Life Style Care (2011) plc

Knights Court Nursing Home

Inspection report

105-109 High Street
Edgware
HA8 7DB
Tel: 0208 381 3030
Website: www.lifestylecare.co.uk

Date of inspection visit: 14 July 2014
Date of publication: 11/03/2015

Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

We inspected Knights Court Nursing Home on 14 July 2014. This was an unannounced inspection.

We carried out two inspections during 2013 when we found concerns that required actions. The service met the regulations we inspected against at their last inspection on 2 January 2014.

Knights Court Nursing Home provides accommodation and nursing care for up to 80 older people, some of whom may also have dementia. There were 52 people living at the home when we visited. The reason for the low number of people using the service was that the local authority placed an embargo on admissions between April and October 2013 following several serious concerns. The registered manager was appointed in July

Summary of findings

2013 and registered in March 2014. She ensured that new admissions since October 2013 had been actioned slowly so that there was no risk of further concerns. 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 requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Further concerns about staffing issues were raised anonymously in June 2014. We checked on the issues during this inspection and did not find any evidence to corroborate these concerns.

Staff we spoke with during our visit told us that there had been "great improvements" since the registered manager was appointed. One staff member said, "She is a superb manager, very supportive." A relative said, "Things have really improved over the last three to four months. The staff have got to know [my relative's] ways much better and they are now able to communicate with them." The registered manager made changes in the management structure and responsibilities, and appointed new staff and nurses so that there was an improved level of staffing on all units. The registered manager was aware that there were still challenges to address in order for the service to be able to provide a consistently good level of care. They ensured a gradual increase in new admissions to ensure that staff were able to meet all their needs. The provision of responsive dementia care was not consistent throughout the home, and the provider was making some changes to the environment to address this.

People told us that there were always staff available to help them when needed. Relatives of people who used the service told us that they visited the home at different times and on different days, and the staff always made them feel welcome. They said that staff were caring and treated people with respect, and that their relative was always comfortable and looked well cared for. One relative said, "I would recommend this home." Another relative said "I wish I could move [another relative] into this home; I would be very happy if [this relative] was here."

The service was meeting the requirements of the Deprivation of Liberty safeguards (DOLS). The registered manager and staff understood when an application for a DoLS authorisation should be made and how to submit one. The registered manager was aware of the 2014 High Court judgements which widened the scope of the legislation.

Staff told us that they had regular training that provided them with the skills to understand and meet the needs of people who used the service. A new member of staff said they had been given training as part of the induction so that they were able to respond to people's care needs.

Staff were aware of people's rights to be involved in decisions and to make choices about their care and treatment. Care plans showed these preferences. People who used the service and their relatives told us that they had agreed their care plans and they were able to make their views known.

Staff treated people with dignity and respect and supported them in a caring way. Three members of staff were 'Dignity Champions 'with additional training and responsibility for encouraging other staff to respect people's dignity.

Care plans for people with dementia provided information on how each person communicated and the best way for staff to support them with their specific needs. All staff completed training in understanding dementia. Our observations in the dementia units showed that people were mostly alert and interested in their surroundings. Staff engaged people in conversation and talked with them while assisting them. However provision of dementia care was not consistent in the two units, due to differences in the environment. In one unit the lounge was divided and chairs arranged in small social groups to encourage socialising and conversation. In the other unit chairs were arranged around the outside of the lounge and people only engaged in conversation when staff spoke to them.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People who used the service and their relatives told us that the home provided a safe environment. Staff were aware of different forms of abuse, and of their responsibilities for reporting any concerns. There were sufficient numbers of staff to keep people safe and meet their needs.

Where people were not able to make decisions about their care their relatives and appropriate health professionals made decisions for them in their best interests as required by the Mental capacity act 2005. Applications for Deprivation of Liberty safeguards (DOLS) authorisations had been made for people who were assessed as requiring a restriction on their activities in order to maintain their safety.

Is the service effective?

