Mr C and Mrs LA Gopaul

Kenilworth Nursing Home

Inspection report

26-28 Kenilworth Road
Ealing
London
W5 3UH

Tel: 02085671414

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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

This comprehensive inspection took place on 21 and 22 May 2018 and was unannounced.

The last comprehensive inspection took place in May 2017. The service was rated requires improvement in the key questions is the service safe and well led? and overall. We found one breach of regulations relating to safe care and treatment for which we served a warning notice on the provider. This was because they did not always administer medicines as prescribed and staff medicines competency assessments were not recorded at the time of the inspection. We asked the provider to make the necessary improvements by 7 July 2017.

On 31 August 2017, we carried out a follow up inspection to check that improvements to meet legal requirements planned by the provider after our May 2017 inspection had been made. We inspected the service against two of the five questions we ask about services: is the service safe and well led? This is because the service was not meeting some legal requirements. No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. On 31 August 2017, we found the provider was meeting the regulation relating to safe care and treatment

However, at the inspection on 21 and 2 May 2018, we found the provider was again not fully meeting the regulations relating to safe care and treatment and good governance.

Kenilworth Nursing Home is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Kenilworth accommodates a maximum of 40 people. At the time of the inspection, 30 people were using the service. The maximum of 40 people is if people are sharing double rooms and the provider was actively moving people to single rooms as they became available.

The service is family run as a partnership and the registered manager is one of the partners. 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.

During the inspection we found medicines management was inconsistent and audits did not always identify discrepancies to help ensure people always received their medicines in a safe way.

The service had systems in place to monitor, manage and improve service delivery and to improve the care and support provided to people. However, these were not always effective. Record keeping was not always complete or contemporaneous, for example when monitoring people's weight, and medicines audits did

not always identify discrepancies.

Incident forms recorded the details of the incident and the resulting actions. Risk assessments were in place but the risk management plans did not always have enough detailed guidance which meant they did not always mitigate risks to people.

There were procedures for reporting and investigating allegations of abuse and whistle blowing. Staff we spoke with knew how to respond to safeguarding concerns. Safe recruitment procedures were followed to ensure staff were suitable to work with people. People told us they thought there was enough staff to meet their needs.

Staff we spoke with understood how to manage infections and wore appropriate protective equipment to reduce the risk of the spread of infection.

People's needs had been assessed prior to moving to the service and care plans included people's likes and dislikes. There were also records of end of life wishes and Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms where these had been completed.

Care workers had relevant training, supervision and annual appraisals to develop the necessary skills to support people using the service.

People's dietary and health needs had been assessed and recorded so any dietary or nutritional needs could be met.

The principles of the Mental Capacity Act (2005) were followed.

People were treated with dignity and respect and we observed care workers communicated with people with kindness, care and encouragement.

Care plans had information about people's likes and dislikes and included their cultural and religious needs.

People were involved in planning their care and care plans contained information to give staff guidelines to care for people in their preferred manner.

The provider had a complaints procedure and addressed any complaints appropriately.

People using the service and staff told us the registered manager was available and listened to them and took action where necessary to act on their suggestions or concerns.

The provider received feedback and shared information through monthly team meetings and completed annual surveys.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to the safe management of medicines and good governance. 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?

Requires Improvement

The service was not always safe.

Medicines management was inconsistent and audits did not always identify discrepancies to make sure people received their medicines safely.

People had risk assessments but the risk management plans were not detailed enough to provide clear guidance about how to minimise the risk of harm.

Safeguarding and whistle blowing policies were up to date. Staff followed these and knew how to respond to safeguarding concerns.

Safe recruitment procedures were followed to ensure staff were suitable to work with people using the service.

The provider had infection control procedures in place which were followed by staff.

Is the service effective?

Good

The service was effective.

The provider acted in accordance with the requirements of the Mental Capacity Act (2005) to promote people's rights.

People's needs were assessed prior to their move to the home which helped to ensure the provider only supported people whose needs they could meet.

