

Windy Knowe Limited

Windy Knowe Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

This inspection was carried out on 06 and 07 November 2018 and was unannounced. Windy Knowe Nursing Home is a large detached three-storey house with a large back garden and is situated in Oxtan, Birkenhead, Wirral. The home is registered to provide nursing care for up to 49 older people and at the time of our visit the service was providing support for 35 people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

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

Following the last inspection, we asked the provider to complete an action plan to show how and when they would make improvements to the décor of the home, increase washing facilities, and ensure regular checks where completed on door guards. These actions have been completed.

Although there have been improvements made in the service, we found there will still improvements required to the key questions, 'safe' and 'well-led'. This is the second consecutive time the service has been rated 'Requires Improvement'.

The service ensured people had an assessment before moving into the home. Care plans contained important information relating to people's likes and dislikes, their previous occupation and families. Care plans detailed people's needs, and risk assessments were in place, however we found the information wasn't always sufficient to support people's needs safely.

Record keeping was inconsistent. There were areas of good practice but also evidence that information in records was not updated and were not always completed in a timely manner.

Our observations throughout the day showed that people were treated with dignity and respect. People received comfort when needed. Staff used their knowledge of people to engage them and help build positive relationships. Staff understood people's individual needs for care and were able to talk to us about the ways in which they provided this.

Since the last inspection, improvements had been made to the recording of the administration of people's medicines. However, there was a lack of guidance in place for staff on the support people required to take medicines which had been prescribed to be taken 'as required'.

The home had undergone a full refurbishment since the last inspection and looked clean throughout. However, there were still areas of the home that were malodorous.

Staff told us that they didn't always feel there was enough staff. They also reported some issues with some of the agency staff used. The home had tried to manage issues and ensured agency staff were suitable by following safe recruitment practices. The registered manager told us new staff had been recruited and were in the process of having checks completed.

The management team completed various quality audits, including infection control, care plans, medicines and health and safety. However, not all of these audits had proved effective at identifying issues. For instance, care plan audits had not identified inconsistent care information.

The registered manager and the management team had created an open and supportive culture in the home. Staff told us they felt the managers were approachable and accommodating.

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 consistently safe.

Risk plans did not always sufficiently detail how to manage people's behaviour safely.

Information relating to 'as required' medication was not always clear.

Staff had been recruited safely.

Systems were in place to protect people from harm and abuse.

Is the service effective?

Good 

The service remained effective.

The provider worked in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to ensure any restrictions on people's freedoms had been authorised appropriately.

People were supported by staff who felt supported and received regular supervisions.

People had access to a range of healthcare services when required, in order to maintain good health.

Is the service caring?

Good 

The service remained caring.

Our observations throughout the inspection showed staff treated people with kindness and compassion.

People were treated with dignity and their privacy was respected.

Is the service responsive?

Good 

The service remained responsive.

Care plans did not always record consistent or up to date

information.

The provider had a complaints policy and procedure in place. People knew how to complain.

Care plans accurately recorded people's likes, dislikes and preferences. Staff had information that enabled them to provide support in line with people's wishes, including on the best way to communicate with people.

Is the service well-led?

The service was not always well-led.

The service had a manger who was registered with Care Quality commission.

The registered manager had completed quality audits, but they were not always effective at identifying issues.

People and staff had their views sought so that improvements could be made through feedback received.

Requires Improvement 

Windy Knowe 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.

This was a comprehensive inspection which took place on 06 and 07 November 2018 and was unannounced. The inspection was carried out by two adult social care (ASC) inspectors.

Before the inspection we reviewed information relating to the service including notifications sent to us by the provider. A notification is information about important events which the provider is required to tell us about by law. We also used information the provider sent to us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority quality assurance team, to ask their views about the quality of the service provided.

During the inspection we spoke to the registered manager, the deputy home manager, the operations assistant manager, one nurse, and two members of care staff on duty. We were also able to speak with two visiting relatives and a visiting healthcare professional to gain their views and experiences on the service. We observed several other people who were supported by the service, who were unable to talk with us.

