Knotty Ash Residential Care Home Ltd

Knotty Ash Residential 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?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 21 June 2018 and was unannounced.

Knotty Ash is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provides support to up to 35 people and there were 29 people living in the home on the day of the inspection, many of whom were living with dementia.

At the last inspection in December 2016, the registered provider was found to be in breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's confidential records were not always accurate, up to date or stored securely, the environment was not always safely maintained and systems in place to monitor the quality and safety of the service were not effective. We asked the provider to complete an action plan to show what they would do to improve the key questions of safe and well-led to at least good. During this inspection, we looked to see if they had made the necessary improvements.

At the last inspection the provider was in breach of Regulations as the systems in place to monitor the quality and safety of the service were not effective. We found during this inspection, that they were still not effective. Quality assurance processes were not in place to review all areas of the service and those that had been completed did not always reflect what actions had been taken to address the issues. If more robust quality assurance processes had been in place and were being monitored closely, then the serious issues that were found during the inspection would have been identified earlier by the registered manager or the provider and dealt with.

Following the last inspection, the provider submitted an action plan to inform us of what they would do to improve the service based on the concerns identified. We found that they had not evidenced all of the things they told us they would do.

CQC had not been notified of all events and incidents that occurred in the home in accordance with our statutory requirements. Records showed that a number of incidents had taken place that had been referred to the local safeguarding team, however CQC had not been informed.

We found that risk to people was not always well managed. When risks such as weight loss were identified, we found that there were not always clear records to show how the risk had been addressed. Care plans were not in place to cover all of people's needs. This meant staff did not have clear guidance on people's care needs or how to meet them.

Medicines were not always managed safely within the home as they were not booked in accurately, people's allergies were not recorded on medicine charts and directions for administration were not always clearly recorded by staff. We found medicines were not always administered as they had been prescribed.

We found serious concerns with the care plans we observed as they did not reflect people's current needs or their individual preferences regarding their care and treatment. Care plans were reviewed regularly but not always updated when people's needs changed and planned care was not always recorded to show it had been provided.

When able, records showed that people provided consent to their care. However, consent was not always gained in line with the principles of the Mental Capacity Act 2005 and best interest decisions were not clearly recorded.

There was no clear system in place to oversee accidents and incidents as although a log was maintained, no information was analysed to establish potential themes or trends. This meant it would be difficult for lessons to be learnt or for actions to be taken to prevent recurrence of some incidents.

Deprivation of Liberty Safeguards applications had been made for people appropriately, however, the outcome of these applications was not always clearly recorded within people's care files.

A registered manager was in post and feedback regarding the management of the service was positive. 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.

People told us they felt safe living in Knotty Ash. We saw that there were sufficient numbers of safely recruited staff on duty to meet people's needs in a timely way. Staff had completed safeguarding training and we saw that safeguarding referrals had been made to the Local Authority appropriately. Systems were in place to help ensure the building and equipment was safely maintained.

The home appeared clean and well maintained during the inspection. Staff had access to personal protective equipment such as gloves and aprons and bathrooms contained paper towels and liquid hand soap to help prevent the spread of infection.

Staff told us they felt well supported and received an induction, an annual appraisal and regular supervision. Regular training was also available to support staff knowledge.

Staff were aware of people's dietary needs and preferences. People had a choice of meals and we saw that people were offered drinks and snacks throughout the day.

The home had been adapted to meet the needs of people living there and help to maintain people's safety and independence.

People living in the home spoke very highly of the staff who supported them and told us they were treated with respect and relatives were also very happy about the care provided. We observed people's dignity and privacy being respected by staff during the inspection. We saw many examples of warm, positive interactions between staff who worked in the home and the people who lived there.

Equipment was in use within the home when people needed it, to help maximise their independence and we saw staff encourage people to do as much for themselves as they could.

We saw friends and relatives visiting the home during the inspection and they told us they could visit

whenever they wanted to. When people had no friends or family to support them, details of local advocacy services were available.

Activities were available and we saw people joining in and enjoying singing and dancing during the inspection.

A system was in place to manage complaints and we saw that they had been dealt with appropriately.

Ratings from the last inspection were displayed within the home as required.

You can see what action we told the provider to take at the back of the full version of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Risk to people was not always assessed or managed appropriately and care plans were no in place to cover all of people's needs.

Medicines were not always managed safely within the home.

Accidents and incident records were not analysed to establish potential themes or trends.