Staff were supported to develop professionally through, training, supervision and appraisals.

People's dietary and health needs had been assessed and recorded.

Is the service caring?

Good

The service was caring.

People using the service said they were treated kindly and with respect.

Care plans identified people's needs and preferences and provided staff with guidelines to care for people in a way that met people's needs.

Care workers supported people to have choice around day to day decisions.

Is the service responsive?

Good

The service was responsive.

Care plans included people's preferences and guidance on how to support them. Reviews were held regularly.

The service had a complaints procedure and people knew how to make a complaint if they wished to.

People had their advanced wishes for end of life care recorded so staff were aware of these and were prepared to meet these if they developed.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had data management and audit systems in place to monitor the quality of the care provided. However, these were not always effective as they did not identify the concerns raised at the inspection.

People and staff were able to approach the registered manager to discuss any aspects of their work and felt supported.

People using the service and staff had the opportunity to provide feedback to improve service delivery.

Kenilworth Nursing 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.

The inspection took place on 21 and 22 May 2018 and was unannounced. The inspection was carried out by one inspector, a specialist nurse 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.

Prior to the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We contacted the local authority's safeguarding team to gather further information about their views of the service.

During the inspection we spoke with 15 people using the service, four relatives, seven care workers, one catering worker, two nurses, three healthcare professionals, the deputy manager and the registered manager. We viewed the care records of seven people using the service and seven care workers files that included recruitment, supervision and appraisal records. We looked at training records for all care workers. We also looked at medicines management for ten people who used the service and records relating to the management of the service including service checks and audits. After the inspection we spoke with a further three healthcare professionals.

Requires Improvement

Is the service safe?

Our findings

At the inspection on 3 and 4 May 2017 we found a breach of the regulation relating to safe care and treatment. This was because we found that the provider did not always ensure staff administered medicines as prescribed. The provider told us they assessed the competency of staff who administered medicines but this had not been recorded at the time of the observation. On 31 August 2017, we returned to the service to check the provider was meeting the regulation and found they were.

At the inspection on 21 and 22 May 2018 we found the provider was again not meeting the regulation for safe care and treatment in respect of medicines administration. We carried out a check of 15 boxed medicines for four people using the service and identified that the stock for six medicines were not correct against the projected balance. We saw one medicine that was not signed for and no exception code was recorded on the medicines administration records (MAR). Furthermore, the balances had not been carried forward from the previous 28 day cycle so we had to look at previous MARs which made it difficult to identify what the exact balance should have been due to poor recording. One of the medicines prescribed to be given when required (PRN) did not have a PRN protocol in place for the nursing staff to follow.

We did not see any evidence of consistent pain assessments in respect of pain relief for staff to monitor the effectiveness of pain relief medicines. There were some risk assessments in place, but these were not always appropriate to people's needs and the monthly reviews did not always include meaningful information.

Additionally, we observed part of the morning medicine round which was being carried out by two nurses. The trolley was positioned in the lounge/dining area. One nurse was putting the tablets into a medicine pot and handing it over to her colleague who then administered the medicines. We noticed that the nurse did not always looked at the MARs while administering and dishing medicines into the medicine pot. We pointed this out to one of the nurses, who stated they would review and reflect on this practice.

We saw that most risk management plans had guidance for staff on how to manage the risk. However, one person had a bedrails risk assessment in place that stated the person was at risk of climbing over the bedrail, but it did not explain why the bedrails were still considered in spite of the risk, or how the risk of climbing over the bedrails was to be managed. We discussed this with the registered manager who advised the person was at risk if they became agitated and at these times they had one to one support. This information needed to be included in the risk management plan.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we alerted the registered manager to the medicines discrepancies, they carried out an audit on all separately boxed medicines and informed us they would undertake this audit fortnightly and would also carry the balance forward on the MARs.

