Knights Care Limited

Abbey Court Care Home - Leek

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 18 August 2016 and was unannounced. Abbey Court Care Home provides nursing and personal care to a maximum of 52 people. There were 50 people using the service at the time of our inspection.

There was a manager in post who was in the process of applying to become a registered manager. 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.

Medicines were not always managed safely. Medicine was not always given as prescribed and there were not consistent protocols in place for 'as and when required' (PRN) medicine. Medicine was not stored in a consistently safe way.

Appropriate referrals were made to health services when required. However, the advice given by professionals was not consistently followed.

Evidence had not been consistently documented for people who had a representative with Lasting Power of Attorney (LPOA). There were Mental Capacity Assessments in place and appropriate DoLS application had been made. Staff were observed seeking consent from people before being supported so people had the choice.

There was not always enough staff to meet people's needs and they had to wait for support, particularly in the morning.
People were offered a choice of food however they did not always like the variety and felt it could be presented in a more appealing way.

Quality assurance systems were in place to monitor the quality of the service, such as medicine paperwork audits and care plan audits, however not all issues had been identified so the systems were not effective.

People we spoke with told us they felt safe. Staff knew how to recognise abuse and knew how to report concerns if they suspected someone was being abused. We saw evidence that safeguarding referrals had been made, investigations were undertaken and actions had taken place.

Risk assessments and associated plans were in place to reduce the risk of harm occurring to people.

Recruitment practices meant that appropriate checks were in place to ensure staff were fit to work with vulnerable adults. This involved checking with the Disclosure and Barring Service (DBS) for criminal records, getting references from previous employers and checking identity documents.

People were involved in planning their care and making choices and their preferences were documented within their care plans. The care plans were regularly reviewed.

People were encouraged to partake in activities and access the local community. People also had their spiritual needs catered for as religious ceremonies were held in the home.

People knew how to complain and felt able to raise concerns if they needed to. The home had a complaints policy and people who had complained had their complaints investigated and responded to in line with the home's policy.

Staff treated people in a caring manner and people told us they liked the staff. People's privacy and dignity was respected. People had been able to decorate their rooms to their own taste and had their own personal items in their rooms.

People and staff told us the manager and the management team were approachable and that they felt supported by them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not always administered as prescribed or stored correctly.

There were not always enough staff to meet peoples' needs at particular times.

People were protected from harm by staff that were aware of different types of abuse and how to report concerns.

Safe recruitment practices were followed to ensure appropriate staff were working with vulnerable people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Guidance from health professionals had not always been followed.

Staff checked people consented to their support on a day-to-day basis however evidence of the documentation regarding the right of legal representatives to make decisions on behalf of people at the home were not consistently available.

There was a choice of food, but people felt it could be improved.

Staff felt sufficiently trained to carry out their role.

Is the service caring?

Good

The service was caring.

People told us the staff were helpful and friendly.

Staff knew people well and supported people in a caring manner.

Privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People and relatives were involved in care plans and reviews and people had their preferences catered for.

There was a seven day service available for people who wished to take part in activities, which included events within the home and accessing the community.

People knew how to complain and felt able to raise concerns if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance systems were in place but they did not always identify issues.

People knew who the managers were and felt able to discuss things with them.

The manager felt supported by the provider.

There were meetings with people, relatives and staff and improvements made if suggestions are made.

Abbey Court Care Home - Leek

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.

The inspection took place on 18 August 2016 and was unannounced. The inspection was carried out by two inspectors.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also asked commissioners and Healthwatch if they had any information they wanted to share with us about the service. Healthwatch is an organisation that gathers information from people and relatives who use services and provides feedback to commissioners and regulators (like the CQC) about those services.

We spoke with seven people who use the service, four relatives, seven members of staff that supported people and three professionals that have contact with the people who use the service. We also made observations in communal areas. We reviewed the care plans and other care records (such as medication records) for five people who use the service and looked at management records such as quality audits. We looked at recruitment files and training records for four members of staff.

