Ashdown Care Limited

Knappe Cross Care Centre

Inspection report

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Date of inspection visit:
04 July 2017
19 July 2017

Date of publication:
12 September 2017

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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 4 and 19 July 2017.

Knappe Cross Care Centre provides care and accommodation for up to 42 older people. The home is a detached house set in its own beautiful grounds in the seaside town of Exmouth in the coastal area of East Devon. On the first day of the inspection there were 30 people staying at the service.

The service did not have a registered manager when we visited. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The registered manager had left the service the week before our inspection. They had submitted their application to the CQC to cancel their registration. A new manager had been appointed and had shadowed the registered manager for one week. They confirmed they would be completing their application with CQC to become the registered manager at the service. Although the manager had only been at the service for 7 working days, staff were very positive about their impact and said the staff morale had improved at the home. People and visitors said they had met the new manager and were also very positive about their approach. One person commented "Manager is getting involved, willing to see how things are done, taking the job seriously."

The service was previously inspected in May and June 2016 when the service was rated as 'Requires improvement' overall with no breaches of regulations. The effectiveness and leadership at the service was rated as requiring improvement. This was because changes had been put into place at the service which had not been embedded and staff training and updates to ensure staff were competent and effective had not always been updated in a timely way. At this inspection, we found improvements had been made in these areas although further work was being undertaken to ensure all staff had received the provider's mandatory training.
The new manager had identified gaps in staff training matrix and wasn't assured staff had received all of the provider's mandatory training. They had set up a training planner for the next year to ensure staff would receive the required training. Individual risks to people's safety had been assessed and care plans written to show how these were being addressed. We found one person's care plan was not fully updated to guide staff how to provide care when their needs had changed a few days before our visit due to an injury. This was reviewed promptly after we discussed it with the manager.

The manager said their first priority at the home was looking at wound care management. This was following an incident which had occurred at the home which had been reported to the local authority safeguarding which had been resolved. The CQC are working with the provider regarding this incident and whether there is any potential risk to others at the home.

People were supported to take part in some social activities. The provider was actively recruiting a new activity person. One member of staff undertook additional duties to do some one to one sessions with

people. However there were still limited activities for people who remained in their rooms. After the inspection the manager told us they had arranged additional hours with a staff member to undertake more activities while they were recruiting. This was to ensure people were not at risk of social isolation.

Medicines were safely managed and procedures were in place to ensure people received their medicines as prescribed.

People were supported by staff who had the required recruitment checks in place. Staff received an induction and were knowledgeable about the signs of abuse and how to report concerns. Staff relationships with people were caring and supportive. They delivered care that was kind and compassionate.

There were adequate staffing levels to meet people's needs. Staff knew people well, understood their needs and cared for them as individuals. People received person centred care and were involved with developing their care plans. Improvements were being put into place so people where possible, and appropriate family members would also be involved reviewing their care plans. People's care plans and assessments were reviewed each month by the nurses. The operations manager and manger had recognised the need to involve people more if they chose with their reviews.

People's views and suggestions were taken into account to improve the service. Professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them. Communication with health and social care professionals was being strengthened and improved.

The provider and manager demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. The provider's operations manager was working with staff to further improve their understanding of the MCA and how to put into practice. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were supported to eat and drink enough and maintain a balanced diet. People were positive about the food at the service.

The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. There had been two complaints received at the service since our last inspection. These had been dealt with in line with the provider's policy. The manager was very active around to he and was in discussions with people and relatives to find out their views and if they had any concerns. The home had developed individual personal evacuation plans to support each person in the event of a fire or other emergency. The premises and equipment were managed to keep people safe.

At this inspection the provider was meeting the requirements of the regulations. The provider's representative and the new manager had identified areas which required further improvement and were taking action to make these improvements.

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.

There were sufficient numbers of suitable staff to ensure people were kept safe and had their needs met.

People were protected from the risks of abuse by staff who understood their responsibilities.

Medicines were stored, recorded and administered safely.

Individual risks to people's safety had been assessed.

