Integrated Nursing Homes Limited

The Knolls Care Centre

Inspection report

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Ratings

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

Overall summary

This inspection took place on 10 November 2015 and it was unannounced. When we inspected the service in November 2014 we had found the provider was not meeting all the legal requirements in the areas that we looked at. We had found that the registered person did not use people's views, comments and complaints to effectively monitor, evaluate or make improvements to the service provided. During this inspection we found that improvements had been made to quality assurance processes.

The service provides accommodation, support and nursing care for up to 56 people with a variety of social and physical needs. Some people may be living with dementia. The home had three units within it. One providing nursing care, another providing residential care and a 6 bed roomed rehabilitation unit where people can stay for up to six weeks. At the time of our inspection there were 47 people living at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

Staff understood their responsibilities with regards to safeguarding people and they had received effective training. Referrals to the local authority safeguarding team had been made appropriately when concerns had been raised.

People told us that there were insufficient members of staff on duty and they did not have their care needs met at their preferred time or their call bells answered in a timely manner. Staff were competent in their roles and felt supported with regular supervisions and appraisals had been completed. Robust recruitment procedures were in place.

It was not clear whether or not people had been involved in planning their care and deciding the way their care was provided. Each person had a care plan which reflected their preferences and included personalised risk assessments, but they lacked detail and there were inconsistencies within the records. People's health care needs were being met and they were assisted to receive support from healthcare professionals when required. Medicines were managed safely and audits completed.

Positive relationships had been formed between people and members of staff. Staff were kind and caring, and provided care in a respectful manner that maintained people's dignity. Staff knew people's needs and preferences and provided encouragement when supporting them. There were a wide range of activities available and people received relevant information.

People were not aware of the presence of the registered manager and there was a lack of overall strategic management of the home. People, their relatives and staff knew the senior staff they could raise concerns to. Quality assurance processes were in place and were used with a view to improve the service being provided.

During this inspection we found the service to be in breach of some of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement

The service was not always safe.

Some people did not feel safe living in the home. There were insufficient members of staff on duty at all times to ensure people's needs were met.

Personalised risk assessments had been completed with a view to reduce the risk of harm to people, but there were inconsistencies within these records.

Staff knew how to safeguard people.

There were robust recruitment processes in place.

Is the service effective?

Requires improvement

The service was not always effective.

Capacity assessments and best interests decisions were not consistently recorded in people's care records.

Authorisations to lawfully deprive people of their liberty had not been requested for some people who were being restricted.

Staff received regular supervision and appraisals to assist in identifying their learning and development needs.

People were supported in meeting their health needs.

Is the service caring?

Good

The service was caring.

Staff were kind, friendly and compassionate.

Staff treated people with dignity and respect.

Support was individualised to meet people's needs.

People were provided with information regarding the services available.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans lacked detail regarding some aspects of people's care.

Daily records were not consistently completed.

A wide range of activities were on offer and people were encouraged to participate.

There was a complaints policy in place.

Summary of findings

Is the service well-led?

The service was not always well-led.

There was a lack of clear strategic leadership across the home and people were not aware of the presence of a manager.

Statutory notifications to the CQC had not been completed.

There was an obvious tension amongst staff and they were reluctant to talk about their experiences of working in the home.

There had been improvements made to the quality assurance processes.

Requires improvement 

The Knolls Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 10 November 2015 and was unannounced. The inspection team was made up of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the evidence available to us about the home such as reports from the local authority, information received about the service and notifications. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with 14 people who lived at the home, five relatives, three nurses, four care workers, one cook, two domestic staff, the deputy manager and the registered manager.

We carried out observations of the interactions between staff and the people living at the home. We reviewed the care records and risk assessments of five people who lived at the home, checked medicines administration records and reviewed how complaints were managed. We also looked at six staff records and the training for all the staff employed at the service. We reviewed information on how the quality of the service was monitored and managed.

Requires improvement

Is the service safe?

Our findings

There were differing views amongst people we spoke with regarding whether they felt safe and secure at the home. People in the rehabilitation unit and those receiving residential care were positive. One person told us, "Yes I feel safe here. I have everything I need to hand." Another person said, "I do feel safe, I couldn't be looked after any better. They are so good here." A relative told us, "I have no concerns about [relative's] safety really." However people supported in the nursing unit and their relatives did not feel that it was safe. One person told us, "No I don't feel safe. There are not enough staff on duty in the morning to meet our needs." Another person told us, "Within the room I feel safe, but no one comes when I call. I want to get up but I have to wait until after 12 noon for two carers to be available to get me up, that doesn't make me feel secure." A relative told us, "I have grave concerns about the response [relative] has to the call bell. When I am here it takes ages, so I don't know how long it is when I am not."