We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including five people's care records, four staff files and other records relating to the management of the service, such as policies and procedures, medication records, training records and audit documentation.

Is the service safe?

Our findings

At our last inspection in September 2017 we found evidence of insufficient bathing facilities due to bathrooms being out of commission, lack of safety checks on door guards that are supposed to release in the event of a fire and infection control concerns relating to malodours and equipment (padded mats) not looking clean. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the service was now meeting this regulation.

During our inspection we looked at fire safety audit documents and identified that door guard checks were now incorporated as part of these weekly checks. These checks also included fire exits, fire alarms and fire equipment. We noted that any actions identified on the checks were followed up quickly.

We found that the service had undergone a full refurbishment, with carpets being replaced, either with new carpet or hard floor. The registered manager informed us hard floor had been chosen to reduce the infection control risk. We found that parts of the home were still malodorous, particularly one person's room. The registered manager told us the carpet was going to be replaced in that room. We also observed one person's sensor mat within their bedroom looked dirty. We were informed that these mats are due to be replaced. The home did however look clean throughout.

We saw that the home had four showers and that bathrooms had been refurbished and were all in use on the two floors that were occupied.

We found that risks to people were not always assessed and managed safely. For instance, on the first day of the inspection we saw a prescribed product used for thickening people's drinks if they had swallowing difficulties, stored in a kitchen area off the dining room on the ground floor. We found that this area was accessible to people on two occasions during the inspection. This meant that vulnerable people may be at risk of ingesting the product. A hot water urn was also accessible during these times, posing a risk of scalds. We raised this with the registered manager and on the second day, saw that the thickening agent had been removed and stored securely, however the kitchen was again accessible on one occasion.

Some people living at the home had behaviours that could challenge the service. Where this was the case, we saw their care plans identified how to reduce the likelihood of the person expressing these behaviours and how staff should support the person. However, we found that these plans did not provide sufficient information to ensure staff could safely support people who may be agitated or displaying behaviours that could challenge. For instance, one person's file advised staff to use diversional therapy, but did not state what worked for the person. Staff were able to clearly describe some triggers that could instigate or escalate these behaviours and clear ways on how they managed this and ensured the person remained safe during these times, however this was not recorded within the plan of care. This was raised with the registered manager and on the second day of inspection new plans had been created for two people who use the service.

We saw that there were procedures in place to manage medicines safely. Temperature measurements were recorded daily for both the room and the medicine fridge. Medicine Administration Records (MAR) were used to record the administration of medicines. We checked a random sample of MAR charts and found they were mostly suitably completed, where drugs were omitted the reason was noted in full on the appropriate part of the MAR sheet and there was clear guidance on disposal of any medication that had been refused. However, we found that there were some occasions where the time of the medicine being administered had not been completed. This meant that people may not have received medicines at the right time. We also found that protocols for medication to be taken 'as needed' were not always clear. One person was receiving medication that was recorded to be given when "agitated" although there were no indications as to what this behaviour looked like. One staff member said "[the person] doesn't need it every time he's agitated; I just know when to give it". This could mean the person receives medication when it is not needed.

Care files did not always provide accurate information to ensure staff had access to up to date information regarding people's needs. For instance, one person who required their drinks to be thickened had inconsistent information within their file and medicine records as to how much thickener they required. This meant that this person was at risk of receiving an incorrect amount of thickener in their fluids. Most staff we spoke with were aware of the correct amount they needed and the registered manager ensured that the care file was reviewed and updated by the second day of the inspection.

Personal emergency evacuation plans were available. They advised staff how to support people to a safe place within the home, but did not identify what support or equipment people would need to get down the stairs should a full evacuation be required. We found however that evacuation equipment was available to help ensure people could be supported to leave the building in the event of an emergency and staff had been trained to use the equipment. This was raised with the registered manager, and on the second day of inspection new evacuation plans had been created that included detailed information on use of equipment.