There were sufficient numbers of safely recruited staff on duty to meet people's needs in a timely way.

Systems were in place to help ensure the building and equipment was safely maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent was not always gained in line with the principles of the Mental Capacity Act 2005 and best interest decisions were not clearly recorded.

DoLS applications had been made for people appropriately, however, the outcome of these applications was not always clearly recorded within people's care files.

Systems were in place to support staff in their role.

The home had been adapted to meet the needs of people living there and help to maintain people's safety and independence.

Is the service caring?

Good

The service was caring.

People spoke very highly of staff and we saw that people were treated warmly and with respect.

Staff knew people they were supporting well, including their needs and preferences.

Equipment was in use within the home when people needed it, to help maximise their independence.

Visitors were able to visit at any time and were always made welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not detailed, did not reflect people's current needs or their individual preferences and were not always updated when people's needs changed.

People and their relatives had been involved in the creation of their plans.

Activities were available and we saw people joining in and enjoying singing and dancing during the inspection.

A system was in place to manage complaints and we saw that they had been dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

Systems in place to monitor the quality and safety of the service were still not effective.

Not all of the actions the provider told us they would take after the last inspection were evidenced.

CQC had not been notified of all events and incidents that occurred in the home in accordance with our statutory requirements.

Ratings from the last inspection were displayed within the home as required.

Knotty Ash Residential 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 inspection took place on 21 June 2018 and was unannounced. The inspection team included an adult social care inspector and an inspection manager.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service to gain their views.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with four members of the care team, as well as the registered provider, the registered manager, deputy manager and the chef. We also spoke with five people who lived in the home and five visiting relatives.

We looked at the care files of five people receiving support from the service, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various points during the inspection.

Some of the people living in Knotty Ash were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in December 2016, we found that the provider was in breach of regulation and the safe domain was rated as requires improvement. This was because some radiators were very hot and put people at risk of injury. During this inspection we looked to see if improvements had been made and found that although concerns regarding the radiators had been resolved, other issues were identified.

We looked around the home and found that environmental risks were not always well managed. For example, we observed a fire door had been wedged open, a fire action sign designed to inform people of what action to take in the event of a fire was blank and we saw a person living in the home in bed without the brakes on. There was a risk they could fall from bed if the bed moved. The registered manager applied the brakes straight away. The lock in place on the laundry door was also easy to open. This meant there was a risk vulnerable people could access this area.

People's care plans contained risk assessments in areas such as mobility, nutrition, falls and skin integrity. We found however, that risk was not always recorded appropriately. For instance, care files did not include risk assessments when people had had seizures to identify risks relating to seizures. There was also no information recorded within care plans to inform staff how to manage seizures.

When risks were identified, we found that they were not always clear records to show how they had been managed. For example, we saw that one person was at serious risk of weight loss. They had lost weight and their care plan stated that they should be weighed weekly. A referral had been made to a dietician to support this person but this information had not been recorded on the care plan. The person had not been weighed for a period of two months following the identification of the risk. The nutritional risk assessment tool had been completed each month, however it was not accurate as the person's weight had not been checked so it was not reflective of their current needs.

Another person's records showed that they had lost a significant amount of weight over the last three months. Although a referral to the dietician had been made, there were no care plans available during the inspection to establish whether any measures had been taken to prevent further weight loss whilst they waited for the dietician's advice. We were told however, that fortified milkshakes were provided each day.

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

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), for people living in the home. We found that medicines were not always managed safely. For example, not all medicines had been booked into the home appropriately as the amount received was not always recorded. This meant we were unable to check whether the amount remaining was correct and whether they had been administered as prescribed.

People's allergies were not recorded on their MAR charts. Recording allergies helps to prevent people being

administered medicines they are allergic to. Records for a person that had recently come into the home were not fully completed and did not include directions as to how many tablets should be given or at what time of the day. We checked this with their prescription and saw that they had been administered correctly, however, not all medicines on their prescription had been included on the MAR chart. We also saw several gaps in the recording of medicines that had been administered. We checked and saw most of these medicines had been given, but one had not. This meant that medicines were not always administered as prescribed.

This is a risk of Regulation 12 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they felt safe living in Knotty Ash. One person told us, "I feel safe and I am well looked after." Another person told us that when they were feeling unsafe they spoke with the staff who reassured them and helped them to feel better.