People in the rehabilitation unit were happy with the staffing levels and expressed no concerns. However we received negative views from people, their relatives and staff about the staffing levels throughout the rest of the home. One person told us, "The staff do seem to change very often, we do seem to have a lot of agency staff to fill in. They do appear to be very rushed sometimes so you can tell that they are short staffed." One member of staff said, "It is frustrating because we want to provide good care, so we all work really hard but don't have time for the niceties like chatting to people which these people deserve." A relative said that they felt there was not enough staff to meet the needs of their family member, "I come and find [relative] still in bed at lunchtime because there are not enough staff to get [them] up." There was no formal system for assessing staffing levels, which considered the needs of people and the layout of the building. We spoke to the registered manager who explained that the staffing levels were determined by the number of people at the home and their assessed needs. There were vacancies within the staff team where the recruitment had not yet been completed and staff were feeling stretched. The registered manager confirmed that they looked for agency staff when shortages were identified, but the agency could not always provide the necessary staff at very short notice. During our inspection, we observed some occasions where members of staff were unable to attend to everyone who required their support at the same time.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the recruitment files for some staff and noted that the provider had effective systems in place to complete all the relevant pre-employment checks. These included obtaining references from previous employers, checking the applicants' previous experience, and Disclosure and Barring Service (DBS) reports for all the staff. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed. This robust procedure ensured that the applicant was suitable for the role to which they had been appointed before they were allowed to start work with the service.

There was a current safeguarding policy and information about safeguarding was displayed in the entrance hallway. All the members of staff we spoke with told us they had received training on safeguarding procedures and were able to explain these to us, as well as describe the types of concerns they would report. They were also aware of reporting to safeguarding teams. Training records for staff confirmed that they had undergone training in safeguarding people from the possible risk of harm.

There were personalised risk assessments in place for each person who lived in the home which addressed identified risks. The actions that staff should take to reduce the risk of harm to people were included in the risk assessments, but some information was in conflict with that within other risk assessments. For example for one person, a risk assessment detailed that their call bell should be placed within their reach at all times, while another assessment indicated that the person lacked the capacity to be able to use the call bell. For another person, one risk assessment stated that the person required the support of one member of staff at all times, whereas another assessment stated this support was only required at night time. These inconsistencies made it unclear to the reader as to the correct actions that should be taken and it put people at risk of unsafe or ineffective care. Risk assessments also included identified support regarding mobility, nutrition and hydration, receiving personal care and specific medical conditions.

Requires improvement

Is the service safe?

Staff told us that they were made aware of the identified risks for each person and how these should be managed by a variety of means. These included reading people's care plans and their risk assessments, reviewing daily records and by talking about people's needs at handover.

Accident and incidents had been reported appropriately and these had been analysed by the registered manager who had reviewed each report. This analysis was used to identify any trends or changes that could be made to prevent recurrence and reduce the risk of possible harm.

The registered manager had carried out assessments to identify and address any risks posed to people by the environment they lived in. These included fire risk assessments. Information and guidance was displayed in the entrance hallway to tell people, visitors and staff how they should evacuate the home if there was a fire.

There were effective processes in place for the management and administration of people's medicines and there was a current medicines policy available for staff to refer to should the need arise. We reviewed records relating to how people's medicines were managed and they had been completed properly. Medicines were stored securely and audits were in place to ensure these were in date and stored according to the manufacturers' guidelines. Regular audits of medicines were carried out so that that all medicines were accounted for. However, staff were not recording the receipt or disposal of medicines that were not packaged by the pharmacist in a blister pack, so the auditing of these medicines was not always clear. The auditing processes helped to ensure that medicine errors were minimised, and that people received their medicines safely and at the right time. We observed two members of staff administering medicines during our inspection and they both demonstrated safe practices.

Requires improvement

Is the service effective?

Our findings

People told us they thought staff were well trained and had the skills required to care for them. Staff told us that there was an induction period for new members of staff, an ongoing training programme in place and that they had the training they required for their roles. They told us that this was conducted in a number of ways including formal training sessions both in house and externally, training videos and practical observations. One member of staff told us, "Training is very good here and very timely. All mandatory training is up to date." Another member said, "Training is good, we are supported well in this area."

