personalised way; however, the dietary needs of other people were met. People praised the quality of the food and received appropriate support to eat and drink enough.

With the exception of the management of diabetes, staff were suitably trained and supported in their work. They followed legislation designed to protect people's rights.

People were supported to access healthcare services when needed, including doctors and specialist nurses.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion. Staff interacted positively with people and supported them in a friendly and relaxed manner.

Staff supported people to maintain and develop friendships and

important relationships. They protected people's privacy at all times and encouraged them to remain as independent as possible.

People, and their families where appropriate, were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

People received personalised care from staff who understood their individual needs. Care plans contained comprehensive information and were reviewed regularly.

People were supported and encouraged to make choices about every aspect of their lives. They had access to a range of meaningful activities.

The provider sought and acted on feedback from people to help improve the service. There was an appropriate complaints policy in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had failed to ensure that the ratings from the previous inspection were displayed in the home, although this was addressed during the inspection.

Staff acted in an open way when incidents occurred, but did not provide written information to the relevant person as required.

A limited range of audits was conducted to monitor the quality and safety of the service. The registered manager was working with a social care professional to develop a more robust quality assurance system.

People were happy living at the home and had confidence in the management. Staff were also positive about the management of the service. They communicated effectively and worked well as a team.

Kynance Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 and 10 February 2017 and was unannounced. It was conducted by one 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 we reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 10 people living at the home, four family members and a visiting community nurse. We also spoke with a director of the provider's company, the registered manager, the two deputy managers, five care staff, a member of kitchen staff and a housekeeper. We looked at care plans and associated records for five people, staff records, recruitment files, accident and incident records, and quality assurance records.

We observed care and support being delivered in communal areas of the home. 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.

Requires Improvement

Is the service safe?

Our findings

Individual risks to people were not always managed effectively. One person was at risk of choking on their drinks. They had been assessed by a speech and language therapist in November 2016, who had advised that the person's drinks should be thickened with a thickening powder to reduce the level of risk. At lunchtime, the person took their meal in the main lounge. We saw their fruit squash was not thickened and this caused them to cough whenever they drank it. Staff were available in the lounge, providing support to people; when the person coughed, they advised them to take smaller sips. A staff member responsible for giving drinks to people told us the person only had the thickening powder in cups of tea, not squash; a senior staff member told us the thickening powder was "only used when [the person] needed it, not all the time". The registered manager was clear that all the person's drinks should be thickened and that the person should be monitored at all times when drinking and eating due to the level of risk. The need for thickened fluids was documented in the person's care plan; however, there was no specific risk assessment for this or any guidance to staff about the level of monitoring the person needed when drinking or what to do in the event of a choking episode. We discussed this with the registered manager who took immediate action to ensure all staff were aware of the support the person needed with eating and drinking.

The failure to mitigate risks to the health and safety of people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most environmental risks were managed appropriately. Repairs to fixtures and fittings were made promptly; gas and electrical equipment was checked regularly; and the water temperature of sinks was regulated and checked on a monthly basis. There was a process in place to check fire safety equipment and personal emergency evacuation plans (PEEPS) had been completed for each person. These detailed the specific support each person required to evacuate the building in the event of an emergency. Staff received regular fire safety training; however, two senior staff members, who were responsible for taking charge of fire safety arrangements in an emergency, did not have a good understanding of the evacuation procedures and were not clear about how, or to where, they would evacuate people in the event of a fire. We discussed this with the registered manager who undertook to provide additional training for staff.

Other risks to people were managed appropriately. They had been assessed and recorded, along with actions identified to reduce those risks. For example, people who were at risk of falling had risk assessments in place detailing the support staff should offer to help them mobilise safely. One person was at risk of falling out of bed and we saw their bed had been lowered to the floor with another mattress next to it in case they rolled out. Action had also been taken to reduce the risk of people developing pressure injuries due to remaining in one position for too long. People's individual risk level had been assessed, using a nationally recognised tool, and special pressure-relieving mattresses and cushions had been supplied. One person needed to be supported to change position in bed every two hours and records confirmed this was done. During the inspection we observed staff monitored people and offered support in line with these risk assessments.