Most people we spoke with using the service told us they felt safe. Comments included, "The best place I've

been. I feel safe, they have the best staff", "I do yes, I don't know why. People are so friendly and caring" and "Very good, yes I belong to them, good."

There were systems in place to help safeguard people from abuse including safeguarding and whistle blowing procedures, and safeguarding adults training. Care workers we spoke with could identify the different types of abuse and knew how to respond appropriately. Comments included, "Approach my manager and the safeguarding officer from Ealing" and "Go to the line manager and then management and if I haven't seen any changes I would go to the council safeguarding team." One care worker also told us, "Whistle blowing is if you know or see your colleague doing something wrong, report it straight away and it's confidential."

We saw evidence that when a safeguarding concern was raised, the provider took appropriate action to investigate, document and respond to the concern. The report included 'lessons learnt' and the information was sent to the local authority and CQC as required.

For example, as a result of one safeguarding concern, we saw the provider learned from the situation and implemented an audit to check if the correct healthcare referrals were being made for people. Additionally, because of one person's hospital admission, they had introduced training the week before the inspection to ensure staff knew how to identify hydration and nutrition needs and concerns.

We saw people using the service had risk assessments and risk management plans in place to minimise the risk to them. Assessments included moving and handling, pressure ulcers, nutrition risks associated with falls and fire risks. Also as part of managing people's risks we saw hourly checks being completed during the day and night checks at frequencies that were dependant on the person's needs.

Incident forms recorded the details of the incident and the resulting actions. When there was an incident, staff rang the registered manager or deputy manager and they would always come to the home to provide support. The provider had an on-call system that someone within the management team was always on call day and night.

The provider had checks in place to ensure the environment was safe. These included a home environment risk assessment, fire risk assessments and data sheets for cleaning products. Fire drills were undertaken regularly and the last one was in 02 April 2018. Maintenance checks were also up to date, such as for lifts, hoists, fire equipment and gas safety. The health and safety audit checklist for April 2018 included an action request and checked the environment. The kitchen was clean and appropriately organised and had a 5 which meant a 'very good' food and hygiene rating.

People told us they thought there were enough staff to meet their needs and that call bells were generally responded to promptly. Comments included, "100% good staff", "Yes always enough staff", "Yes, weekends and night", "They come straight away and knock on the door [if I ring the call bell]", "They come straight away" and "Yes, they come after a while." A relative told us, "Can't say I've seen them too busy, they'll always spend time with [person]. They're very patient." We observed the provider had a suitable amount of staff to meet the needs of the people using the service and that the staff team was stable. The service did not use agency staff but had their own bank staff who were familiar with the needs of the people using the service.

Recruitment procedures were in place and being followed to ensure only suitable staff were employed. Application forms were completed and we saw evidence that gaps in employment had been explored and recorded. References were obtained including from the person's previous employment. We also saw identification documents with proof of permission to work in the UK if required, criminal record checks and

the verification of registered nurse qualifications where required.

The deputy manager told us staffing was based on people's needs. The provider used a number of tools including a dependency tool to indicate what level of staffing people required. The registered manager said the home always had two nurses and eight care workers all day and extra care workers came in to escort people in the community or to cover any staff absence. They found having a good staffing level helped to reduce people's falls as staff were available to monitor and offer prompt support if people needed it.

Medicines were stored appropriately in a medicines trolley that was locked and fixed to the wall. There was a lockable room, containing stocks of medicines not currently used in the trolley, the medicines fridge, controlled drug cabinet, topical medicines, dressings and food supplements. Medicines stored in original packaging were dated on opening. We noticed the temperature in the room was a bit high. The deputy manager responded immediately by bringing a portable air conditioning to the room and staff members were able to explain what they would do if any of the temperatures rose above the recommended safe levels.

Medicines were delivered weekly from the pharmacy and medicines left in the dosette boxes were collected by the pharmacy weekly. The service has a designated medical waste contractor and medical waste was stored and recorded appropriately.