During our inspection we observed staffing levels to be adequate. We observed people being supported when needed and staff engaging with people with a relaxed approach. However, staff told us there was not always enough staff on duty. They told us the management were always recruiting and always tried to cover shifts but last-minute sickness was often a problem. Agency staff were used when required, although not all agency staff had English as their first language and this could cause communication difficulties. This was raised with the registered manager, who informed us that any agency staff they found not suitable to work in the home were not used again.

People who lived at the home were not able to tell us if they felt safe living at the home. We observed people being supported by staff in ways that were safe. For example, we saw staff support people with their mobility needs using techniques and approaches that were safe. We also observed people's body language and verbal expressions which showed they were relaxed and comfortable with the staff. This in turn helped show that people felt safe with the staff.

We looked at how staff were recruited and found that most safe recruitment practices were followed. Evidence of application forms, photographic identification, references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. We found however, that not all references could be verified. We discussed this with the registered manager who agreed to improve this process. The manager also completed regular checks to ensure that the qualified nursing staff had a current registration that did not place restrictions on their practice.

Personal protective equipment was available for staff and we saw that this was used appropriately. This helps to prevent the spread of infection. We found however, that equipment was not always maintained to ensure it was clean, which means it could be an infection control risk.

There were clear systems in place to protect people from the risk of abuse. The provider had policies and procedures in place for safeguarding vulnerable adults, including a whistleblowing policy. These contained guidance on what staff should do in response to any concerns that were made or identified, and were shown in a flow chart diagram, making it easy to understand. Staff we spoke with knew about the different types of abuse and how to recognise potential signs of abuse. Staff told us they would report any concerns to a senior member of staff or other agencies if needed. We also saw posters around the home regarding whistleblowing, and the daily checks completed by the registered manager or deputy manager, documented discussions with staff regarding safeguarding and whistleblowing.

We looked at how accidents and incidents were managed and found that they were recorded and reported appropriately. A monthly log of incidents was recorded and analysed to look for any potential trends or themes. We saw that appropriate actions were taken following incidents, such as contacting the GP, emergency services, referral to other professionals, or observations. We also saw evidence of learning from incidents being shared with staff through supervision. One piece of learning from an incident related to information about people not always being easily available in an emergency. This has prompted the service to implement a coding system for things such as 'do not resuscitate' instructions on the front of each person's care file.

Is the service effective?

Our findings

Staff told us they were well supported in their role. They had regular supervisions and an annual appraisal. They also had access to regular training considered mandatory by the provider, such as infection control, fire safety, moving and handling, dementia care, first aid and safeguarding. The provider kept an electronic training record for each staff member along with a staff training matrix. The training matrix highlighted staff that were due a refresher training. New staff also completed a comprehensive induction with some shadowing sessions to ensure they had the skills and competencies appropriate to their role. We identified during the inspection that staff would benefit from more training surrounding supporting individuals with behaviours that challenge. This was also identified on the previous inspection. We discussed this with the registered manager who had identified training to support people with behaviours that challenge, and had a schedule in place for staff attendance.

Steps had been taken to support people living with dementia to remain safe and orientated. For instance, bedroom doors contained numbers and people's names. Some rooms had memory boxes outside that had been filled with mementos from family members. We also found that there were tasteful pictures on the walls of celebrities that people may recognise, such as Cilla Black, as well as pictures of local areas in days gone by.

The service liaised with other members of the multidisciplinary team to ensure people's needs were met. Records showed that advice was sought from people's GP, mental health team, chiropodist, speech and language therapist and social workers. Relatives told us staff recognised when people became unwell and sought medical advice in a timely way.

We spoke with a visiting health care professional during the inspection who informed us that the service worked well with them to provide care for some of the individuals in the home under the 'enhanced health in care homes' model. This had worked to reduce the number of hospital admissions by allowing individuals to be treated in the home. We were also told it had improved communication between the service and GP and that health issues affecting individuals had been addressed quickly.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met and found that they were.

We found mental capacity assessments had been completed for specific decisions and we saw that relevant people had been involved in best interest decision making when a person was assessed as lacking capacity to make that decision or provide consent. However, capacity assessments began with the assumption that the person lacked capacity. We asked the registered manager to review this part of the process.