There were appropriate procedures in place for the safe ordering, administering, storing and disposing of

medicines. Staff were suitably trained to administer medicines and the registered manager assessed their competence to do this on a yearly basis. One of the deputy managers completed a weekly audit of the medicines in stock to check they tallied with the medication administration records (MAR). The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines initialled the MAR chart to confirm the person had received their medicine. We randomly checked the MAR charts for seven boxed medicines and found that the quantity of tablets shown in stock did not tally for two medicines. The deputy manager told us this indicated that staff had signed to say they had given these medicines to people, on three occasions in the previous week, when they had not done so. We discussed the above issues with the deputy manager who undertook to investigate the cause of the MAR chart anomalies and introduce additional monitoring of medicine administrations.

Guidance issued by the National Institute for Health and Clinical Excellence (NICE) recommends that the MAR charts include a photograph of each person to help ensure that the right medicines are given to the right person. We found photographs were absent for seven of the 31 people living at the home. There was a risk that those people might not receive the right medicines, although this risk was reduced because the staff who administered medicines knew people well. We discussed the above issues with the deputy manager who undertook to add the missing photographs to the MAR charts.

Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. People confirmed they were offered and could access pain relief when needed. Body maps were used to remind staff where to apply topical creams to people and a system was in place to help ensure that creams were not used beyond their 'use by' date. Staff supporting people to take their medicines did so in a gentle and respectful way, explaining what the medicines were for. For example, a staff member told one person, "They are paracetamol for the pain in your legs." People were given time to take their medicines without being rushed.

There were enough staff to meet people's care needs. People told us staff responded promptly when they pressed their call bells. One person said, "I've not suffered any long waits." Staff told us they were very busy during the mornings but most felt their workload was manageable and they were able to meet people's needs. During the mornings, we observed that staff were task orientated, although they had more time to spend with people during the afternoon when they were able to interact, relax and talk with people more. The manager told us staffing levels were based on people's needs and were kept under constant review. Absence and sickness were covered by permanent staff working additional hours which meant people were cared for by staff who knew them and understood their needs.

People told us they felt safe at the home. One person said, "The best thing about being here is safety. I feel safe and secure and wish I'd come here years ago." Another person said, "At night time they [staff] come round every hour to check that you are okay. It gives you a good feeling of security." A family member told us, "[My relative] is very safe at Kynance."

The provider had appropriate policies in place to protect people from abuse. Staff had the knowledge and confidence necessary to enable them to respond appropriately to concerns about people's safety. They knew how to identify, prevent and report abuse and were aware of people who were at risk. For example, two people occasionally engaged in verbal altercations with one another. Staff were fully aware of this and supported them closely throughout the day to reduce the risk of the situation developing into physical conflict.

Staff told us they would have no hesitation raising concerns and had confidence that the registered

manager would take appropriate action. One staff member said, "I would go to [the registered manager]. She would act on it immediately; she's really good." Staff were also aware of external organisations they could contact for support, including the local safeguarding authority.
Where safeguarding concerns were identified, the manager conducted appropriate investigations and took action to keep people safe. For example, when bruising had been found to one person, the investigation showed the probable cause was a gap between the person's bed and the bed rails, so staff filled the gap with soft material to prevent a recurrence.

The provider had safe recruitment procedures in place, which included seeking references, obtaining a full employment history and completing checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We found these checks had been completed before new staff started working with people.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, in February 2016, we identified breaches of two regulations. Decisions taken on behalf of people were not documented in accordance with legislation designed to protect people's rights; and people were not protected from the risk of being deprived of their liberty unlawfully. At this inspection, we found action had been taken and the provider was meeting the regulations.

Staff followed the Mental Capacity Act (MCA) to protect people's rights. The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Care records confirmed that where people lacked capacity to make decisions, staff completed assessments using the recommended two-stage test. They consulted with family members and made decisions in the best interests of people. These included, for example, decisions relating to the administration of people's medicines and the use of bedrails. Where people had capacity to make decisions, there was no record to show they had agreed to receive the care and support that was offered; however, staff sought verbal consent from people and the registered manager was planning to introduce 'consent forms' for people to sign.

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 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 the provider was following the necessary requirements. DoLS applications were submitted where needed and one had been approved. Staff understood their responsibilities and knew how to keep people safe in the least restrictive way.