The controlled drugs were stored in a locked cabinet and there was an appropriate controlled drug register. The weekly checks of the balances of controlled drugs were consistent.

There was a clear list of all the nurses' signatures at the front of the MAR folder. A sheet contained a clear up-to-date photograph that preceded each MAR chart. All people who were identified as having an allergy had this recorded at the front of the MAR to alert staff. There were medicine related policies and guidance on administering medicines in the MAR folder so staff could refer to these to ensure they were following correct procedures.

Infection control procedures were in place and being followed. There was an infection control policy and infection control cleaning schedule which included checks for hoists, weigh scales, wheelchairs, walkers, zimmer frames and turner stands. People had their own slings for use with moving and handling equipment, to negate any risk of cross-infection. We observed staff disposed of materials in a safe way and used personal protective equipment (PPE) such as disposable gloves and aprons.

Good

Is the service effective?

Our findings

During the inspection we found referrals being made to the GP when people were unwell and there was input from other health professionals in people's care plans. One health care professional said that while the staff were "well motivated and caring", they thought in some instances staff needed to respond more quickly to medical situations and considered this might require further training. The registered manager considered that this comment was around a specific incident which they believed they had responded appropriately to. Additionally, they had implemented training as a result of the incident.

People's needs were assessed prior to moving to the home. People using the service had been placed by local authorities or clinical commissioning groups (CCG) which also provided background information and assessments as part of the provider's assessment process to ensure the service could meet the needs of the people being referred to them. We also saw people's preferences and dislikes were recorded.

Care workers had completed relevant courses identified as mandatory by the provider which helped to provide staff with the skills and knowledge required to deliver effective care. This included infection control, moving and handling, safeguarding adults, first aid, fire safety, medicines and dementia awareness. Care workers files indicated they had completed an induction and were completing health and social care qualifications at levels 2 and 3 with the in house trainer. Care workers were supported to develop professionally through supervisions and appraisals. A relative who was also a healthcare professional said, "They do understand about dementia. The carers are very well trained in coping with difficult behaviour."

People using the service had mixed opinions about the quality of the food. They told us, "Everything is sandwiches only", "I enjoy my food, but no choice", "Yes [the food] is very good", "I like the food" and "It's the best food I have ever had here." A relative said, "The food is really very, very good. The kitchen is always spotless." During the day we saw drinks were available for people to help themselves and care workers offered drinks to those people unable to get their own drink. Lunch was eaten in the lounge and people each had a small table of their own to eat from. We observed people being shown a choice of food. The cook said they talked with the people using the service about the menus and care workers asked people what they would like to eat each day, but people could ask for meals outside of the main menu. The cook had a record of people's required diets such as diabetic, high cholesterol, fortified and low fat. This was reiterated by a care worker who said, "We talk to residents about what they want to eat. We need to know what kind of food they can have. It's on the chart in the kitchen." Managers carried out random spot check of meals with a summary, recommendations and action required to improve the quality of people's meal experience.

The service had daily handovers so care workers knew what had happened on the previous shift and what was required of them each day. Care workers said, "We observe [people using the service] every morning. We have handover and [the previous shift] mention what people want" and "We have very good teamwork. We have good communication and work well as a team." We saw evidence of input from other healthcare professionals including the dietician, mental health team, audiology, physiotherapy, speech and language therapist, dermatologist, optician, tissue viability nurse, podiatrist and palliative care nurse. Each person had an appointment record that was taken to appointments for either the professional or the care worker to

write notes on, so the outcome of the meeting was clear.

People's comments indicated they thought their health needs were addressed and they told us, "Never feel ill. They know what they're doing and how to look after me", "[Staff] just call the nurse or get me a doctor straight away. I saw an optician and they gave me glasses" and "I have tablets and injections. I ask staff questions." Healthcare professionals said, "They've been very helpful. Patient information is available in the file and staff are available to answer questions. Staff have been helpful in supporting changing recommendations", "Staff are good at facilitating visits" and "[One person's] physical health has significantly improved since the move over a year ago and they have maintained mental health stability including being supported with on-going hospital treatments and reviews. [Local authority] mental health clients who were discharged to Kenilworth Nursing Home have done significantly well and have not been readmitted for mental health deterioration."