Feedback regarding meals was positive. Relatives were able to join people for lunch if they chose to. We observed a lunch time meal and saw that staff were available to support those people who required assistance to eat their meals. They provided support in a dignified and respectful manner. A relative told us they often joined their family member for lunch and was "Impressed" by the meals available. A staff member said, "The food is lovely, I eat here every day".

At staff request, some staff had been allocated as dignity and falls champions. The idea of these roles was for 'champions' to be a source of support for all staff and to complete extra training and share learning and best practice with the rest of the staff team.

Is the service caring?

Our findings

People continued to be supported with compassion, dignity and respect. Staff were able to clearly describe how they protected people's privacy and dignity. This included knocking on people's doors, ensuring personal care was provided in private and using towels to cover people when they were receiving personal care. One compliment we saw from a relative said "Thank you for caring for [person] and giving him his dignity and providing love and support".

A relative told us the care was, "Faultless, amazing and brilliant." A staff member told us, "Staff give their heart, work their hardest and give the best care we can." Records from resident's meetings showed that people were happy with the care that they received. One recorded comment stated, "I am happy here, staff are nice."

We observed staff being caring, attentive and responsive and saw positive interactions and appropriate communication. For example, staff knew how to communicate effectively with a person who was unable to verbally communicate their needs. They were aware of certain facial expressions and actions, which determined how the person was feeling and what they needed. We also observed staff using their knowledge of people's histories to make conversation, for example talking with one person about their previous work and hobbies. The visiting healthcare professional we spoke to said, "all staff know people very well". This was clear to see from the interactions we observed.

During the inspection we found a log of compliments completed by relatives and friends. One comment thanked staff for help and support during an emergency assessment. The relative commented that "care at Windy Knowe was excellent". Another compliment recorded said "Thank you very much for your kind support and some great memories. I am very proud to know you and rate you all the best carers I know".

We found that confidential records were not always stored securely. During the inspection, we saw that offices were not always locked and care files were stored within them. These care files included people's confidential information and meant that people who did not need to see the records, had access to them. We raised this with the registered manager who then ensured the door was locked. We observed staff being reminded to lock the office.

We found that links with advocacy services were good, with clear information available in the home for all to see. The registered manager told us they had supported one relative to see dementia advocacy services for support.

There was a social room available for people to give time and space to spend private and uninterrupted time with their family and friends. Relatives told us that they could visit at any time and felt welcome.

Is the service responsive?

Our findings

No one within the home was receiving end of life care at the time of the inspection, however some staff had completed this training meaning they would be able to appropriately support someone when needed. We did also see evidence that care files included information regarding people's future wishes; where they would like to be cared for and their end of life care preferences. For people registered with one GP practice, emergency health care plans were in place. DNAR's (Do Not Attempt Resuscitation orders) were clearly stored in people's files when appropriate and we saw that relevant people had been involved in those discussions.

We found that care plans did not always provide up to date or consistent information regarding people's needs. For instance, one person's assessment of needs reflected that they were incontinent, but other parts of their file stated that they were continent. Their nutrition plan stated that they required a normal diet, however the review reflected a fortified diet was provided.

We saw that records were not always updated in a timely way. For example, we found that three people were assessed to need fifteen-minute observations, but only one person was recorded as receiving this. We also found that on one occasion during our inspection these fifteen-minute observations for one person had not occurred for one hour. After speaking with staff and completing some observations it was clear that observations were taking place, but they were not always recorded in a timely manner. We also found records relating to repositioning support and diet and fluid charts, had not been fully completed on the second day of the inspection. Staff told us they were often too busy providing support to update the paperwork. This meant there was not always a clear record of the support people had received, so it could be reviewed to ensure it remained effective.

Information regarding people's preferences in relation to food and drinks were available to staff in the small kitchen areas off the dining room and staff we spoke with knew what people enjoyed. Care files included 'This is me' documents which family members had completed. They provided information about the person's life, their family, past jobs, holiday's and interests. This enabled staff to get to know people as individuals. A staff member told us one person preferred to have female carers to support them with their personal care and that this was always respected.