Good

The service was effective. Care plans provided information for staff on each person's individual needs and staff received training to enable them to understand and meet the assessed needs.

People were provided with a choice of nutritious food and drink. Staff were aware of how to monitor people for risk of malnutrition and took actions when required to address these risks.

Staff understood and addressed people's healthcare needs and people had access to appropriate healthcare services.

Is the service caring?

Good

The service was caring. People told us that staff were caring and treated them with respect. Three members of staff were dignity champions and promoted good practice in treating people with respect for their dignity and privacy.

People were able to express their views and to be actively involved in making decisions about their care, treatment and support.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. Provision of dementia care was not consistent throughout the service, due to differences in the environment. Staff did not consistently support and enable people to take part in individual activities of their choice.

Assessments of people's needs were carried out before they were admitted to the service, and regularly reviewed. Care plans were updated with any changes and provided information for staff to meet people's needs.

People were aware of the provider's complaints policy and were able to raise any concerns. Complaints were responded to appropriately.

Summary of findings

Is the service well-led?

Good

The service was well-led. Staff, people who used the service and their relatives said that the service had improved since the registered manager was appointed.

There were regular meetings for staff and for people who used the service and their relatives. A relative told us that the meetings were open and they were able to discuss any concerns that they had in a supportive atmosphere.

The provider's area manager carried out monthly audits of procedures and records at the service. Actions required from the audits had been addressed.

Knights Court Nursing Home

Detailed findings

Background to this inspection

We carried out an unannounced inspection of Knights Court Nursing Home on 14 July 2014. The inspection team consisted of an inspector, a specialist nursing advisor and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience for this inspection had experience of caring for a person who lived in a nursing home.

We spoke with eight people living at the service and three visiting relatives. We observed people in the two dementia units using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We spoke with six care workers, an activities coordinator, four nurses, the clinical lead nurse and the registered manager. We also looked around the home and saw the way staff interacted with people. We looked at six people's care plans as well as a range of records about people's care and how the service was managed.

Before we visited the home we checked the information we held about the service, including notifications of significant events that the provider had sent to us. No concerns had been raised and the service met the regulations we inspected against at their last inspection on 2 January 2014. 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.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this service were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is this service safe' sections of this report.

Good

Is the service safe?

Our findings

People told us that there were always staff available to help them when needed. Relatives we spoke with said that they never had a problem finding staff when they visited. One relative said, "Staff are always with [my relative] when I am not there. They always have time to sit and chat with them." Another person said, "Staff are always there for [my relative] and they communicate with them better than I can."

The registered manager told us that she carried out an assessment of staffing needs every month, and she was able to increase staffing levels according to the level of people's needs. Following the latest assessment additional staff were allocated to two units during the mornings. Staffing rosters showed that there was one registered nurse and two care workers allocated to each of the units for people with dementia, and one registered nurse and three care workers allocated to the units for people with high nursing needs. We observed sufficient staff in each unit to meet people's needs during our visit. Staff told us that they were able to meet people's care needs and to have time to talk to individuals and spend time with them. We observed staff assisting people when they needed attention, and sitting with individuals to talk with them and give them attention.

People told us that they felt safe and secure at the service. Staff told us that they had attended training on safeguarding adults and the training records confirmed this. Staff were aware of the signs of different types of possible abuse and the actions they should take to report any concerns. The provider had procedures for safeguarding that complied with the London multi-agency policy and procedure to safeguard adults from abuse. The registered manager had taken appropriate action in reporting safeguarding concerns to the local safeguarding authority, and working with them on investigating the concerns.

Staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) Code of Practice and how to make sure that people who did not have the capacity to make decisions for themselves had their legal rights protected. We noted that mental capacity assessments were carried out when required and decisions made in the person's best interests. For example we saw capacity assessments for two people which showed that they were not able to make decisions about their medicines, and their relatives and the GP were involved in making a decision in their best interests about the medicines they needed. Another person had a capacity assessment that showed that they were not able to make a decision about receiving cardiopulmonary resuscitation (CPR) in an emergency. The best interest decision made by their family members was that they should have CPR if it was needed.