Since the last inspection the home had two shared rooms remaining and a person in one of those rooms was in the process of moving to a single room. People using the service had rooms which were decorated to their tastes. The provider had an annual maintenance / décor plan which had been updated for 2018, It projected work for each room and work completed comments. There were a number of projects scheduled for June 2018 including developing the larger lounge as people using the service wanted to change the layout of the room, so instead of sitting side by side, people were facing each other to make it easier to talk with each other. The provider had built a new gazebo and had new garden furniture in the back garden.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Staff we spoke with understood the principles of the MCA in terms of people having choices. Comments included, "We check the care plan to know what is the best care. Talk to the family and [other professionals]. You ask the person what they want. If [person] can't make decision on their own you make a decision with somebody in their best interests.", "Depends on individual. Some people will have capacity so can ask them what kind of care they want. If assisting with personal care can ask what they want: a shower or bath and what they want to wear. Best interests is what is good for the patients to do or have. The manager and social worker who assesses them have best interests meetings and we see what is on their notes."

Three people were receiving covert medicines. Covert administration is the administration of medicines in a disguised format, for example in food and drink, without the knowledge or consent of the person receiving them. All three people had mental capacity assessments to determine their capacity to make a decision around their medicines. As they did not have capacity, best interests decisions were made with others including the GP.

For one person whose relative was signing care plans, we saw a lasting power of attorney, for health and welfare, which provided them with the legal right to sign on behalf of the person.

We saw DoLS applications were submitted in advance of the existing authorisations expiring, however there was a delay on the part of the local authority authorising new DoLS applications.

Good

Is the service caring?

Our findings

People were treated with kindness and care. One person using the service told us, "[Staff] are good" and a relative said, "They [staff] all have such care with each of the patients on many different levels." Healthcare professionals said, "When [person] ran up debt, Kenilworth didn't leave it and found creative ways to manage it so it didn't feel like their independence was being infringed upon" and "The staff are caring, and supportive and always promote a calm atmosphere for the clients."

Care workers were encouraging. For example, we saw one person request a cooked breakfast at 10.30am which the care worker organised. She then, in a kind manner, encouraged the person to have a shower after their breakfast. When they returned to the lounge an hour later, after having had a shower, the care worker greeted them and said how nice they looked which visibly made the person happy. In another example we saw a person struggling to drink. A care worker brought a chair to sit by the person and helped them with instructions and encouragement such as 'hold it in your left hand, lift it up, that's good'. However, we did hear one member of staff talking about a person's health condition in the lounge. We raised this with the registered manager to address. He said there had been training on privacy and confidentiality but he would arrange for further training and would also discuss the matter with the relevant staff.

We saw two people who spoke the same language sat next to each other and observed more than one care worker speaking with them in their first language. Care workers were cheery and patient. From the conversations we heard, they clearly knew about people's preferences and interests. Whenever the registered manager came into the lounge, he spoke with people and everyone responded positively.

Care plans had information about people's likes and dislikes and included information about how to meet their cultural and religious needs. During the inspection we noted that a church representative came into the home to give communion to some people of the Christian faith. Other people were supported to attend mosques, temples and churches, either with their family or with care workers according to their faith. One care worker told us how they respected a person's wishes to be greeted according to their culture and supported them with their spiritual needs. Other care workers told us about ensuing people's personal care and hygiene needs were in line with their faith beliefs and one care worker supported a person to attend lunch once a month at their cultural club. Another care worker explained, "I think the person-centred care here is very good. Like for birthdays everyone gets a party that suits their tastes. For example [one person] likes shopping and Caribbean food so on their birthday they went to the market to shop and went for a Caribbean lunch. In the evening they had a cake and there was reggae music. They enjoyed it a lot."