The care and dietary needs of people with diabetes were not always met. Staff told us five people controlled their diabetes through their diet, but said they all received a "normal diet". The MAR charts showed that two people's diabetes was further controlled through oral medicines. Staff told us the chef provided low sugar desserts for people with diabetes, but when we spoke with the chef, they said they were not aware of anyone with diabetes and did not make low sugar desserts. One person, who understood their diabetes well, said of the staff, "They bring me really sweet things sometimes that I can't eat; like meringues with chocolate on. I have to tell them to take it away and give me a yoghurt, but they don't even have yoghurts without sugar in them."

Staff conducted weekly checks of the blood sugar levels of each of the five people with diabetes. However, this had not been requested from doctors or specialist nurses and staff were not clear why they conducted the tests at this frequency or what action to take following the tests. This meant some people may have been subjected to unnecessary testing while others may not have had their blood sugar levels tested often enough. One person did not have a care plan detailing the support they needed with their diabetes and the care plan for another person did not contain sufficient information to enable staff to provide appropriate

support. For example, they did not specify an appropriate diet, the normal range of the person's blood sugar levels or the signs they might display if their blood sugar levels were too high or too low. Two staff members demonstrated a good understanding of these signs, but a third staff member lacked any knowledge of them, so may not have recognised when medical intervention or blood sugar testing was needed. We discussed these issues with the registered manager who undertook to seek advice from a specialist, to review the support provided to people with diabetes and the provision of appropriate diets.

The failure to ensure people's diabetes care needs were met in an appropriate and personalised way was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people's dietary needs were met and people praised the quality of the food. Since the last inspection, we saw the provider had installed a warming cabinet to keep food warm until it was served. One person said, "The food is better than it was last year, it was always cold, now it's better." A family member confirmed this and said, "The food is good; nice and warm". Another person told us, "The food is good, if you want more you just ask. You have a choice of two sets of meals." People were offered a varied choice of meals and told us they could ask for an alternative if they did not want anything from the daily menu. For example, one person said, "I can't eat pork so I always choose something else. You can ask for a cold meat salad or soup if you want to."

The care plans for people who did not have diabetes included appropriate information and specified their nutritional needs. These included people's food and drink preferences, allergies, specialist diets or medical conditions and were followed. For example, some people needed their food in a softer format or pureed and this was provided. At lunchtime, staff were attentive to people and supported them appropriately. They prompted people to eat, cut up their food where necessary and offered additional portions. One person needed additional support to eat. We saw the staff member sat alongside the person and gave them a spoon so they could try to eat the meal independently; they did not rush the person and encouraged them in a gentle and supportive way.

Jugs of squash and water were available throughout the home. We saw people's glasses being topped up regularly and people being encouraged to drink often. Hot drinks and snacks were also offered to people throughout the day. With the exception of one person, who could not be weighed, all other people had their weight monitored on a monthly basis to identify if they started to lose unplanned weight. Appropriate action was then taken, including closer monitoring of the person's intake, referral to their GP and the provision of calorific supplements.

With the exception of diabetes care, people and their relatives all felt staff had the necessary skills to support them to meet their needs. Comments from family members included: "The care is excellent here" and "Everyone looked after [my relative] really well when she was poorly; for example, they mashed up her food so she could cope with it."

Staff told us they had completed a wide range of training in the past year, including medicines administration, moving and handling, safeguarding adults, and the MCA. They were positive about the skills they had developed and demonstrated a good understanding how to apply the training in practice. For example, staff supported people to move using appropriate equipment and techniques and communicated effectively with people living with dementia. A staff member described how they supported a person to wash their hands when they were dirty; they said, "[The person] sat on their hands and was resistant to them being washed, so I offered them a pampering. When we got to the table, they happily put their hands out and let me clean and pamper them. It was important as they eat their food with their fingers." They added, "You have to have a positive approach; you have to smile a lot and be patient so you can engage them."

The registered manager monitored staff training to help ensure it remained up to date. Where training needed to be refreshed, we saw this had been done or was planned. Staff told us they could request additional training they felt would benefit people. For example, a member of staff had requested, and had been allocated, a course in end of life care and a senior staff member had been supported to attend a 'team leading course' to prepare them for their supervisory role. The registered manager also encouraged staff to obtain relevant vocational qualifications and most staff had been supported to do this.