Requires Improvement

Is the service safe?

Our findings

Medication Administration Records (MARs) are documents which record what medication a person needs and records when the medicine was administered by staff. We saw that some staff were signing MARs to show the medicine had been administered when a different member of staff had given this medicine. MARs should only be signed by the person who administered the medicine. This meant there was a risk of people not receiving their medicine correctly and it not being documented correctly.

If medicine is prescribed to be given 'as and when required' it is called PRN medicine. If someone has PRN medicine there should be a PRN protocol in place which helps staff to identify when the medicine should be given. We saw that PRN protocols were not always in place but some people did have PRN protocols in place. This meant people may not have had their medicines when they needed them as staff were not consistently informed about when they should give medicines. The provider has informed us that since the inspection they have now conducted an audit and PRN protocols are now in place.

Peoples' medicines were not always managed and administered safely. We saw one person's time-specific medicine being administered an hour later than it should be. This meant the symptoms of the person's condition may not have been managed safely and the person may have developed discomfort as a result of their symptoms. This meant that people were not always receiving their medicine in a safe way and according to prescriptions.

Some medicines need to be refrigerated in order to ensure it remains effective. This meant that refrigeration equipment needs to be maintained and kept at an appropriate temperature. Information was available to staff which told them the temperature range the refrigerator should be. However, we found the fridge had not been checked consistently and when the refrigerator was out of the determined safe range, there was not always action documented to ensure the refrigerator was within the correct range. We found that some people may need oxygen to help them breathe. Cylinders containing oxygen were stored in the medication room which had signage to warn people and staff that there was oxygen present in the room. However they were not chained to the wall as required. This could pose a risk if a cylinder was faulty or opened. This meant that medicines were not always stored safely.

People told us there were not always enough staff to meet their needs, particularly in the morning. One person we spoke with told us, "Sometimes it is great when I press the buzzer but other times it can be longer. I think they are short staffed this morning as I am still waiting for my bath". When we spoke to relatives one person told us, "They are short of staff. The staff step up and do their best". We spoke to members of staff and one told us, "Extra staff are needed in a morning as many people need two staff to support them". Another member of staff told us, "Sometimes especially in the morning we could do with more staff as people want to get up". We saw that people sometimes had to wait for support to go to the toilet or to be assisted back to their room. One person had to wait 45 minutes to be assisted to the toilet. This meant people would not always have their needs met when required.

People felt safe living at the home. One person we spoke with told us, "Oh yes, I feel very safe. There are

people around me and I can rely on someone coming if I need them". Another person told us, "I feel safe. I can't get out but there are staff around and I have regular meals and they make sure my room is clean everyday". This meant people felt safe in the place they lived.

People were protected against the risks of potential abuse. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff we spoke to were able to tell us about the different types of abuse and what they would do in the event of suspected abuse. When a safeguarding incident had been identified, it had been reported correctly and a full investigation documented. This meant people were protected from the risk of abuse by staff who were aware of what constituted abuse, how to report it and incidents were documented and investigated.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. We saw evidence that if someone had a change in their needs, staff had documented the change and had completed a body map where necessary and actions taken were documented. People were protected against hazards such as falls, slips and trips. One relative we spoke to told us that since their relative had started to live at the home, the number of times they had fallen had reduced. This meant that risks were assessed and plans were in place to reduce the level of risk.

We saw there were fire risk assessments and people had a personal evacuation plan in place, which identified the level of support they required should they need to be evacuated from the building. Other relevant checks were completed such as fire alarm tests and electrical safety checks. This meant that people were protected in the event of an emergency occurring in the home.

The service followed safe recruitment practices. Staff files we viewed included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK as their identity had been checked. This meant that people were supported by staff who were suitable to work with vulnerable adults.

People told us that staff always wore appropriate protective clothing when being supported, such as aprons and gloves. We also saw staff wearing these when supporting people. This meant that there were infection control measures in place and people were protected from potential cross-contamination.

Requires Improvement

Is the service effective?