The provider had robust recruitment processes in place.

The premises and equipment were managed to keep people safe.

Is the service effective?

Good

The service was effective.

It was not clear is staff that had received all of the provider's mandatory training with some gaps identified on the provider's training matrix. The manager had identified this and action was being taken to address this.

People were supported to maintain a healthy, balanced diet, with food of their choice. Specific dietary requirements were catered for.

Staff understood their responsibilities in terms of legislation. Where people's liberty was restricted, staff had ensured they worked within the Mental Capacity Act 2005.

People were supported to access health services.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and compassionate.

People were involved in making decisions about their day to day care.

People were treated with dignity and respect.

People's families were able to visit when they wanted.

Is the service responsive?

Good

The service was responsive.

Care records were updated when there were changes to people needs. However on one occasion we found they hadn't been.

People were supported to take part in social activities. Improvements were being put into place to ensure people were not at risk of social isolation.

People received care that met their needs, preferences and aspirations.

There was a complaints policy and procedure. People said they knew how to complain. There was evidence to show that complaints had been dealt with in line with the provider's policy.

Is the service well-led?

Good

The service was well–led.

Staff and people knew the new manager and were very positive about the changes and impact they had already had.

Checks and audits to ensure the quality of the service were undertaken and actions were completed to make improvements where issues were identified.

People's views and suggestions were taken into account to improve the service.

Knappe Cross 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 was 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 4 and 19 July 2017. The first day of the inspection was unannounced and carried out by an adult social care inspector, a specialist advisor who was an occupational therapist and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service. We announced the second day of our visit so we could be sure the new manager was available. On this day only the adult social care inspector visited.

Knappe Cross Care Centre provides care and accommodation for up to 42 people. On the first day of the inspection there were 30 people staying at the service.

Prior to the inspection we reviewed information we held on our systems. This included reviewing whether any statutory notifications had been submitted to us. A notification is information about important events which the service is required to tell us about by law. We had asked the provider to complete 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. The provider had completed this in May 2017.

We met the majority of people who lived at the service and received feedback from nine people who were able to tell us about their experiences. We spent time in communal areas observing the staff interactions with people and the care and support delivered to them. We also spoke with two visitors to ask their views about the service.

We spoke and sought feedback from 12 staff, including the new manager, nurses, care workers, cooks, kitchen staff, maintenance person and laundry person. We also spoke with the provider's representative referred at the service as the operations manager.

We reviewed information about people's care and how the service was managed. These included four people's care records and five people's medicine records, along with other records relating to the management of the service. This included staff training, support and employment records, quality assurance audits and staff rotas. We contacted the local authority safeguarding team, health and social care professionals and commissioners of the service for their views. We received a response from two of them.

Good

Is the service safe?

Our findings

People said they felt safe living at the home. Comments included, "Pretty good in all fairness"; "I like it here very much"; "I feel very safe"; "I'm comfortable here, they're very nice people"; "I feel very safe, I always get help to walk, fine from that point."

People were protected by staff that were knowledgeable about the signs of abuse and had a good understanding of how to keep people safe. They knew how to report abuse both internally to management and externally to outside agencies when necessary. One care worker said, "I have not seen anything like that here… I would report it straight away." Before the inspection there had been an alert raised with the local safeguarding team. The service had worked with the local authority safeguarding team regarding the concerns highlighted and this has now been closed.

People when asked said they felt there were enough staff. Comments included, "There's plenty of them around. They do shift work… it can get really busy; it depends on what they're doing. You don't wait long it's good here" and "Going back some time it has been 30 minutes before someone comes. 'Recently up to 10 minutes, depends on how busy they are. If you press the emergency button the response is good." However some added, "On the whole they are very good, they could do with a few more of them. There are two floors, two on upstairs and one here is always helping them' 'there should be two here, there's only one (this had already being resolved by an additional staff member being allocated each morning)" and "I think they would probably say they need more staff, they're a bit rushed. It depends how busy they are, I've never felt uncomfortable waiting."