New staff completed an appropriate induction programme before they were permitted to work unsupervised. Arrangements were also in place for staff who had not worked in care before to undertake training that met the requirements of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. It provides assurance that care workers have the skills, knowledge and behaviours to provide compassionate, safe, high quality care and support.

People were cared for by staff who were appropriately supported in their role. A staff member told us, "I have regular contact with [the registered manager]. They have been very understanding and supportive [in relation to a medical condition]." Another staff member said, "If you ask, [the managers] are there for you. They have time for you and we are listened to." All staff received one-to-one sessions of supervision, which were recorded. These provided an opportunity for senior staff to meet with members of staff, discuss their training needs, identify any concerns, and offer support. Senior staff used supervisions to reinforce the training. For example, we saw recent supervisions had focused on the MCA and the administration of people's medicines. The registered manager had not completed any yearly appraisals with staff, but told us they were planning to introduce these in the near future.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. They also had access to dental care and eyesight tests when needed. One person told us, "They got the doctor for me the other day as my eyes were sore. I got some eye drops." Another person said, "I had a problem last year with swollen legs. The home arranged for someone to see me and I was prescribed water tablets." A community nurse said of the staff, "They call us when needed, at an early stage if they need advice. They also follow our advice, for example with pressure area care."

Good

Is the service caring?

Our findings

People told us they were cared for with kindness and compassion. They described staff as "nice", "friendly" and "caring". Comments from people about the staff included: "They are excellent, they can't do enough for you"; "The carers are very special people. The compassion is there. They do their very best for you"; "They are always very patient with me. They're very gentle and take their time; and "They are all lovely; really kind". A person described the night staff as "good, nice and kind". They added, "I've asked for a cup of tea at night and they have brought one in for me." Family members shared these views. One told us, "[The staff] are very friendly. They're all helpful; We're thrilled to bits with them" and another said, "The carers always speak to [my relative] nicely." A community nurse who had regular contact with the home said of the staff, "They have a very good rapport with the residents and know them well."

We observed many positive interactions between people and staff. Staff used people's preferred names and approached them in a friendly and relaxed manner. When supporting people to move, staff gave clear instructions in a patient and supportive way and praised people for the effort they made. When people, for example those living with dementia, struggled to express themselves, staff observed the person's body language and facial expressions and were able to understand their needs from their knowledge of the person. Staff also spent time engaging with people at eye level and used touch, appropriately, to reassure people when they became upset.

Staff spoke about people warmly and demonstrated a detailed knowledge of them as individuals. For example, a staff member spoke enthusiastically about how they enjoyed celebrating people's birthdays by having birthday teas with a birthday cake and bunting in the lounge. Another staff member told us, "I treat them [people living at Kynance] like my mum and dad. It gives me a lot of satisfaction and I feel I am really achieving something for them."

Staff also described how they showed consideration for people's feelings. For example, a staff member said they took care to work closely with colleagues when supporting people to use the hoist. They said, "I like the person to feel as comfortable and confident as possible, so I make eye contact with my colleague and we work in coordination to make it as smooth and seamless as possible [for the person]." This was confirmed by a further staff member who told us, "We work as a team, which provides a lovely environment for [people]; they are treated with the utmost respect." A further staff member told us how they supported a person with personal care. They said, "[The person] really feels the cold, so we get the room nice and warm and make sure the bath is lovely and warm for her."

People were supported to maintain friendships and important relationships. Relatives told us they were encouraged to visit whenever they wished and at lunchtime people were supported to sit in small groups with people whose company they enjoyed. A staff member told us how they had supported a new person to meet other people already living at the home over lunch. They said, "They had a glass of sherry and some wine with their meal. We though they would get on and wanted to make it really special for them; they had a great time together." The person confirmed this when we spoke with them. They said, "I've made lots of friends and they [staff] introduce me to new people."

People told us their spiritual needs were met. A member of the local church team brought communion for one person regularly and people told us there was a "Sunday service" some weeks. Another person said, "There are people attached to the church who come in to see you if you want to talk to them."

People's privacy and dignity were protected. Staff took care to make sure toilet and bathroom doors were closed when they were in use and described practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and checking people were ready and willing to receive the proposed care and support.