People were treated with dignity and respect, particularly with personal care. People we spoke with said staff supported them to get washed if they needed support and care workers told us, "Personal care is important so they feel comfortable and get the right care they require. Speak to them. See what they want. It's a choice", "You give them the chance to make their own choice. They have plenty of time to do things in their own way" and "We never force anyone. We always offer. A lot of the time people refuse a wash the first time but it's about how you persuade them. Some don't want a wash in the morning but by lunchtime do."

The staff welcomed relatives when they visited and supported them to maintain contact with their family members. One relative said, "When I come in I am always offered a cup of tea or coffee. They always greet people very nicely."

Good

Is the service responsive?

Our findings

Where possible people were involved in developing their care plans. Not everybody was aware they had a care plan but those who were generally said they were consulted. Comments included, "Yes, I do have a care plan", "Yes, I'm involved" and "They ask me if they make changes." Healthcare professionals said, "The service provision is in line with service users' care plans" and "They have provided services as agreed in care plans."

We saw initial assessments and information from other organisations such as the local authority or CCG. Care plans identified people's needs, recorded how to achieve aims and who else might need to be involved, for example, a dietician. Care plans contained people's preferences such as a male or female carer, meal preferences and morning and evening routines. In addition, daily observation charts regarding personal care and daily logs were completed by staff. These were mainly task orientated but indicated people were receiving support in line with their care plans.

The service had an activity co-ordinator. Comments about activity provision from people included, "We play games - all sorts", "Music, bongo drums. We had party for the royal wedding" and "Picture cutting, partly for the royal wedding." Several people said they did not take part in activities in the home and we saw that some people attended activities outside the home. During the inspection we saw cake decorating, chair exercises and manicures in the home. We were aware of one person being supported to go to Kew Gardens and another went to a day service. A healthcare professional told us, "[The service is] really helpful with getting [person] to appointments. Really adaptive and are flexible about encouraging them to go out. It is one of the reasons the court agreed they should stay here."

The service had a complaints procedure included in people's service user guide that indicated who to contact including the local authority and CQC. We saw complaints were addressed appropriately. People we spoke with mostly knew how to make a complaint and their comments included, "I don't have anything to complain about" and "Everything is ok." Relatives comments about the home included, "It's the perfect place for [my relative] because it's a home", "It's been pretty excellent. Anything we've asked for they've done" and "If I had a complaint I would go straight to the manger or the deputy."

Files contained evidence of end of life discussions with people and their families. Do not attempt cardiopulmonary resuscitation (DNACPRs) forms were in place as appropriate or confirmation people wanted to be resuscitated. However, one person's DNACPR was issued by the hospital in April 2018 and was placed at the back of the person's file which meant it was not immediately visible to staff in an emergency. The deputy manager said they would transfer this to the home's own DNACPR records.

Requires Improvement

Is the service well-led?

Our findings

During the inspection we found that although there were systems in place for assessing, monitoring and improving the quality of the service, these were not always effective. For example, a medicine audit was completed monthly but did not pick up the issues identified during the inspection. As a result of the discrepancies we found, the registered manager completed an audit of everyone's medicines on the first day of the inspection and the action plan from that was to 'implement stock control audit and balancing.'

The provider's quality assurance systems had not identified that staff were not appropriately monitoring people's conditions. In a few cases we saw that staff were not maintaining adequate records when monitoring people's conditions to ensure their day to day health and wellbeing needs were being met. Records maintained by the provider did not support them to demonstrate that referrals to healthcare professionals were being made in a timely manner. We saw that one person had a care plan for a pressure ulcer and the dressing was changed regularly according to the regime as recommended by the tissue viability nurse. However, the repositioning chart was inconsistent, had gaps and stated ranges of times rather than the actual time of repositioning. We could therefore not be assured that people were being repositioned appropriately to prevent pressure ulcers from developing. The care plan also stated that the person's blood pressure should be checked weekly, however this was not completed consistently to demonstrate their health was being adequately monitored.