The preferred staff level each morning was a nurse on duty and six care workers. In the afternoon there was one nurse and five care workers. At night there was a nurse and two care workers. There was also the manager, administrator, cooks, kitchen assistants, laundry and housekeeping staff, a maintenance person and gardener. Those staff also interacted with people while undertaking their roles and assisted as required. The manager made us aware they had more nurses employed than they required and they used the additional hours to have two nurses on some shifts. This meant the additional nurse could work alongside staff and support them with their practice as well as undertake care planning and reviews. The operations manager said they were in discussions about putting in place the role of 'team leader'. They said their role would be to oversee the care staff during the shifts to ensure people were all receiving the care they required.

Where there were gaps in the staff rota, staff would take on extra duties. On the first day of our visit a staff member had called in absent. This was quickly covered by a staff member who agreed to undertake the shift. Staff said they felt the staffing levels were adequate to meet people's needs. One care worker said, "It depends on what happened on the day. There are enough on a normal day." The manager had undertaken a call bell audit to look at staff response times. They had spoken with staff who had not responded promptly about the need to respond more quickly. The call bell panels at the home were usually silent because staff carried pagers, so were alerted to people requiring their assistance. This was so people were not disturbed by call bells. However on the second day due to technical issues the call bells were sounding but this was

being looked in to. Call bells were responded to promptly during our visit.

The recruitment and selection processes in place ensured fit and proper staff were employed. Staff had completed application forms and interviews had been undertaken. Any employment gaps had been explored. In addition, pre-employment checks were done, which included references and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisation's policies and procedures.

People said they were happy with how their medicines were managed. Comments included, "They do it pretty well at the same time. Sometimes the nurse in charge is a bit late coming, they will say sorry there's been an emergency up there"; "Very rarely do I have to ring the buzzer to say, will you bring my tablets''. If everything is running smoothly you get things when you should"; "They are very nice here, very helpful"; "Yes, they've got nurses doing that, lovely in nature" and "If I want extra pain relief, I've only got to ring, they are very good."

People received their medicines safely and on time. Medicines were administered by nurses at the home. Medicines were managed, stored, given to people as prescribed and disposed of safely. Where people had medicines prescribed on an 'as required' basis (known as PRN), protocols were in place about when they should be used. This meant the nurses were aware of why and when they should administer these medicines to people appropriately. There were facilities for medicines which required refrigeration to be stored at the recommended temperature. The medicines fridge and medicine storage area temperature was recorded each day. The administration of topical creams was being undertaken safely. There were cream charts in place with body maps to guide staff about what cream people were prescribed, where it needed to be applied and frequency of administration. Care staff then signed they had administered the creams. The manager had requested a pharmacy review which had taken place the day before our second visit. They had raised no significant concerns.

People were protected because risks for each person were identified. Risk assessments about each person were undertaken which identified measures taken to reduce risks as much as possible. These included risk assessments for falls, skin integrity, bed rails, nutrition, taking a bath or shower.

The environment was safe and secure for people who used the service and staff. A new maintenance person was employed at the home. They undertook regular checks of the water temperature and window restrictors. The manager had already undertaken a walk around the home and drawn up a plan of priorities and what needed to be done. External contractors undertook regular servicing and testing of moving and handling equipment, electrical and lift maintenance. Fire risk assessments and general risk assessments and the monitoring of environment had been undertaken.

Fire checks and drills were carried out and regular testing of fire and electrical equipment. Legionella precautions were in place. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person.

The home was clean throughout with a few pockets of odours present which were dealt with. Some areas of the home were in need of decorating which was scheduled to be undertaken. During our visits corridors were in the process of being painted.

Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as

gloves and aprons. The laundry was well managed with a washing room and a clean laundry room. This was where washed laundry was taken to be sorted and ironed as necessary and redistributed. There was a designated laundry staff member undertaking laundry duties each day. Staff said there were always adequate chemicals available. Soiled laundry was segregated and laundered separately at high temperatures in accordance with the Department of Health guidance.