Staff told us that they received regular supervision and felt supported in their roles. They spoke highly of the senior members of staff who lead the units in which they were working. One member of staff told us, "[Nurse] is very supportive and so is [Nurse]. They are really helpful and the training provided is very extensive." We noted that regular supervision meetings were being held with staff and the staff we spoke with all confirmed they had received an appraisal.

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 homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that people's capacity to make and understand the implication of decisions about their care were assessed and documented within their care records. Staff had received training on the requirements of the MCA and the associated DoLs and we saw evidence that these were followed in the delivery of care. Where it had been assessed that people lacked capacity we saw that best interest decisions had been made on their behalf following meetings with relatives and health or social care professionals, however these were not consistently documented within their care plans.

A number of authorisations of deprivation of liberty were in place for people who lived at the home as they could not leave unaccompanied and were under continuous supervision. We saw the registered manager had made appropriate applications for other people living at the home and was awaiting the outcome of these applications from the relevant supervisory bodies. However there were also a number of people who had restrictions in place and required applications to be made, but the registered manager had not yet done so. When asked the reason for not submitting the applications, the registered manager informed us that the GP and the local authority had requested that applications were not all submitted at the same time. This meant that the provider had not always ensured that they met the DoLS requirements to send applications for everyone who met the criteria . We acknowledge the provider had acted in good faith on advice from others about the applications needing to be made. However, in order to meet the requirements of the deprivation of liberty standards, applications must have been submitted for all people who are having restrictions placed on their liberty for the restriction to be legally applied. The onus is on the provider to make the application within the legal timescales required to satisfy their responsibility under the safeguards.

Staff told us they asked for people's consent before assisting them and we observed them doing so throughout the day. At lunchtime we observed members of staff seeking permission from people before supporting them with their meals. We saw evidence in the care records that people, or a relative on their behalf where appropriate, had agreed with and given written consent to the content of their care plans.

Although some people told us that they had a variety of food at mealtimes and were happy with the food provided, a number of people expressed concern regarding the food. One person told us, "If we don't like anything on the menu we can always ask for something different. They are very good about that." Another person told us, "I only eat what I like. I like ice cream." A third person told us, "The portion is so big it puts me off." A relative told us, "[Relative] is a vegetarian, [they] don't get any fresh vegetable or fruit. It's

Requires improvement

Is the service effective?

all sandwiches, cheese and jacket potatoes." They went on to say that they were bringing their relative food from home as their relative had told them that the food was "boring." We saw that there was a menu displayed in the hallway informing people of the choices available on that day.

The cook told us that all food was prepared at the home. People were asked for their likes and dislikes in respect of food and drink prior to moving to the home and the kitchen staff were notified. The cook demonstrated a good knowledge of people and their preferences and explained that they spent time in the afternoons talking to people in the home seeking their feedback on the meal from that day to identify any changes that they could make to the menu. Records held in the kitchen detailed people's preferences and specific dietary needs, such as diabetic diet, fortified diets and allergies. There was no-one living at the time of our inspection who required a special diet for cultural or religious reasons, but the cook confirmed that cultural diet choices could be catered for. Members of staff were aware of people's dietary needs and this information was documented in the care plans.

People told us they were assisted to access other healthcare services to maintain their health and well-being, if needed. One person said, "They are going to book a dentist appointment for me, it's very important to me." Another person said, "I am going to hospital tomorrow, it has all been sorted out by the nurses." One member of staff said, "We can always contact the surgery if we need to and call the GP out." Records confirmed that people had been seen by a variety of healthcare professionals, including the GP and district nurses. Referrals had also been made to other healthcare professionals, such as dietitians and physiotherapists.

People in the rehabilitation unit confirmed that they had daily visits from physiotherapists, occupational therapists and members of staff from the continuing healthcare team.

Good

Is the service caring?

Our findings

People and their relatives were very complimentary about the staff. One person told us, “The staff are kind, caring and treat you with respect.” Another person told us, “They are all kind and compassionate.” A third person told us, “The girls are brilliant. They are patient and never rush me.” A relative told us, "They are excellent here, I just feel sorry for them because they have so much to do."