We looked at how safeguarding was understood and managed within the home. Most staff told us they had completed safeguarding training regularly and that they knew how to raise any concerns they had. A policy was also in place to help guide staff in their practice and details of the local safeguarding team were available. This enabled referrals to be made to the relevant organisations. We found that appropriate safeguarding referrals had been made to ensure they were investigated and acted upon.

We could see that accidents, incidents and safeguarding events were recorded, however there appeared to be some confusion in the home as to what constituted each type of incident and how they should be recorded and managed. We could see that action had been taken in response to accidents and incidents, but the audit trail of this was not clearly recorded. There was no clear system in place to oversee accidents and incidents as although a log was maintained, no information was analysed to establish potential themes or trends. This meant it would be difficult for lessons to be learnt or for actions to be taken to prevent recurrence of some incidents.

We looked at how the home was staffed. During the inspection, as well as the registered manager and provider, there were three carers, a senior carer, deputy manager, cook, laundry assistant, two domestics, an administrator and an activity coordinator on duty to support the 29 people living in the home. We viewed staff rotas for the previous six weeks and saw that these staffing levels were usually maintained. The shifts were covered with staff who worked in the home and a very small use of agency staff. During the inspection we saw that staff responded quickly when people needed help and calls bells were answered in a timely way. People we talked with spoke very highly of the staff and the care that they provided. None of the people we spoke with raised any concerns about staffing levels.

We looked at how staff were recruited within the home. We looked at four personnel files for staff who had commenced work since the last inspection and saw that adequate checks had been completed. This included photographic identification, appropriate references and Disclosure and Barring Service (DBS) checks. 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.

Systems were in place to help ensure the building and equipment was safe and well maintained. For example, external contacts were in place to check the gas, electrics and lifting equipment. We viewed the certificates for these and they were in date. Internal checks were also completed on the fire alarms, fire safety equipment, fire doors, water temperatures and call bells.

The home appeared clean and well maintained during the inspection. Staff had access to personal protective equipment such as gloves and aprons and bathrooms contained paper towels and liquid hand soap to help prevent the spread of infection. We saw that redecoration of the communal areas was almost complete. We were told that new carpets were also being fitted. We saw that the decorating was being completed in stages to minimise disruption to the people who were living in the home. The manager explained to us that one person had been upset and anxious by the decorating so they had changed the approach to how it was completed. This had taken longer but was better for the well-being of the person.

Requires Improvement

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

When able, people provided their written consent in areas such as medication administration, use of equipment, first aid, telemedicine, care provision, access to records and use of closed circuit television (CCTV). We found however, that there was very limited information available regarding the use of CCTV to advise people when and where they would be recorded to enable them to provide informed consent. Not all the care files we viewed showed that people had consented to being recorded in their home. One care file contained a blank consent form, so their consent to all areas of their care and treatment was not recorded.

When people were unable to provide their consent due to cognitive impairment, we found that mental capacity assessments were not always in place. For example, one person's file showed they received their medicines covertly (hidden in food or drink), but there was no capacity assessment to establish if the person could understand the consequences of refusing their medicines. Another person's file showed that an application had been made to deprive them of their liberty, but there was no mental capacity assessment in place to establish whether the person could consent to living in the home or not.

When mental capacity assessments had been completed, we found that best interest decisions were not always clearly recorded. For instance, one person's file contained a consent form that had been signed by their next of kin and it stated a best interest meeting had been held. However, there was no record to say when the meeting took place, who was involved, what was discussed and what decisions were made in the person's best interest. Another person's file showed they lacked capacity to consent to living in the home, but there was no evidence of any best interest decision being made.

It was evident that there was a lack of understanding in relation to consent and the MCA. We looked at one person's file and saw some hand-written directions in relation to their care that had been sent to the home from their relatives. The person did not have the mental capacity to make this decision. Their family members did not have a legal power of attorney in place to make this decision on behalf of the person. Therefore, the document was not lawful and should not have been in place at the front of the person's file. This meant that there was a risk that potentially life-saving measures would not have been given had staff followed these directions. We asked the registered manager to remove the document immediately and take steps to ensure that the Mental Capacity Act was followed in relation to this issue.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 found that DoLS applications had been made for people appropriately, however, the outcome of these applications was not always clearly recorded within people's care files. This meant staff may not have access to this information to ensure they could provide appropriate support to people.