Furthermore, in one person's file, weights were recorded only twice in April and once in May 2018 despite the fact the person had lost weight and their health had deteriorated significantly. We saw a further two files where people's weight was recorded in an inconsistent manner which meant their condition was not being adequately monitored. For example, one person's nutrition care plan said they should be weighed monthly and referred to the dietician if required. We saw evidenced of a referral but not of up to date weight records. A second person's nutrition care plan recorded they were overweight and the aim was to reduce their weight but there were no records of weight to monitor this. Changes in people's weight can indicate other problems with their health and without the correct records and information about people's weight, the provider was not able to effectively monitor and demonstrate that plans to meet people's individual needs were being met.

We also saw that data management systems did not always identify if the risk management plan was robust enough to mitigate the identified risk. For example, the risks to the person who might climb over the bed rails that were in place, were not adequately identified, assessed, mitigated and addressed in the risk assessment. This meant the provider could not ensure a consistent quality of care to protect people from the risk of unsafe care and treatment.

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

The culture of the service promoted open communication. The registered manager was visible to people using the service and we observed a positive and genial rapport between himself, people using the service

and staff. When we asked people if the registered manager was available to them they told us, "[The registered manager] is brilliant. I wish every place was run like this", "He is lovely" and "He is okay." A relative said, "[Registered manager] is very much a hands-on manager. He is always available and approachable and helpful."

Staff also found the registered manager approachable and told us, "[The registered manager] is helpful whenever you need him. He does his best. Any concerns he gets involved. Whenever we need support he is there to support that individual" and "Everyone is like a team and no one is above anyone. Everyone's opinion is treated the same."

The provider had a number of data management systems in place to monitor service delivery. Audits included complaints, falls, best interest decisions and mental capacity assessments, staff files including criminal record checks and a health safety audit checklist that included the environment and health and safety training. A 'key challenges' audit form was completed in May 2018 and included challenges faced by the service such as people sharing bedrooms. We saw an action plan for moving people to single rooms and evidence this process had begun and was ongoing. The provider also had a training data base so they could monitor staff training and ensure it was up to date. In addition, the provider had an annual maintenance / décor plan for 2018 to improve the home's environment in a way that met the needs of people using the service.

The provider received feedback from staff and shared information through monthly team meetings. Topics included activities, menu and dietary needs, fire safety and training. The provider also held meetings for people using the service and one person confirmed, "We have regular [residents'] meetings every month." They also undertook a service user satisfaction survey in April 2018. 21 out of 25 people responded and overall the feedback was positive. A staff survey was completed at the same time. Both surveys had summaries and action plans to help improve service delivery.

The registered manager informed the Care Quality Commission of notifiable incidents as required. The registered manager and deputy manager kept up to date with good practice through reading social care publications and received emails from the local authority and Skills for Care with updated guidance. They attended the local authority's provider forums and the deputy manager was undertaking a year long 'Home Life' manager's course.

We saw evidence the provider worked with a number of other professionals including the dietician, mental health team, audiologist, physiotherapist, optician, tissue viability nurse and podiatrist. Health care professionals told us that Kenilworth Nursing Home worked collaboratively with local agencies and gave the example of how they worked together to help meet the needs of a new person being admitted to the home. Comments included, "Kenilworth is responsive to recommendations made about clients' care" and "I have found the staff and management always easy, willing and helpful to work with, in achieving positive outcomes for clients."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risks to the health and safety of the service users and do all that is practical to mitigate any such risks. Medicines were not managed in a safe and proper manner. Regulation 12(2) (a) (b) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure systems were operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Nor did they maintain accurate, complete and contemporaneous records in respect of each service user to protect them against the risks of unsafe care and treatment that can arise as a result of poor records keeping. Regulation 17(2) (a) (b) (c)