CQC is required by law to monitor the operation of the MCA Deprivation of Liberty Safeguards (DoLS) for care homes, and to report on what we find. Where there is a deprivation of a person's liberty DoLS requires the provider of the care home to submit an application to a 'Supervisory Body' for authority to do so. The provider notified us that they had made appropriate applications for DOLS authorisations and we saw evidence of this when we visited the service. The registered manager was aware of the 2014 High Court judgements which widened the scope of the legislation.

Individual risk assessments were completed for people who used the service, and provided guidance for staff on how to manage the risks and ensure that people were safe. We saw risk assessments for each person for skin integrity, nutrition, moving and handling and falls, which provided guidance to manage individual risks. For example, the falls risk assessment for one person showed that the risk was mostly at night. A mattress was placed by the person's bed to prevent injury if they fell, and staff made hourly checks of their safety throughout the night. Another person walked around during the day, and the risk assessment provided guidance for staff to encourage them to sit and rest regularly in order to prevent fatigue which could lead to a fall.

There were effective systems in place to reduce the risk and spread of infection. The home was clean in all the areas that we visited. Staff had training on infection control. The provider's procedures followed the guidance in the Department of Health guide, "Prevention and Control of Infection in Care Homes. Staff told us about the procedures that they followed, including the use of colour coded cloths and mops for different areas of the home. Each bedroom had facilities for staff to wash their hands using liquid soap and paper towels to ensure effective prevention of the risks of infection. The procedures for handling laundry ensured that the risks of infection were minimised.

Good

Is the service effective?

Our findings

People told us that staff had the training to meet their specific needs. One person said, "The staff are helpful and know what I need." Relatives told us that there had been an improvement in the understanding of the staff over the last few months. One person said, "Things have really improved over the last three to four months. The staff have got to know [my relative's] ways much better and they are now able to communicate with them." Another relative said, "Staff can understand and communicate with [my relative] better than I can. My relative really responds to the staff who talk to them."

Staff told us that they had regular training that provided them with the skills to understand and meet the needs of people who used the service. A new member of staff said they had been given training as part of the induction so that they were able to respond to people's care needs. Training records showed that 72% of staff had attended the annual training in the first six months of 2014. There was a rolling programme of training to ensure that all staff attended by the end of the year. The regular training programme included safeguarding, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, health and safety and infection control, nutrition and food hygiene, dignity in care, mental health and dementia awareness, moving and handling and medication.

A nurse said that the training was frequent and relevant to their work and to the needs of the people they cared for. We spoke with the newly appointed practice development coordinator. She provided training for staff on nursing and care issues through working with them and assessing their capabilities.

Staff told us that they had regular one to one meetings with their line manager for supervision of their work and discussion of any training needs. There were also monthly staff meetings on each unit where information was given to staff and they could raise any questions or concerns. All the staff we spoke with felt that they were supported in their work, and they were able to discuss any concerns with managers of the service. One person said, "I enjoy my work and the manager is very supportive."

People were provided with a choice of suitable and nutritious food and drink. Menus were provided in large print and with pictures to enable people to understand what was offered and to make their choices. Water and juice were available on all tables at lunch time and we observed staff offering a choice of hot and cold drinks during the morning and afternoon. At lunchtime staff addressed people by name and reminded them of their meal choices. They offered help with cutting up food or with eating and they encouraged people to drink during the meal. We observed a staff member assisting one person who was unable to eat and drink independently. The staff member talked to the person, held their hand gently and listened to them while assisting them to eat. When the person became agitated the staff member stopped offering them food, spoke to them until they settled down and then resumed assisting them to eat.