People living in the home were supported by staff and other health and social care professionals, such as the GP, dentist, dietician, chiropodist, social worker and physiotherapist. Records from visiting professionals were recorded and relatives told us they were always kept informed of any changes in their family members care. The home also utilised a virtual nurse system which provided a video link to a health professional for their advice. This helped to enhance the delivery of care as staff had access to healthcare advice to assist them in meeting people's needs. An tablet computer was also available and used to access health advice, reminiscence activities and for people to video call their relatives. Equipment was also in use to support staff in meeting people's needs safely. This included adapted baths, hoists, wheelchairs and a passenger lift.

We looked at systems in place to ensure staff were supported in their role. Staff told us they felt well supported and received regular supervision. Supervision sessions between staff and their manager give the opportunity for both parties to discuss performance, issues or concerns along with developmental needs. Records showed that most staff had also taken part in an annual appraisal of their role.

We saw that when staff started in their role an induction checklist was completed to ensure they had the knowledge required to support people safely and effectively. We also saw that staff worked "shadow shifts" where they worked alongside the existing staff to enable them to get to know the people who lived in the home and how they liked to be cared for.

Training was then provided in areas such as fire safety, medicines management, dementia awareness, infection control, safeguarding, first aid, moving and handling and food hygiene. Some staff had completed training regarding the MCA and DoLS and equality and diversity and further training sessions were arranged for other staff later in the year.

Menu's showed that a variety of healthy meals were on offer and that alternatives were also available. The chef showed us the systems they had in place to ensure they were aware of people's dietary needs. They catered for people's individual needs and at the time of the inspection were providing diabetic meals, soft and liquidised meals and meals for one person based on their religious requirements. Snacks and drinks were also available throughout the day.

People could choose where they sat for their meals and we saw a number of people sitting together in the dining room. The days menu was advertised on the wall for people to see. The chef told us they always asked for feedback after a new meal was served to establish whether it had been enjoyed. In a recent survey that had been completed, people's feedback regarding the meals was positive.

The building met the needs of the people living in the home. The corridors were wide, well-lit and had handrails that were a contrasting colour to the walls. This made them easy to see and people could use them for support when required. People had numbers on their bedroom doors and the registered manager told us they were in the process of designing new pictures with people for their doors. Some people already had their photograph on their door. This helped people to recognise their own room.

The dining room also contained a clock and an orientation board, informing people of the day, date and

weather. We saw that there were some items on the walls which could help stimulate people's senses and some people had their own twiddle cushion that contained zips and buttons. This could help people to maintain concentration and coordination.

There was a large lounge and dining area, as well as a quiet lounge available for people to sit and relax in. There was also a secure garden area with seating available so people could enjoy the outside space in nice weather.

Good

Is the service caring?

Our findings

People living in the home spoke very highly of the staff who supported them and told us they were treated with respect. One person told us, "I have bouts of not knowing where I am. [Staff] look after me when that happens." Another person told us, "They are lovely; the girls, they help me when I need it. It's not home but it's the next best thing."

The relatives we spoke with were also very happy about the care that their relatives received. Their comments included, "We can relax knowing that he is safe and well looked after. It's made such a difference to our lives" and "You can ask them anything and they will always help us to sort it out." We also spoke with two prospective relatives who were visiting the home for the second time to decide if they wanted their relative to live there. They told us that the "warm, family atmosphere" in the home had helped them to choose the home.

We observed people's dignity and privacy being respected by staff in many ways during the inspection, such as staff knocking on people's door before entering their rooms and referring to people by their preferred name. Personal care activities were carried out in private and people did not have to wait long if they needed support. Care files containing people's personal information were stored securely to maintain people's confidentiality in line with the Data Protection Act.

We saw that staff responded quickly when people required support or assistance and prioritised the needs of the people who lived in the home, regardless of their job role. For example, we saw the housekeeper, the domestic staff and the kitchen staff engaging with people living in the home and supporting them to ensure that their needs were met and not leaving these tasks for just the care staff. We saw staff leaving the task that they were doing to ensure that the people living in the home were attended to as soon as they requested help. During time spent in the lounge, we observed that staff had time to sit and chat to people, or to encourage people to join in with the activities that were taking place.

We saw many examples of warm, positive interactions between staff who worked in the home and the people who lived there. One person was wandering around the home and appeared when the staff were offering biscuits to people with their cup of tea. The person was confused and asked a staff member how much the biscuits cost to buy. The staff member gently reminded the person that this was their home and they could have as many biscuits as they wanted. The person was then unable to choose so the staff member handed them a biscuit and put an alternative in the person's pocket for later.