Positive relationships had developed between people who lived at the home and the staff. Staff knew some people well, spoke about people with warmth and understood some of their preferences. The knowledge staff had about people enabled them to understand how to care for them in their preferred way and to ensure their needs were met. People we observed appeared confident and at ease in the relationships that they had developed with staff and staff spoke with them about activities they enjoyed, interests that they shared and referred to recent television programmes in conversations. We also observed people and staff laughing and sharing jokes.

People’s bedrooms had been furnished and arranged in the way they like and many had brought their own personal items with them when they came to live at the home.

We observed the interaction between staff and people who lived at the home and found this to be kind and caring. We observed members of staff using each person's preferred name and taking time to ask people questions and understand their needs. Staff were patient and gave encouragement when supporting people. We saw members of staff assisting people with their meals in the lounge areas and they were friendly and positive when communicating with people. Additional assistance was provided in a pleasant and unhurried way.

People told us that staff protected their dignity and treated them with respect. One person said, "I always feel like I am treated with respect and dignity." Another person told us, "I have no qualms about my care, it is excellent. I am treated very well, always respected." Staff members were able to describe ways in which people’s dignity was preserved such as knocking on bedroom doors, making sure they closed curtains and ensuring that doors were closed when providing personal care in bathrooms or in people’s bedrooms. We observed staff carry out these measures when supporting people. Staff explained that all information held about the people who lived at the home was confidential and would not be discussed outside of the home to protect people’s privacy.

People had access to information about the service that was provided. There were a number of information posters displayed within the entrance hallway which included information about the home and the provider organisation, safeguarding, a fire safety notice and activities available. We also saw information from other services and charitable organisations that offered support to older people and people living with dementia.

Requires improvement

Is the service responsive?

Our findings

People we spoke with were unable to tell us if they had been involved in deciding what care they were to receive, how this was to be given or if any review of their needs that had taken place. When asked a question about their care plan one person told us, “I don’t think I have ever seen one before. I don’t know what one is.” However care plans were in place for each person and records showed that pre-admission assessment visits were undertaken to establish whether the home could provide the care people needed. Each plan was individualised to reflect people’s needs and included instructions for staff on how best to support people, but lacked detail with regards to some aspects of their care. For example, one person had a catheter in place and although the care plan instructed staff of the need to change it regularly there was no record of how often it needed to be changed. Neither were there any instructions for caring for the catheter whilst in situ. Another person had a percutaneous endoscopic gastronomy tube (PEG) via which they received all fluid and nutrition. The care plan in place detailed how nutrition should be given, but there was no instruction on how the PEG tube should be cared for to ensure it remained effective. We also found that the care plans did not always accurately reflect people’s individual needs and had not been updated with any changes as they occurred. We also reviewed daily records completed for people in relation to the amount of fluid they drank and found that there were inconsistencies and records were not completed at the time of the care being given. On the day of our inspection, despite people having had breakfast, a mid morning drink and lunch, staff did not complete the charts until after 14:00.

The care staff we spoke with were aware of what was important to some people who lived at the home and were knowledgeable about their life history, likes and dislikes, hobbies and interests. They had been able to gain information on this by talking with people and their families and explained how this knowledge developed with time. The information gained enabled staff to provide care in a way that was appropriate to the person.

People told us there were a wide range of activities in place and we saw an extensive schedule displayed in the lounge and in the hallway. Activities for people were provided by a designated activities coordinator and included visits from external services. One person told us, "I enjoyed the remembrance service yesterday and no doubt there will be a lot more coming up soon for Christmas.” Another person told us, "I did go down to the lounge to listen to the singing couple but I couldn’t stand it and came back to my room.” A third person told us, “No doubt we could go down to the lounge if we wanted but I like to read a lot and I have a TV in my room. I am quite happy and don’t feel the need to get involved in bingo and quizzes.” Staff we spoke with said the wide range of activities on offer met people’s needs and they had the option to join in if they wished. We saw that a monthly newsletter was produced for people detailing the activities that were planned for the coming month and included photographs of recent activities and events that had taken place.

People we spoke with were not all aware of the complaints procedure or who they could raise concerns with, but when prompted they suggested they would speak to a senior member of staff. However one person told us about a complaint they had made to the provider organisation and that they had spoken with the registered manager in response to their concerns. A relative we spoke with explained how they had made a complaint after their family member had raised a concern with them and was waiting for a response. We saw that seven formal complaints that had been received in the past year were recorded. There was an investigation into each concern and the actions to be taken in response included in the record. Each complainant had received a response to their concern and the registered manager had recorded the outcome from each.