Pre-admission assessments were detailed and identified the support people would require. This meant that staff were aware of people's needs and could meet them from the day they were admitted to the home.

The service was meeting the Accessible Information Standard (AIS). AIS was introduced by the government in 2016 to ensure that people with a disability or sensory loss are provided with information in a format that they can understand. People's care files included an accessible information needs care plan. One person's plan advised that the person required glasses and reminded staff to speak to the person in short concise sentences to aid their understanding. During our inspection, we observed staff communicating with people in ways that helped their understanding. For instance on one occasion we observed a staff member holding someone's hand to calm them, whilst speaking to them clearly, calmly and in short sentences.

The complaints procedure for the home was available for all to see, and the form had been updated and written in pictorial format to ease understanding. Relatives told us they knew how to make a complaint if needed. There was a feedback board, "You Said-We did" which updated people, staff and visitors on any changes made as a result of complaints, feedback, incidents or updated best practice. We saw from the feedback board that staff had suggested dignity champions and this had been implemented. There had been one recorded complaint since the last inspection, which was regarding inaccurate repositioning records. We saw that this had been managed appropriately.

Activities were available to people, although there was no activity coordinator in post at the time of the inspection. A carer was allocated each day to provide activities and the registered manager told us they were in the process of recruiting a new activities coordinator as the last person had recently left the service. Relatives told us there had been a number of trips out, to places such as art galleries, canal boat trips and coffee shops. The registered manager told us they had access to the providers minibus on a regular basis to support activities in the community.

Is the service well-led?

Our findings

There was a registered manager in place supported by a deputy manager who were both present during the inspection. People using the service weren't able to tell us verbally about how they felt the home was run. However, we saw that one person, freely entered the registered manager's office throughout the day and senior staff interacted with them, this suggested that the person felt at ease.

The registered manager and deputy manager informed us they had an "open door" culture, allowing staff to get support any time. There was also a phone that was managed by the registered manager and deputy manager on a rota, which was available 24/7 to staff. This ensured staff working evenings and weekends could access management support.

Staff told us they enjoyed their job, that they worked together well as a team and were well supported by the management team. They described the manager as, "Supportive", "Approachable", "Wonderful", "Marvellous" and "Accommodating."

Systems were in place to gather feedback about the service. For instance, regular resident and relative meetings took place and records showed people were able to have their say and share their views. Regular staff meetings were also held and we saw that areas such as recruitment, staff, refurbishment and infection control were discussed. Quality assurance surveys were also utilised to gain people's views. We saw that they had last been distributed in June 2018 and the results had been analysed. Areas that scored low were included within an action plan which identified what actions would be taken to improve these areas. This showed that the provider gathered feedback and took action to make improvements when necessary.

Systems and processes were not always effective in ensuring records were kept up to date and information was shared. For example, although daily handover meetings were held, information relating to people's needs were not always documented. One person was required to have thickener but this was not recorded on the handover, and some information relating to people's DOLs status was also missing. This was brought to the attention of the registered manager and deputy manager, and was updated on the second day of the inspection. This shows responsive action by the management team.

During this inspection we found that the registered manager had acted upon most of the findings from the last inspection, and had completed all actions set out in the action plan.

The registered manager undertook quality assurance audits to ensure a good level of quality was maintained. We saw audit activity which included, health and safety, infection control, medicines, health and safety and care planning. However, the audits of medicines had not routinely picked up issues that we identified at this inspection in relation to medicines management. For example, omissions in recording of time of dose, and incorrect information regarding one person's thickener requirements. Care plan audits had also not picked up the inconsistencies with people's care information.

During the inspection we spoke with the assistant operations manager who had been in post for

approximately ten months, and had supported the service for a few weeks prior to the inspection. It was clear that the registered manager felt supported by the assistant operations manager and was implementing new processes that had been recommended as part of service improvement. We also saw evidence of new initiatives being implemented that had worked well in other homes, such as breakfast club, dignity tree, falls analysis and plans for a local nursery to attend. This shows good organisational learning and openness to continuous improvement.