It was clear from discussions that staff knew the people they were supporting well, including their needs and preferences. We heard staff speak to people in ways that were appropriate and that they could understand. One care file we viewed provided specific instructions to staff on how to communicate with the person. This helped to ensure their needs could be understood and met by staff.

Equipment was in use within the home when people needed them, to help maximise their independence. This included the use of walking frames, wheelchairs and bath hoists. Some care plans included prompts to

remind staff to encourage the person to make any choices they could, such as what to wear, and to encourage people to do as much for themselves as they could. This enabled people to continue to be as independent as possible, whilst helping to ensure that they remained safe. A sensory bath was also available to support people and assist in their wellbeing.

Staff assisted people to express their views and be involved in decision making. For example, they supported people to complete quality assurance surveys so that people's views could be heard. We looked at the service user guide and statement of purpose which were available within the home. These contained information about the service, facilities available, fees, safeguarding, activities available, meals, fire safety and the rights of each person who lived in the home. It also included information regarding advocacy services that could be accessed if a person did not have anyone to support them to make decisions. An advocate is a person that helps an individual to express their views and wishes, and help them stand up for their rights. This showed that people were given information and explanations regarding the service and were supported in decision making.

We saw friends and relatives visiting the home during the inspection. Those we spoke with told us they could visit at any time and were always made welcome. We saw that relatives could join their family member in the lounge or visit privately in the person's room. This helped people to maintain relationships that were important to them and prevent isolation.

Requires Improvement

Is the service responsive?

Our findings

All of the people we spoke with were really positive about the care that they received and the staff who supported them. One person told us, "There is nothing negative really, it's all good. The staff are really good and you can rely on them."

The care files we looked at showed plans were in place in areas such as nutritional needs, personal care, continence, mobility, medical history, communication, social, cognition and skin integrity. However, we found serious concerns with all of the records we observed. The records did not reflect people's current needs or their individual preferences regarding their care and treatment. This meant there was no clear record to inform staff of people's needs, or how they should be met. It appeared that the service relied heavily on the staff's knowledge of people rather than a recorded plan of care, as staff we spoke with knew what care people required. In one person's file, the care plans made no reference to seizures or dietary needs yet we saw letters from medical professionals in the file that showed that the person had serious concerns in both of these areas. Their file also reflected that they received their medicines covertly, however, there was no care plan in place to inform staff how to administer these safely.

Care plans were signed and dated when they were reviewed and we saw that they were reviewed regularly. However, we saw that the care plans were not updated when there were changes in people's needs. For instance, one person's review form stated they were on antibiotics due to an acute illness, but this was not recorded in any of the care plans. This meant that information regarding people's current needs was not always easily available to ensure staff were kept up to date and could meet people's needs effectively.

Care plans did not show that people's preferences were considered when planning their care. For instance, one person's plan informed staff they would require support when bathing, however another part of their file showed that they preferred a shower due to a fear they had. The registered manager told us the person did receive a bath rather than a shower.

Planned care was not always recorded to show it had been provided. For instance, one person's file showed they required their weight to be monitored every week. However, records showed that this was only monitored and recorded each month.

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

Care files showed that people and their relatives had been involved in the creation of their plans, through signed consent forms and evidence of discussions held regarding care.

The home employed two activities coordinators who provided a variety of activities. During the inspection we observed an interactive singing and dancing session in the lounge. 10 people were present and eight of them were actively involved in the activity. People were singing and dancing or tapping their feet to the music. The staff told us that they recognised the importance of music to people and the links to people's

past memories and lives. We saw that the mood changed in the room when different songs came on. It was obvious that many people really enjoyed the activity. A couple of visiting relatives also joined in with the fun and encouraged their family member to take part.

A recent survey showed that 25% of people who responded were not very satisfied with the activities available. The registered manager told us they had developed a new activity rota in response to this and feedback from people during the inspection was positive.

We looked to see how complaints were managed within the service. The registered manager told us that they had spoken directly with relatives and asked them to raise any concerns and they would be recorded and we saw the complaints policy was displayed for people to see. We looked at the complaints records and saw that two complaints had been recorded and responded to appropriately. One issue appeared to be very minor but the manager explained that it had been very important to the person and their relative. This demonstrated that the service took people's feedback seriously.

We looked at systems in place to support people at the end of their lives. Care files included very basic plans which showed that some discussions had taken place with people regarding their wishes. Most plans reflected that family members would be involved, but these plans could be further developed to evidence meaningful discussions had been held to ensure people received support where and how they wanted it at the end of their lives. The registered manager told us they worked with GP's and community nursing staff to support people during this time.