Requires improvement

Is the service well-led?

Our findings

At our inspection in November 2014 we had found that the registered person did not use people's views, comments and complaints to effectively monitor, evaluate or make improvements to the service provided. During this inspection we found that improvements had been made to quality assurance processes, but further improvement was still needed.

We found that there were now a range of audits completed by the registered manager to monitor the quality of the service provided. These included satisfaction surveys, complaints management, a food satisfaction survey, action plans in response to local authority reviews and records of action from meetings held with people and their relatives. A director from the provider organisation visited the home on a regular basis and also conducted audits to ensure the home was monitored and continued to develop. Any issues found in these audits had been addressed by the registered manager and improvements made where required. We saw action plans that had been completed following the audits and that the senior team had checked progress on the identified improvements .

People we spoke with could not recall completing any surveys, however the registered manager showed us results from questionnaires that had been sent to people and their relatives. The registered manager had completed a statistical analysis of the responses and shared the results with the respondents. An action plan to address the responses that were not positive had been completed by the registered manager. However, we noted that individual comments made were not included so not all of the views of people or suggestions made were used to improve the service.

Services that provide health and social care are required to inform the CQC when Deprivation of Liberty authorisations are granted by supervisory bodies for a person living within the service. Authorisations of Deprivation of Liberty were in place for some people who lived at the home, but the CQC had not been notified. This meant that prior to completing this inspection, we were unaware that authorisations had been granted, whether the service was working within the principles of the MCA, and whether any conditions on the authorisations to deprive a person of their liberty were being met.

This was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

The home had a registered manager who had been in post for over a year. The registered manager was supported by a deputy manager who confirmed that they oversaw the running of the service in the manager's absence. There was also a head of residential care and senior nursing staff who oversaw the rehabilitation unit.

Neither the registered manager or deputy manager was at the service when we arrived and it was clear that there was no identified leader in their absence. Members of staff on duty were unclear for a significant period of time on who should speak to us until a senior nurse approached us and took the lead. The Registered Manager and deputy later assisted us with the inspection process.

People we spoke with told us that they did not know the registered manager or see them often. Only one person we spoke with knew the registered manager by name. When asked about the registered manager comments included, "I thought we were getting a new manager soon. Have we got one now?", "I have never met a manager if we have got one" and "Have we got one? I thought we needed one." Members of staff we spoke with confirmed they knew who the registered manager was, but they did not seem them frequently. One member of staff said, " We do not see the manager very often but I could go to [them] if I need anything."

During our inspection the registered manager, deputy manager and members of staff on duty could not confirm the total number of people living in the home. It was clear that each unit was being managed separately and there was no overall strategic leadership being demonstrated. Some members of staff we spoke with confirmed that they did not know the home's visions and values, and felt that they did not understand the direction of the whole service. The registered manager was not visibly present around the home during our inspection.

We noted that, whilst members of staff were helpful and pleasant in their interactions with the inspection team , there was obvious tension amongst some staff members and there was a reluctance to discuss their experiences of working in the home. People living in the home told us that

Requires improvement

Is the service well-led?

staff had "got into trouble" for talking about their concerns. One person told us, "People management is not very good here, if they don't appreciate their staff they are going to lose them."

Meetings for people and their relatives were held regularly in the home and minutes from these meetings were available. However people could not recall if they had taken place or were not aware that residents meetings took place. At the most recent meeting we saw that people who attended discussed their concerns that they had in relation to the care being provided and the staffing levels.

Staff were also encouraged to attend team meetings at which they could discuss ways in which the service could be improved and raise any concerns directly with management. Staff we spoke with confirmed that they were given the opportunities to raise topics for discussion, but were not always informed of the action that would be taken as a result of them raising concern or discussing ways the service could improve.

We noted that people's records were stored securely within lockable cabinets at the nurses stations and within the registered manager's office. This meant that confidential records about people could only be accessed by those authorised to do so.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services and others were not protected against the risks associated with insufficient numbers of staff on duty. Regulation 18 (1)

Regulated activity	Regulation
	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had failed to notify the Commission of any request to a supervisory body made pursuant to Part 4 of the Schedule A1 to the 2005 Act by the registered person for a standard authorisation. Regulation 18 (4A)(a)