Staff encouraged people to remain as independent as possible within their abilities and to do as much as possible for themselves. For example, they described how they let people attend to their own personal care when they could, but supported them by washing areas they were unable to reach. One person told us, "I can wash my own face and neck and they [staff] help with the rest." A staff member told us, "Most people can do [some of their own personal care] so I let them. If they miss a bit, I politely ask if they want me to help them, like with their backs. And when they need help to move, instead of grabbing them, I ask them to hold me so they feel as if they are in control." People's care plans also encouraged staff to promote people's independence. For example, one person's personal care routine detailed how they were to be encouraged to wash their own face and hands.

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Comments in care plans showed this process was on-going and family members told us they were kept up to date with any changes in the health of their relatives. Staff told us they also involved people whenever they reviewed their care plans and this was evident from changes that had been made.

Good

Is the service responsive?

Our findings

With the exception of a person with diabetes care needs, all other people told us they received personalised care from staff who understood and met their needs well. One person said, "I'm happy with the care here." A family member told us, "They [staff] are very good at care planning here."

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care. Care plans were then developed and reviewed on a monthly basis so staff had access to up to date guidance about how they should meet people's current needs. Since the last inspection, the provider had introduced a new format for people's care plans that were centred on the needs of each person. They detailed people's normal daily routines, their backgrounds, hobbies, interests and personal preferences; for example, they specified whether people preferred baths or showers and how often they liked them. They also indicated when people preferred to get up and go to bed.

Staff were clear that they were led by people's individual wishes and accommodated them wherever possible. They demonstrated a good awareness of the individual support needs of each person living at Kynance, including those living with dementia. They knew how each person preferred to receive care and support. For example, which people needed to be encouraged to drink; the support each person needed with their continence; and where people liked to spend their day. They knew how people wished to be supported to dress, including details such as which arm people preferred to put into jumpers and cardigans first due to limited movement in their joints. A staff member told us, "Everyone is different and everyone has their own preferences."

Staff recognised that some people's mobility varied from day to day and were able to assess and accommodate the level of support they needed at a particular time. For example, one person usually needed to use a stand aid to mobilise, but on the second day of the inspection was able to mobilise using a walking frame instead. A staff member told us, "If people need variable support, we go with how they are on that day. It helps them stay mobile and independent." One person was unsettled by people and noise, so was supported to spend time in a quiet area engaging with a doll they had been given to comfort them.

Records of the daily care provided confirmed that people had been supported in accordance with their identified needs. For example, one person needed catheter care and received this consistently. Catheters are devices used to drain a person's bladder through a flexible tube linked to an external bag. Staff monitored and recorded the output from the person's catheter to check it was working effectively, changed the bags regularly and sought advice from the community nurses when there were any changes or concerns. Another person was cared for in bed, having been frail for an extended period of time. They appeared comfortable; their records showed they had received all necessary care, including regular turns and appropriate support to eat, drink and wash.

People were empowered to make choices about every aspect of their lives, including when they got up and went to bed, where they took their meals and how and where they spent their day. For example, one person

preferred to stay in their room and staff supported them to meet this wish by providing all their meals and personal care there. The person told us, "I stay in my room, it's my choice." At lunchtime, people were offered serviettes or clothes protectors; some declined these and staff respected their decision. A staff member told us how they supported people with cognitive impairment to make choices. They said, "We don't just take over; we always give them choice. Like with getting up and dressing, to help them with choosing clothes we would offer one option at a time so as not to confuse them." Another staff member said, "We offer people baths and showers, but if they don't feel like it, we offer them a [body wash] and a foot soak instead. They always enjoy a foot soak."

People were provided with appropriate mental and physical stimulation through a varied range of activities. The home's activity coordinator was on a period of extended leave, so care staff spent time arranging activities for people on a group or individual basis. The provider had purchased some hand held computers, which they were waiting to be configured, for people to use to keep in touch with family members and to research topics of interest to them. One person had an adult's colouring book on their table and was encouraged by staff to complete some more. A family member told us about a Christmas party they had attended that people had enjoyed and another family member brought in their dogs for people to interact with. External performers provided musical entertainment and a volunteer ran a 'tuck shop' for people once a week and spent time engaging with them on a one to one basis.