Our findings

People accessed a range of healthcare support from different professionals in order to help their wellbeing. We spoke with a District Nurse who visited the service regularly. We also saw evidence of a GP visiting regularly, as well as physiotherapists, Speech and Language Therapists (SALT), opticians and dentists. However, although there was involvement from a range of professionals, we saw that professional advice was not always followed. One person had been advised to only drink thickened fluid from an open cup with no straw to reduce the risk of choking. Their care plan had not been updated to reflect this and we witnessed staff giving this person unthickened drinks and also drinking through a straw. This meant that this person was at risk of choking as advice was not being followed. We raised this with the manager and they updated the care plan whilst we were present in the home.

One person had recently been reassessed by SALT as needing a fork mash diet which could include bread with no crusts, whereas they had previously been on a pureed diet. We witnessed this person being given pureed food at lunch time. The person's records had not been updated and the information not passed on to the kitchen staff following their reassessment. This meant the person was not being supported to eat a diet which was appropriate to their needs and information about changes had not been passed on effectively to those who needed to be aware of changes.

Another person had received advice from the hospital which stated they should be weighed weekly due to their needs. The records showed that the person had not been weighed on a weekly basis but had been weighed less frequently and this showed the person had been losing weight and no referrals to the dietician or GP had been documented. This meant the person may then be at risk of continuing to lose weight and their health being affected.

People were offered a choice of food, however people told us the food could be improved. One person we spoke with told us, "The food is ok, I get a choice. I can have something else if I don't want what is on the menu and there is a variety of sweets." Another person told us, "The food could be better, the variety is the same each week and the way it is presented could be improved". Another person also told us that, "The presentation could be improved". This meant that people may not always have been receiving food that appealed to them. The provider has told us that since our inspection the menu has been changed following discussing this with people to determine their preferences.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. A person who has Lasting Power Of Attorney (LPOA) has the legal right to make decisions and sign agreement on behalf of someone who has lost their capacity to make their own decisions.

We saw documentation that had been signed by relatives and forms to state that some relatives had LPOA; however the evidence of the LPOA was not available and had not been documented as seen by staff at the

home. This meant the home had not verified that some relative's had the legal authority to sign documentation on the person's behalf and there was a risk the relative may not have been acting in the person's best interests. However, in another person's file the evidence of LPOA was available and the relative who held LPOA had been involved in the writing of the care plans. This meant that people were not consistently protected by the MCA as appropriate checks had not been documented.

We observed staff checking for people's consent prior to supporting them and when we spoke to staff they explained to us how they check for consent before assisting someone. For example, a member of staff was administering medicines and they asked a person first whether they wanted to have their medicine or whether they chose not to have. This meant people were offering people the opportunity to make decisions about their care and the principles of the MCA were being followed.

We saw evidence that decision-specific mental capacity assessments had been carried out in order to determine the type of decisions people were able to make for themselves. We saw staff checking with people that they gave consent prior to supporting them, for example they checked with the person prior to administering eye drops. We saw evidence of care plan's being signed off by the person themselves when they had capacity which showed the service supported people to make decisions where they were able. This meant that people's ability to decide was being checked and that some principles of the MCA were being adhered to and people with were protected.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. For example, we saw evidence of two people who had a DoLS applications made because they had bed rails fitted for their protection. We found appropriate DoLS applications had been made and people's liberty was protected.

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One person we spoke to told us, "Staff are well trained in some things". Another person we spoke to said, "[Staff member's name] is excellent, one of the best". This means people were supported by staff who had effective training to meet their needs.

People's needs were met by staff who had access to the training they needed. Staff told us they had the training they needed and one staff member told us, "I feel confident in my job". Staff had received training which included; safeguarding, safe moving and handling, dementia awareness and palliative care. Some staff were also completing the nationally recognised Care Certificate. We witnessed that staff used the correct moving and handling techniques when supporting people. This meant staff were trained effectively in to meet the needs of the people they supported.