Emergency systems were in place to protect people. There were individual personal evacuation plans in each person's care file which took account of people's abilities and the assistance they required. This meant, in the event of a fire, emergency services staff would be aware of the safest way to move people quickly and evacuate people safely.

Accident and incidents were reported and identified the immediate actions taken to reduce risks. The manager reviewed all accidents and incidents daily to ensure appropriate action was taken.

Good

Is the service effective?

Our findings

Staff had completed the provider's induction training when they started working at Knappe Cross. Induction training for new staff consisted of a period of 'shadowing' experienced care workers to help them get to know the people using the service. New care workers who had no care qualifications were supported to complete the 'Care Certificate' programme which had been introduced nationally in April 2015 as best practice. It was not clear from the provider's training matrix whether staff had received all of the provider's mandatory training. The provider's mandatory training included, fire safety, infection control, moving and handling, food hygiene, health and safety and safeguarding vulnerable adults. The gaps included, food hygiene, infection control and health and safety. The manager had identified these gaps and could not assure themselves that staff had received all of the training required. Therefore they had set up a training planner for the next year, so this would be addressed. Staff were positive about the training they had received. One care worker commented, "A lot of training, interesting and useful." Staff were observed moving people with the assessed equipment they required, this included hoists. They were skilled and confident and people seemed quite relaxed being moved around. Staff said they received regular supervision and an annual appraisal and felt supported in their roles.

People said they felt the staff had the skills required to support them. Comments included, "Pretty well I would say, there is always the actual nurse on duty, they're always on the ball'; "Yes I think so, I've never found anyone not to, they are all very helpful and nice"; "First class" and "Most of them…one of the staff here is helping me to walk, (staff member) is very supportive."

Checks were made to ensure nurses working at the home were registered with the Nursing and Midwifery Council (NMC) and able to practice. The NMC is the regulator for nursing and midwifery professions in the UK. They maintain a register of all nurses eligible to practise within the UK. Nurses were supported to undertake training to support them to perform their roles. Training they had undertaken included, verification of death, venepuncture (the collection of blood from a vein for blood sampling), verification of death, catheterisation and wound care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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.

The nurses at the service assessed people's capacity to make specific decisions. Where people had been assessed as not having capacity, there were processes in place to make best interests decisions on their behalf. For example, whether they could consent to the use of bedrails. Staff had received MCA training and the provider's operations manager was working with staff to further increase their understanding of the MCA and how it was used in practice.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest

and legally authorised under MCA. The application procedures for this in care home are called the Deprivation of Liberty Safeguards (DoLS). Staff had identified people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body, although they said they were all waiting to be assessed. The manager was fully aware of the procedure to follow should a DoLS application be necessary.

The manager said their first priority at the home was looking at wound care management. This was following an incident which had occurred at the home which had been reported to the local authority safeguarding. The Care Quality Commission (CQC) are working with the provider regarding this incident and whether there is any potential risk to others at the home. The manager was a registered nurse and had undertaken a visual review themselves of wounds at the home. The nurses completed a wound register which contained the individual wounds being managed, a wound assessment along with photographs and the provider's tissue viability policy. Improvements planned by the manager and operations manager was that all future wounds that occurred at the home would have a 'Root cause analysis' undertaken. Root cause analysis can be used to review people's care and treatment and identify improvements to prevent similar occurrences in future. The operations manager also confirmed that they were looking to add additional information regarding dressing regimes to the 'wound assessment chart'.

People had access to healthcare services for ongoing healthcare support. They were seen regularly by their local GP. People's care records contained the contact details of GPs and other health care professionals for staff to contact if there were concerns about a person's health. The manager was working to build stronger communication and working relationships with local health professionals. They had met with the community nurse team manager and were planning to meet local GP practice managers. To improve information being shared, the manager had set up a folder in the nurse's office for the community nurses to record what they had done and who they had seen. To further improve communication around the home, the provider had issued a mobile phone for the nurses to carry. This enabled health professionals to contact them or for the administrator to make them aware that there was a landline call.