Two people told us they had made comments about aspects of their meal choices that were addressed. Four relatives were complimentary about the food provided for their family members. One relative told us, "The food is good. Staff know what [my relative's] favourite foods are." Another relative said, "[My relative] likes soft food, and can have fish instead of meat as it is easier for them to eat."

Appropriate food was available for specific dietary needs, such as diabetic or gluten free diets. The chef told us that these were recorded on the daily meal choice sheets so that staff knew each person's specific needs and wishes. Halal meat was ordered and cooked separately if required to meet a person's cultural requirements, and vegetarian or fish dishes were offered for people who did not wish to eat meat.

Everyone was assessed regularly for the risk of malnutrition. Malnutrition Universal Screening Tool (MUST) assessments were carried out each month or more frequently if required, and people at risk of malnutrition were referred to a dietician for advice. The registered manager told us that 19 of the 52 people who used the service were assessed to be at risk of malnutrition, and measures were in place including food supplements and enriched diets to improve their nutrition. The MUST assessments showed any changes in the person's nutritional risk. For example, we saw records for one person that showed that they had steadily put on weight over the previous 12 months, and the risk of malnutrition had decreased from high to medium.

Care plans provided information on each person's health care needs, with regular monitoring of mental health and skin integrity. Nurses told us that they were treating three

Good

Is the service effective?

people for pressure ulcers at the time of this inspection. The NHS tissue viability nurse visited the service to assess concerns over skin integrity and advise on treatment. Monitoring included the use of body charts and photographs of any wounds. Records showed improvement for two of the three people receiving treatment. The provider was able to supply pressure relieving mattresses when required for managing the risk of pressure ulcers. Nurses told us that any other equipment that was required was provided very quickly.

All staff completed training in understanding dementia. Our SOFI observations in the dementia units showed that people were mostly alert and interested in their surroundings. Staff engaged people in conversation. Care plans for people with dementia provided information on how each person communicated and the best way for staff to support them with their specific needs. For example, one person's care plan stated that to address their anxiety staff must constantly explain what they were doing and reassure the person. We observed the staff acting calmly with this person and reassuring them.

Good

Is the service caring?

Our findings

People told us that staff had the training to meet their specific needs. One person said, "The staff are helpful and know what I need." Relatives told us that there had been an improvement in the understanding of the staff over the last few months. One person said, "Things have really improved over the last three to four months. The staff have got to know [my relative's] ways much better and they are now able to communicate with them." Another relative said, "Staff can understand and communicate with [my relative] better than I can. My relative really responds to the staff who talk to them."

Staff told us that they had regular training that provided them with the skills to understand and meet the needs of people who used the service. A new member of staff said they had been given training as part of the induction so that they were able to respond to people's care needs. Training records showed that 72% of staff had attended the annual training in the first six months of 2014. There was a rolling programme of training to ensure that all staff attended by the end of the year. The regular training programme included safeguarding, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, health and safety and infection control, nutrition and food hygiene, dignity in care, mental health and dementia awareness, moving and handling and medication.

A nurse said that the training was frequent and relevant to their work and to the needs of the people they cared for. We spoke with the newly appointed practice development coordinator. She provided training for staff on nursing and care issues through working with them and assessing their capabilities.

Staff told us that they had regular one to one meetings with their line manager for supervision of their work and discussion of any training needs. There were also monthly staff meetings on each unit where information was given to staff and they could raise any questions or concerns. All the staff we spoke with felt that they were supported in their work, and they were able to discuss any concerns with managers of the service. One person said, "I enjoy my work and the manager is very supportive."

People were provided with a choice of suitable and nutritious food and drink. Menus were provided in large print and with pictures to enable people to understand what was offered and to make their choices. Water and juice were available on all tables at lunch time and we observed staff offering a choice of hot and cold drinks during the morning and afternoon. At lunchtime staff addressed people by name and reminded them of their meal choices. They offered help with cutting up food or with eating and they encouraged people to drink during the meal. We observed a staff member assisting one person who was unable to eat and drink independently. The staff member talked to the person, held their hand gently and listened to them while assisting them to eat. When the person became agitated the staff member stopped offering them food, spoke to them until they settled down and then resumed assisting them to eat.