People were supported by staff who had supervisions (one to one meetings) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any concerns they had. One member of staff told us, "I have chats with [unit manager] and [manager] if anything needs discussing". Another member of staff told, "One member of staff told us "The supervisions are worthwhile, we discuss different things and I feel confident in my role" and, "The supervisions are good to support and help me improve, it gives me a buzz when I get good feedback". We also saw evidence that group supervisions had taken place so staff could discuss things in a group. This meant staff were assisted in their role to support people effectively.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. A person we spoke to told us, "The staff are very good, friendly and helpful". A relative we spoke to told us about their loved one, "They are treated with dignity and respect, very much so". We spoke to a professional who visited the service and they told us, "The staff are friendly and helpful here. I have no cause for concern".

People received care and support from staff who had got to know them well. We saw staff asking people about things specific to that person, which showed the staff knew them well. Peoples' bedrooms were personalised and decorated to their taste. We saw rooms with photographs, individual soft furnishings and their personal effects. We saw staff bent down to the same level of people sitting in wheelchairs when they chatted, so it was much more personal and polite than standing over the person to talk to them. This meant people spent time in an environment personal to them and were being treated with dignity and respect.

Staff were able to tell us how they would ensure people were treated with dignity and respect. Staff told us that people were encouraged to be as independent as possible, they told us, "I offer for people to wash themselves rather than just doing it for them". A person we spoke to told us they go out most days to the shops and were able to be independent. Staff explained they would check consent prior to supporting a person, knocking before entering rooms, keeping doors closed and keeping people covered when assisting with personal care. We saw observed staff following these principles. This meant that people were supported to maintain their privacy and dignity by staff who were caring.

People were given the information and explanations they needed, at the time they needed them. One person we spoke to told us, "[Staff member] is nice and very patient". We saw a staff member assisting a person to eat; they explained what each item of food was and chatted to the person whilst supporting them. When people were being supported to eat, staff took their time and people could eat at their own pace. This meant people were supported in a caring manner and were not rushed.

The home was spacious and allowed people to spend time on their own if they wished. There were communal lounges on each floor, as well as quiet rooms and people could spend time in their own room. One person told us, "I stay in my room in the morning for breakfast then spend the rest of the day in the lounge. I come back to my room to watch some TV before bed". This meant people could choose where they spent their time.

Good

Is the service responsive?

Our findings

People or their relatives were involved in developing their care and support plans. One relative we spoke with told us, "We have been involved in the care plans, risk assessment and in their [relative's] reviews". Another relative told us, "We have been involved with the care reviews and have discussed ongoing treatment and end of life care with staff at the home". Care plans were personalised and detailed daily routines specific to each person. For example, one person who needed assistance to the toilet had a plan in place which stated how they liked to be assisted and their preferences for who supported them. There were also some details of people's life history in their files so staff could get to know a person. This meant people were supported in a way that was personal to them and relatives were involved in the planning and review of the care.

People had a range of activities they could be involved in. A relative we spoke with told us, "There is always something going on". Three activity coordinators (called social therapists) work at the service and they are rostered to work over a seven day period so activities are equally available at the weekend. People told us there were a variety of activities and trips, examples included a trip to Southport, the zoo and going out for meals. We saw the home had been decorated with photos of the trips out together. We were told by a relative we spoke with, "We get invited to activities, we came to the Christmas Party and everyone was there". A minibus was available for trips and it was used to transport people to appointments where necessary. As well as trips, we saw hairdressers attended the service and there was a dedicated space for people to have their hair styled. We saw people playing with a ball together and listening to music as a group. This meant that people were encouraged to partake in social activities and supported to go on trips outside the home.

We saw that religious needs were catered for as there was Holy Communion available for people to attend. One person we spoke with told us, "I always believed in God so it is very important for me to continue with my belief". This meant people were supported with their spiritual needs, as well as their care needs.