People confirmed they were visited by health care professionals when required. Comments included, "We have our own doctor from (local town). They rang the doctor to come to (husband)"; "They tell me when I need that'. If I am unwell, I'd let them know if I'm not feeling too well. Very nice people"; "Doctor comes here, dentist, optician, chiropodist" and "Yes the doctor comes." Health care professionals confirmed staff at the home sought advice appropriately.

People reported positively about the food at the home. Both cooks spoke with pride about their work and the importance of knowing people's preferred meal choices and requirements. The nursing staff had ensured the cooks had good information about any allergies, and people who needed a specialist diet. For example, vegetarian, diabetic or a soft consistency. Specialist diets, including pureed food, gluten free, lactose free and diabetic diets, were catered for.

People were positive about the food they received and said snacks were always available. Comments included, "The food here is good, you always get two choices for lunch, two choices for supper and drinks. Very good''; "Snacks…You can have toast and such. If you want a drink you can ask for it"; "Good food they look after me very well"; "I usually like what they give me…I try and eat. They feed me well" and "Excellent, yes we do. Bananas, biscuits (snacks). We have a choice each meal." Two people said they had previously had concerns about the meals at the service. Staff had worked with them to put in place a specific menu which met their dietary requirements. There were still a few teething problems but things had improved.

There was a four week menu and people were asked their meal choice the day before. There was a selection

of juices in jugs for people to help themselves to in the communal areas and jugs of water/juice in people's rooms. Kitchen staff were aware of which people needed encouragement to eat and drink and increased calorie content of their food and the use of fortified milkshakes. People could have snacks at any time. Where people had any swallowing difficulties, they had been seen and assessed by a speech and language therapist (SALT). Where the SALT had recommended soft or pureed food, each food was separately presented which is good practice. Where people had been assessed as at risk of weight loss, they had their weight monitored regularly.

There is a very bright and well-equipped dining room at the home which people choose not to use.] On the first day of our visit only one person used the dining room. Others chose to have their meals in the lounge with the majority choosing to have their meals in their room. Where people required support with their meals this was given in a respectful manner. The operations manager and manger said people were encouraged to come to the dining room but chose not to. The operations manager said they had a fish and chip lunch and people had used the dining room. They were looking at other ways to encourage people to use the communal spaces more. We were told some people did attend a tea dance which had recently been held and they were considering other similar activities.

The home is very spacious and large with two large lounges, a bar area and dining room. There are several staircases leading to people's rooms over the ground floor and two further floors. The provider had identified that corridors and rooms were bland and were in the process of redecorating corridors in brighter colours. We discussed with the manager and the operations manager on the first day that there was nothing to identify to people which room was theirs, other than a room number. There was no signage to guide people around the home. On the second day of our visit new name plates had been put in place on people's doors with their consent which were bright and enabled people to identify their rooms more easily. The manager said they were also looking in to putting memory boxes outside people's rooms to help people find their rooms. (memory boxes are a collection of items or images from a person's past). Signage on toilets and bathrooms had also improved and was easier to read. The operations manager said they were in the process of getting further signage to use around the home to guide people.

Good

Is the service caring?

Our findings

People were supported by caring staff who treated them with warmth and compassion. Staff knew people well and spoke knowledgeably about them. We spent time talking with people and observing the interactions between them and staff. Staff were thoughtful, friendly and considerate towards people. Some people gave us examples of the friendships they had made with staff. One said, "Two carers have become personal friends, they take us out in the garden." Another said "I met one nurse in town for a coffee. There are some people (staff) here who are outstanding (the person gave names of four staff members). (Staff member) comes down in the evening to talk to us."

People confirmed staff were polite, caring and friendly. Comments included, "Yes on the whole, naturally some of them have their off days"; "They've got a good manager, they've got good nurses. Good manners, very caring"; "They're very kind, they look after me nicely" and "In general yes."