Two people told us they had made comments about aspects of their meal choices that were addressed. Four relatives were complimentary about the food provided for their family members. One relative told us, "The food is good. Staff know what [my relative's] favourite foods are." Another relative said, "[My relative] likes soft food, and can have fish instead of meat as it is easier for them to eat."

Appropriate food was available for specific dietary needs, such as diabetic or gluten free diets. The chef told us that these were recorded on the daily meal choice sheets so that staff knew each person's specific needs and wishes. Halal meat was ordered and cooked separately if required to meet a person's cultural requirements, and vegetarian or fish dishes were offered for people who did not wish to eat meat.

Everyone was assessed regularly for the risk of malnutrition. Malnutrition Universal Screening Tool (MUST) assessments were carried out each month or more frequently if required, and people at risk of malnutrition were referred to a dietician for advice. The registered manager told us that 19 of the 52 people who used the service were assessed to be at risk of malnutrition, and measures were in place including food supplements and enriched diets to improve their nutrition. The MUST assessments showed any changes in the person's nutritional risk. For example, we saw records for one person that showed that they had steadily put on weight over the previous 12 months, and the risk of malnutrition had decreased from high to medium.

Care plans provided information on each person's health care needs, with regular monitoring of mental health and skin integrity. Nurses told us that they were treating three

Good

Is the service caring?

people for pressure ulcers at the time of this inspection. The NHS tissue viability nurse visited the service to assess concerns over skin integrity and advise on treatment. Monitoring included the use of body charts and photographs of any wounds. Records showed improvement for two of the three people receiving treatment. The provider was able to supply pressure relieving mattresses when required for managing the risk of pressure ulcers. Nurses told us that any other equipment that was required was provided very quickly.

All staff completed training in understanding dementia. Our SOFI observations in the dementia units showed that people were mostly alert and interested in their surroundings. Staff engaged people in conversation. Care plans for people with dementia provided information on how each person communicated and the best way for staff to support them with their specific needs. For example, one person's care plan stated that to address their anxiety staff must constantly explain what they were doing and reassure the person. We observed the staff acting calmly with this person and reassuring them.

Requires Improvement

Is the service responsive?

Our findings

One person we spoke with said that the staff were caring and knowledgeable about their needs. They said that they and their relatives were involved in writing and reviewing their care plan. The person said that they were able to make their views known, and they had requested internet access to Skype so that they could communicate with family members. This had been agreed, and the provider had arranged to install an internet access for the person to use. Another person told us that staff responded appropriately to any requests or concerns. They said, "The staff are helpful and know what I need." A relative told us that their relative did not speak English, and staff had pictures to aid communication, and some useful words in the person's language on their bedroom wall. Another person told us that they chose to spend most of their time in bed, and their care plan reflected this choice. The care plan made provision for staff to assist the person to sit in a chair for a short time each day and to change their position regularly while they were in bed in order to avoid the risk of pressure ulcers. Relatives of this person said that the care they received was "excellent". They were involved in reviews of the person's care and staff kept them informed about any changes in the person's needs.

We looked at the care plans for six people. Assessments of people's needs were carried out before they were admitted to the service, and regularly reviewed. Staff told us that they updated monthly each person's assessments of dependency, skin integrity, weight, diet and personal care. We saw evidence of these reviews in the care plans, and noted that care plans were updated with any changes. For example monthly evaluations of the care plan for one person to address their assessed risk of falls showed that their mobility had deteriorated and the person now required two staff to assist them with transfers to and from their bed and chair.

Daily programmes of social activities were displayed in each unit. Some activities took place in the units, and some were for everyone to take part in. During our visit we observed the activities coordinator playing a ball game with people in one lounge, and supporting them with flower arranging. During the afternoon people from all units met to have tea and cakes in the garden. This was a very social occasion, and people enjoyed talking with each other and discussing activities they had enjoyed throughout their lives.