The provider sought feedback from people and their families in a variety of ways. These included the use of questionnaire surveys and 'residents meetings' which were attended by people and their families. Feedback was used to improve the service; for example, minutes of a residents meeting indicated that people wished to have a cooked breakfast once a week and this had been provided. Following the re-decoration of the lounge, only one TV was re-installed, but people asked for a second TV, so this had been added.

People knew how to complain about the service but no complaints had been recorded for the previous year. People and family members felt the registered manager was approachable and that any concerns or complaints would be listened to and addressed effectively. A family member told us, "I'd certainly say if I wasn't happy about anything; I'd go to [the registered manager] or speak to anyone else if she wasn't here." Another family member said, "I'd go to the office if I had any concerns; they would sort it out."

Requires Improvement

Is the service well-led?

Our findings

Following inspections, CQC issue a quality rating, which providers are required to display conspicuously on the premises. The inspection rating from our previous inspection in February 2016 was not displayed at Kynance. We discussed this with the registered manager and by the end of the inspection the previous quality rating was displayed prominently on the home's notice board for people and visitors to see.

Providers are also required to act in an open and transparent way when unexpected accidents or incidents occur. A 'Duty of Candour' regulation requires them to provide an explanation and an apology, both verbally and in writing, to the person or their representative when such an incident occurs. Records showed that three people had incurred significant injuries in the previous year; the registered manager had provided the person or their representative with the necessary information verbally, but they had not followed this up in writing, as required. We viewed the provider's policy and found it did not reflect the requirements of the Duty of Candour regulation. We discussed this with the registered manager, who took steps to update the provider's policy to ensure the regulation was followed in future.

In other ways, the culture of the home was open and transparent. Communication between management and staff was relaxed and open. The registered manager had an open door policy and their office was located in the centre of the home, which made it easy for people and staff to pop in and discuss concerns. The provider notified CQC of all significant events; relatives could visit at any time and were made welcome.

People told us they were happy living at the home and had confidence in the management. One person said, "I would recommend the home to others."

There was an appropriate management structure in place. This comprised of the provider, the registered manager, two deputy managers and senior care staff. Each staff member had individual responsibilities and their work was overseen by the registered manager.

The registered manager monitored the quality and safety of the service through a limited range of audits. These had led to some improvements; for example, the infection control audit had identified the need for pedal bins in the bathrooms and these were being ordered; and a review of the dining arrangements had led to the building of a new dining area to enhance people's meal time experience. However, the registered manager had recognised that a more robust quality assurance system was needed and was working with a social care professional from the Clinical Commissioning Group (CCG) to develop one. Once in place and embedded in practice, this would help ensure compliance with the relevant regulations. They were also working on a business continuity plan to ensure the continuation of the service in an emergency situation; they had already identified nearby premises where people could be provided with immediate shelter if they had to leave the home at short notice.

Staff enjoyed working at the home, were motivated and spoke positively about the management. Comments from staff included, "[The registered manager] is very supportive and friendly. She is very caring and very approachable; so is [the deputy manager]" and "Anything to do with the residents, they [the

managers] fix it just like that."

Staff meetings were held to provide an opportunity for staff to express their views and receive updates about the service. They told us they felt listened to and their views valued. They gave examples of where they had made suggestions for improving the care and support given to people which had been adopted. For example, they had suggested that hand held computers would benefit people and these had been provided. A staff member told us. "I've been to [the registered manager] with a couple of ideas, for example getting a spouted beaker for one person and a non-slip mat for another. They got them and they work well."

Effective communication systems were in place to enable staff to share relevant information. Handover meetings between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. To support this, a 'handover book' was also used to pass important information between staff.

A director of the provider's company told us their vision was to provide a relaxed, homely environment for people. This vision was shared by all the staff we spoke with and people told us it had been achieved. A family member said, "At Christmas they try to make it as homely as possible." A senior staff member told us, "It's a lovely homely place. People and relatives are really happy here."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people's diabetes care needs were met in an appropriate and personalised way. Regulation 9(1) & 9(3)(a), (b) & (i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to mitigate all the risks to the health and safety of people using the service. Regulation 12(1) & 12(2)(b).