People said the staff promoted their independence and their choices and preferences were respected. Comments included, "They're always amazed I can do so much. 'I'm not afraid to ask if I need it"; "They are very efficient, I wash my hands and face"; "They help me with a walker, all floors are different when you have Parkinson's" and "They speak to you about things, they help me." Staff confirmed they gave people choices. One care worker said, "We ask people to come down (stairs) we cannot force them." When people arrived at the home they were asked to formally consent to having care at Knappe Cross. This included permission for photographs to be taken, care record agreements and designated access to care records.

Staff said they felt the care was good at the service. Comments from two ancillary staff included, "I like the care staff, the way I see them dealing with people is wonderful" and "I see the way staff are with the residents, they make them feel it is their home, attention to detail is very good."

Staff treated people with dignity and respect when helping them with daily living tasks. People's comments included when asked, "They're quite good like that, people knock on the door. I don't very often have the door closed"; "I'm covered up'. 'They knock on the door"; "They cover you up with towels after a shower"; "Yes, I wash myself … as soon as I dry myself they leave a towel around me"; "If anyone knocks the door, they say who it is before they get in the room they respect our privacy." At lunchtime people who needed it were offered a protective covering to keep their clothes clean and maintain their dignity.

People were treated by staff with kindness and compassion in their day-to-day care. Throughout our visits staff were respectful in their manner. Staff involved people in their care and supported them to make daily choices. We observed care staff and ancillary staff speaking with people and sharing jokes with them and calling them all by name. They ensured people were comfortable and had refreshments and were encouraging people to have drinks. Staff were heard offering people choices about what they would like to wear and would they like to go to the lounge.

Family members and other visitors were welcomed into the home and could pop in any time. One person said, "I don't get visitors very often but they can visit anytime. A visitor said, "We are always greeted by staff

when we arrive."

People were able to bring in personal possessions to personalise their rooms with things that were meaningful for them. This included family photographs, items of furniture and pictures.

The home was spacious with numerous communal areas for people to choose to use and spend time on their own if they wished. There was also an attractive well-kept garden and outside seating area for people to use if they chose. However the majority of people chose to remain in their rooms. The operations manager and manger were looking at ways of encouraging people to use these areas more frequently.

The provider offered end of life care. They had spoken with people and their families to ask them about where and how they would like to be cared for when they reached the end of their life. This was recorded in their care files. If they had any specific wishes or advanced directives, including the person's views about resuscitation in the event of unexpected illness or collapse. The nurses had undertaken training in the use of syringe drives (a small infusion pump used to administer medicines under the skin often to keep people comfortable at the end of life).

Good

Is the service responsive?

Our findings

The service was responsive to people's needs because people's care and support was delivered in a way the person wished. Wherever possible a pre admission assessment of needs was completed prior to the person coming to the service. People or their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines likes and dislikes specific to each person. The provider described in the Providers Information Return (PIR), "We make careful assessments of the needs of our residents and we update and review care plans monthly. Our registered nurses have responsibility for named residents. There is a schedule for residents/families to be involved in reviews twice yearly, if they wish."

People said they were not always aware of what was documented in their care plans. Comments included, "No not really, but if I thought of anything I would say"; "I don't think so; they look after me very well. I'm comfortable here"; "They (family) gave it to the office when I came here, they check I'm alright going to the toilet and that. They gave me a shower yesterday afternoon" and "We have, until about a month ago we didn't know we had one. The nurse came and talked you through." The operations manager and manger had recognised this was not always happening and they needed to involve people more if they chose with their reviews. This would be easier to achieve with the additional hours for nurses to complete reviews with people. The manager was also speaking with people about their needs and requirements and ensuring care records reflected this. The manager said they had been looking at the current care documentation and was in discussions with the provider about making it a more computerised system.