However staff did not consistently support and enable people to take part in individual; activities of their choice. In the dementia units we observed staff sitting and talking with people who were not able to or did not wish to take part in group activities. However a person in another unit told us that they chose not to join in any social activities or entertainments, but they could not recall any staff approaching them to ask what they would like to do and assisting them with that activity.

Staff had sufficient support and information about dementia care to respond appropriately to the needs of people in the two dementia units. However provision of dementia care was not consistent in the two units, due to differences in the environment. In one dementia unit we observed that it was difficult for people to communicate with each other. Chairs were arranged around the outside of the lounge rather than in smaller groups where people could sit in a more social arrangement. There was nothing available for people to take an interest in, such as familiar items to pick up and examine or use and magazines or books to look at. Staff engaged people in conversation, but people did not communicate with each other. In the second dementia unit the large lounge had been divided into a dining area and two smaller lounges. Chairs were arranged in small social groups to enable people to communicate with each other. There were magazines available for people to look at, a rummage box with items of interest to pick up and examine, and soft toys on a chair. There was a 'tranquillity corner' at the end of one corridor, with a woodland scene painted on the wall and displays of flowers, fabrics and other sensory objects for people to look at and feel and recognise.

People and their relatives told us that they were aware of the provider's complaints procedure and they felt able to raise any questions or concerns they may have. The complaints record showed complaints about the lack of care, communication and an incorrect invoice. The records showed that all complaints were investigated and responded to, and all were recorded as resolved. One person said that they had raised concerns and the staff had responded appropriately and to their satisfaction.

Good

Is the service well-led?

Our findings

Two people contacted CQC, in March and June 2014, to raise concerns about the management of the service Both said that staff numbers were low, and criticised the management of the home. The concern raised in March 2014 was investigated by the local safeguarding authority, which found that the concerns were unsubstantiated. We checked on the issues raised in June 2014 during this inspection and did not find any evidence to corroborate these concerns.

The registered manager was appointed in July 2013 and registered in March 2014. She had made changes in the management structure and responsibilities, and appointed new staff and nurses so that there was an improved level of staffing on all units. The provider told us that 15 staff had left in the previous 12 months, and 20 staff had been appointed. The current staff team were trained and supported to meet the provider's expectations for good practice in providing care.

The registered manager knew the names of all staff and people using the service and we saw that staff were relaxed in her presence. Responsibilities such as clinical oversight and staff supervision were delegated to other members of the management team, and the manager monitored the daily practices in the home by talking with all levels of staff and checking that records and audits were completed accurately and acted on. Staff we spoke with during our visit told us that there had been "great improvements" since the registered manager was appointed. There was more support and training for staff and several members of staff said that staff morale had improved they enjoyed working at the service. One staff member said, "She is a superb manager, very supportive." Staff, people who used the service and their relatives said that the registered manager was "hands on" and they would feel confident in raising any concerns with her. We saw that the registered manager spent time in all the units of the home and assisted staff, for example to help a person to move from their chair.

There were regular meetings for staff and for people who used the service and their relatives. A relative told us that the meetings were open and they were able to discuss any concerns that they had in a supportive atmosphere. Staff said that staff meetings provided them with updates of information and any concerns they had, such as staffing levels, were listened to and acted on.

The provider's area manager carried out monthly audits of procedures and records at the service. The outcomes of the audits showed that the provider recognised the improvements in the service since the registered manager was appointed. The most recent audits showed that full marks had been achieved in all areas. The results of the audits were recorded on the provider's risk register, with an annual action plan for the improvements that were needed. The risk register for 2013 to 2014 showed that actions were needed on care records, staff issues, promotion of dignity and rushed meals. The most recent audits, and our observations during this inspection, showed that these had all been addressed. The registered manager told us that further changes were planned to provide an improved environment in the dementia units.