People told us they felt able to complain. One person we spoke with told us, "I do complain every now and then, you can have a word". Another person told us, "I am able to speak to the staff and the manager". A relative we spoke with said they felt able to complain and had previously had an issue, "It was jumped on straight away and dealt with". The service had followed its complaints procedure and complaints had been documented, the investigation completed and a written response sent to the complainant. The manager told us that the complaints policy was given out to people in their welcome pack to the home.

Requires Improvement

Is the service well-led?

Our findings

The service had quality assurance systems in place however these had not always been effective in identifying issues. We looked at examples of medicine paperwork audits and saw that if an issue had been identified then the action had been documented. However the audits had not picked up that some PRN protocols were missing, if medicine was given at the incorrect time, if it was not being administered as prescribed or that the MARs were not being completed by the person who had administered the medicine. We also viewed some example audits of care plans. The checks we viewed showed where issues had been picked up and action documented. However we found other examples of care files where changes to people's needs were documented but this had not be reflected in the plans the staff used and staff were not following guidance from professionals. For instance, one person's dietary needs had changed but plans had not been updated and another person had received guidance from a professional about how to drink liquids and the plans had not been updated. This meant that although systems were in place, they were not identifying all issues and resolving them. Since our inspection the Provider has informed us that a new audit system is now fully in place and things identified, such as having consistent PRN protocols for people were now in place.

At the time of the inspection, the service had recently had a staffing restructure, with one manager over the home as a whole and two additional managers now over different areas of the home. The overall manager was new in the role and was in the process of applying to become the registered manager with us. Managers were new and new systems were being developed, which had not yet been fully implemented to monitor the care within the home. This meant issues were not being identified and resolved.

The two unit managers split their time between administrative managerial duties and spending time working with people and regular staff. This meant there was a manager available seven days a week for people to speak to, should they wish. One person we spoke with told us, "I feel a manager is always available, [unit manager's name] is very nice". Staff told us the manager is often seen around the home and was not always based within the office.

The manager had notified CQC about significant events. Statutory notifications include information about important events which the provider is required to send us by law. For example, they told us if there had been a safeguarding incident or if someone passed away whilst living in the home. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

People we spoke with told us they felt the manager was amenable. One person we spoke to said, "Oh yes, they are approachable". A relative we spoke to told us, "She is lovely, yes she is approachable". Staff told us they felt supported by the manager and other management staff and that they are available when they needed them. One staff member said, "Yes she is approachable, [name] is brilliant. If I have any queries I can go to her" and, "They appreciate you here". Staff also said the two unit managers were also receptive and they could speak to them if they needed to. People felt they could discuss their care and any issues they may be facing and staff felt they could go to the management team for support. This meant the staff team would be able to provide better support for the people who lived in the home as they felt supported by the

management team and people could raise concerns if they needed to.

The manager and unit managers told us they felt supported by the provider. The provider visited the home once a week and there was other frequent contact should it be needed. The manager told us, "The provider is approachable and any member of staff can call them if needed". We were also told that there are regular managers meetings with the other homes owned by the provider which formed a support network. This means the manager was supported in their role to effectively manage the service and therefore had the confidence and support to effectively manage the home

Relatives told us they were asked for their opinion about the service; they told us they got invited to meetings with the managers and they could complete a survey which could be named or anonymous. We saw staff meetings had been held, with care staff as well as the activity and kitchen staff. We saw in the minutes of a meeting with kitchen staff that when they prepared food for people on a pureed diet, there should be more variety than just soup. We saw at lunch time that people on a pureed diet had the same meals that were available to those who could eat solid foods, but in a pureed format. This meant that meetings held were worthwhile and benefitted the service. Staff told us the manager valued people's/staff feedback and acted on their suggestions. A member of staff told us, "We feedback about the need for more staff in the afternoon and they got extra staff for us". This meant the service listened and made improvements based on feedback.

We also saw that the manager analysed any accidents or falls that had occurred in the home. They looked at the time of the fall, whether a particular person was falling regularly and where the accident took place. The manager explained that as a result of this analysis they had spotted a person who required a review, their medicines were changed and it reduced the number of falls that the person was experiencing. That means people were protected from further risks to their safety.