The care plans related to people's activities of daily living. These included, personal hygiene, eating and drinking, mobility, sleep patterns, mood, behaviour, pain, communication and continence care. The plans identified people's needs and the planned outcome and how the staff needed to support people to achieve them. The nurses reviewed people's care plans and assessments monthly and more regularly if required. We did identify following a change in one person's health need a few days before our visit that their care plan had only partially been reviewed. However it did not identify all of the changes. We discussed this with the manager who confirmed they were aware of the person's changed needs. Following our conversation they reviewed the person's care plan to ensure it reflected all of the changes needed and guided staff appropriately.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. The new manager had introduced a computerised daily handover sheet where staff filled in all relevant information so there was an up to date log of people's needs. This included people's dietary requirements, last GP visit, medical history, skin integrity and key handover information about people, to ensure it was shared. The manager said they could access the computerised log remotely so they could monitor how people were doing.

The provider recognised the importance of supporting people to follow their interests and take part in social activities. They engaged the services of external entertainers who visited the home and arranged a tea dance and fish and chip lunches. One care worker said, "In the lounge we have bingo and karaoke afternoons and

we do activities. They (people) like to play bingo."

People said they were satisfied with the level of activities provided. comments included, "I'm not a person to join in, I'm just as happy here (room)"; "I've done the activities" the person pointed to a picture they had undertaken and said "I'm quite happy with what they do"; "I'm not that way inclined"; "I don't want to join in, that's my choice"; "I've been down there, I used to get involved in painting" and "I'm happy with what I'm doing."

The provider had recently appointed a new activity person who after a few days decided the role was not for them so they were actively recruiting again. A staff member had some additional hours allocated to undertake one to one activities with some people. However as the majority of people chose to stay in their rooms it was not possible to spend time with them all. The manager was looking at ways to extend the range and timescale of activities at the home. They informed us after the inspection that while they were recruiting a new activity person a member of staff had agreed additional hours one afternoon a week to undertake activities. This would help improve the social activities in the home. Social profiles had been completed for most people at the home which identified people past history, hobbies and experience but had not been completed for four new people.

People and visitors were happy they could raise a concern with the nurses or manager. Comments included, "I'd speak to the superintendent, he hasn't been here long"; "I would speak to the manager"; 'Oh yes, I can't actually think I ever have, when I see a problem coming I speak to the person and they do something about it"; "Yes, you'd go to the office. No complaints, I find them all very kind"; "Oh yes, but I wouldn't want to complain'.

People were made aware of how they could raise a concern by the provider's complaints policy. There had been two complaints since our last inspection. These had been dealt with in line with the provider's policy. The manager was meeting with people and visitors to ask their views and to ascertain if they had any concerns. They were very active within the service and said they wanted to manage niggles and concerns before they became an issue.

Good

Is the service well-led?

Our findings

People on the whole said they would recommend the home. Comments included, "Yes, there would be one or two things I would point out to them"; "Yes, I think so, it's all very nice"; "Oh yes" and "Up till now no, we are waiting to see. Keeping our options open."

The service did not have a registered manager when we visited. The registered manager had left the week before our visit and had submitted their application to Care Quality Commission (CQC) to cancel their registration which was agreed on the 19 July 2017. The new manager had started work at the home the week before our visit and had started the process of applying to CQC to become the registered manger. They had worked alongside the registered manager for one week on an induction. The provider notified us about those changes, in accordance with the regulations. When we visited, they were being supported by the provider's operations manager who was at the home during both days of our visit.

The provider had a range of quality monitoring systems which were used to continually review and improve the service. These included a quality assurance and internal audit schedule which the registered manager completed with the nurses and responsible staff were required to complete. For example monthly falls analysis, pressure ulcer audit, pressure mattress and slings checks, six medicine audits a year, a quarterly visual premises check and infection control, six monthly activity and catering reviews. Where concerns were identified these were addressed and staff advised. The provider described in the Providers Information Return (PIR) "The manager conducts monthly audits by schedule to ensure that the service is safe and that potential weaknesses are explored."

The provider's operations manager visited the home monthly or six weekly, to monitor the quality of the service. They spoke with people, staff and visitors and reviewed care plans and documents and developed and action plans which the registered manager completed. They reviewed these actions at their next visit to ensure they had been completed. Their last visit in May 2017 identified that the wound register was to be reviewed by a senior nurse and the manager twice a week and that information that needed to be included on monitoring charts. We found this information had been included and that the manager had reviewed people's wounds the week of our visit. One staff member said about the operations manager "Is easy to approach. When she comes she asks about everybody."