We saw that technology was used within the service to help ensure people's safety and wellbeing. For example, call bells were available in bedrooms and bathrooms to enable people to call for staff when they required assistance. Sensor mats and door were also in place for people at risk and these enable staff to respond to people's needs in a timely way.

Systems were also in place to support people to communicate who may have sensory impairment. Care files showed people were supported to attend appointments with the optician if there were concerns regarding their vision. The registered provider also told us they had a large print version of the service user guide available if people required it. Talking books had also been arranged for people previously and we were told that subtitles were often used on the television for a person who had a hearing impairment.

Inadequate

Is the service well-led?

Our findings

At the last inspection in December 2016, we found that the provider was in breach of regulations and the well-led domain was rated as requires improvement. This was because the systems in place to monitor the quality and safety of the service were not effective. During this inspection we looked to see if improvements had been made and found that these systems were still not effective.

We looked at how the provider maintained oversight of the quality of the service provided. The registered manager told us they completed a weekly report and we saw that this included information on accidents, staffing, staff sickness, any health and safety issues and any safeguarding referrals. The provider told us they received a copy of this report and met with the registered manager each week to discuss any issues, however these meetings, or any actions agreed were not recorded.

We asked to see audits that had been completed and were given an audit file that contained kitchen audits, mobility equipment audits and medicines management audits. We could not understand the purpose of the first two audits as they did not give any valuable information or make it clear as to what the auditor had looked at. The medicines management audits had not identified any of the problems that we found when we had looked at the systems and processes in relation to medicines. This made us question the value of the audits.

Quality assurance processes were not in place to review all areas of the service. We looked at how accidents and incidents were reviewed and found that there was no effective audit in place to look for patterns and trends, only a list of the incidences. The records were not kept in a systematic order to make it possible to easily see what action had been taken and ensure oversight of any issues.

There were no audits available to monitor that planned care was provided or that consent processes were followed and recorded. Four care plan audits had been recorded in March 2018. There was no record that any other care plan audits had been completed.

We also found that when audits identified areas that required improvement, there was not always evidence to show what actions would be taken. For instance, one of the care file audits we viewed highlighted several issues that needed to be addressed. However, there were no actions recorded. When actions were identified, records did not always show if they had been addressed. Care plans did not provide sufficient information to enable all staff to be able to know and meet people's needs.

During the inspection the registered manager and provider had difficulty locating some of the records we requested. Care plans for one person were not accessible and we were told other records had not been kept up to date. These were updated and provided after the inspection. Throughout the inspection we had serious concerns about the oversight of the registered manager and the provider, of the issues and concerns that we identified in the home.

If more robust quality assurance processes had been in place and were being monitored closely, then the

serious issues that were found during the inspection would have been identified earlier by the registered manager or the provider and dealt with. This meant that the systems in place to monitor the quality and safety of the service were inadequate.

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

Following the last inspection, the provider submitted an action plan to inform us of what they would do to improve the service based on the concerns identified. We reviewed the action plan as part of this inspection and found that most actions had been completed, although there was no evidence to show some of the actions had been addressed. For instance, the action plan stated the provider would review all records every six months, but there was no evidence of this provided during the inspection. The action plan also stated that care plans would be audited frequently, but records provided to us showed that only four audits had been completed since March 2018.

We looked to see if statutory notifications submitted appropriately and found that the registered manager had not notified the Care Quality Commission (CQC) of all events and incidents that occurred in the home in accordance with our statutory requirements. Records showed that a number of incidents had taken place that had been referred to the local safeguarding team, however CQC had not been informed. This meant that CQC were not able to monitor information and risks regarding Knotty Ash accurately. We discussed this with the registered manager who told us this had been an oversight and they would ensure all relevant notifications were made in the future.

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. We spoke with staff members who all told us that they were happy working in the home and that the registered manager was approachable and "all for the needs of the residents."

Policies and procedures had recently been reviewed and provided staff with guidance to support them in their role.

Ratings from the last inspection were displayed within the home as required. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

Systems were in place to gather feedback regarding the service, such as regular meetings for people living in the home. The registered manager told us people were encouraged to run their own meetings, but were supported to produce an agenda and to help it run smoothly. Quality assurance surveys were also issued to people and their relatives on order to gain feedback regarding the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always gained in line with the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people was not always accurately assessed or well managed. Medicines were not always managed safely within the home.