Improvements which had been put in place prior to our last inspection had been sustained. The new manager and the quality assurance processes undertaken by the provider had identified other areas for improvement. These included measures being taken to make improvements to the training, activity provision, wound management and care plan reviews with people. These were all being put into place and would need time to see if effective.

People and their relatives were very positive about the leadership of the new manager. Comments included, "I think it will be"; "New manager is willing to muck in, one day they were short staffed and he acted as a carer. He pops in quite regularly"; "Can't tell until he's been here a little while, I presume it will be"; "Manager is getting involved willing to see how things are done, taking the job seriously"; "I think it's a bit early. I think

he's going to be more pro-active than before. I think he will ask. I think he will do something about it"; "He (Manager) comes in and says 'everything alright', a great improvement since he's been in charge"; "Oh yes, he's there for everybody. He goes around to see everybody" and "From what we've seen so far … We are hopeful."

Staff were also positive about the new manager. Staff comments included, "Morale has got better. He is a good manager with hands on approach. If we want to ask something it is not a problem. If we ask for help he will come whatever"; "Massive positive very approachable and the home feels more positive. Since doing handover spent more time with residents much better"; "The new manager has already made some changes in only a few days and is already better…always asks if we need help, will take a tray which means a lot" and "good with the staff, quite calm and likes to communicate everything.

There were accident and incident reporting systems in place at the service. The manager monitored all accidents in the home and ensured staff had acted appropriately regarding untoward incidents. They checked the necessary action had been taken following each incident and looked to see if there were any patterns in regards to location or types of incident. Where they identified any concerns they took action to find ways so further incidents could be avoided. They completed a monthly analysis to identify trends about, time of day/night and the frequency of accidents.

The provider sent annual quality assurance surveys to relatives and friends which covered most aspects of the service. These were returned to the provider's head office and the results collated and shared with the manager, staff and people.

People when asked about did they feel involved in the development of the service had mixed responses. They included, "They include you, they are very nice with it"; "They ask me if I want anything done"; "I don't think so" and "No." One person said about a newsletter which had been produced in the past being "Quite good" saying "They should revive the newsletter."

The service had a positive culture that was person-centred, open and working to be more inclusive. People and their relatives were encouraged to get involved in providing feedback and ideas of how they found the care at Knappe Cross. There were comment cards in the main entrance for visitors to use. The provider conducted an annual survey of relatives. The responses from the last survey had been positive. The manager had held a meeting for people and their families on the 13 July 2017 with a buffet tea provided. They said they had a few people and a couple of visitors attend and had some positive discussions. They said they would be making the minutes available to people and visitors and would work to get more people and visitors involved in future meetings.

Staff were actively involved in developing the service. The new manager had held a full staff meeting and a nurse meeting. They had given the staff the opportunity to share their views and also made them aware of how they wanted to move the service forward. The manager was working with the team to ensure everyone had a clear understanding of their roles and responsibilities. The team had ensured people were referred appropriately to outside healthcare professionals when required. The nurses knew their responsibilities in relation to each person's needs and were knowledgeable about their families and health professionals involved in their care.

The manager said they also wanted to build up stronger links with the local community and outside organisations, so people could maintain their links and build up new one with the local community.

The week before our visit the service was inspected by an environmental health officer in relation to food

hygiene and safety. The service had been awarded the rating of four with the highest rating being five. Where concerns had been identified in relation a seal above the sink this had been completed straight away. The provider was still looking to source new seals for the refrigerator but were taking action. This showed the provider was working to ensure good standards and record keeping in relation to food hygiene.

The provider was meeting their legal obligations such as submitting statutory notifications when certain events, such as a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested. The provider had displayed the previous CQC inspection rating in the main entrance of the home and on the provider's website.