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Thomas Knight Care Home

Inspection report

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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

Thomas Knight care home is situated in the town of Blyth in Northumberland. The service provides accommodation and personal care for up to 54 older people, some of whom have dementia. Nursing care was also provided. There were 45 people using the service at the time of the inspection.

An inspection was carried out in March 2014 and we found two breaches to our regulations regarding respecting and involving people, and safety and suitability of premises. The service was inspected on 1 and 7 October 2014 and these breaches had been met. No further breaches were found, but improvements to the premises were ongoing which were incomplete.

This inspection was carried out on 14 and 18 July 2016. The inspection was carried out by one inspector.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. They were supported by a clinical lead who was also a registered nurse.

Procedures were in place for the safeguarding of vulnerable adults, and staff training had been provided which was up to date. Staff told us they knew how to report concerns of a safeguarding nature and where concerns had been raised we found that the service had taken appropriate action to prevent reoccurrence.

Behavioural disturbance and distress were well managed and staff demonstrated skill and empathy when supporting people. Care plans outlined how staff should support people in a consistent way.

There were suitable numbers of staff on duty and they were effectively deployed to ensure maximum supervision of people. Safe recruitment procedures were followed which helped to protect people from abuse.

A number of safety checks to the building and premises were in place. We found that risk assessments had not been carried out related to glass fronted cabinets. The manager told us they would address this immediately. Improvements had been made to the design and layout of the building, and dementia friendly design had been used to good effect. Appropriate procedures were in place to minimise the risk of the spread of infection.

Individual risks to people were assessed including falls and nutritional risks, these were regularly reviewed and updated. A record of accidents and incidents was maintained and these were regularly reviewed to monitor for patterns or trends.

Medicines were managed safely and regular audits took place to ensure compliance with the home's

medicine procedures. The competency of staff to administer medicines was assessed on a regular basis.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service was operating within the principles of the MCA 2005 and applications to deprive people of their liberty in line with legal requirements.

Staff received regular training, supervision and appraisals. This meant that their learning, development and support needs were considered by the provider. The health needs of people were met. They had access to a range of health professionals. Visiting professionals were happy with the response of staff during their visit, and found the staff organised and efficient.

Staff were caring. There were numerous examples of positive interactions between staff and people. People displayed positive signs of psychological well-being and were mainly relaxed and happy during our visit.

Person centred care plans were in place, and these were personalised, detailed and were reviewed monthly.

There was a complaints procedure in place which was prominently displayed. There were a number of feedback mechanisms to obtain the views from people, relatives and staff. These included meetings and surveys. The registered manager carried out a number of audits and checks to monitor the quality of the service. The provider also arranged regular quality monitoring checks by an external consultant to ensure high standards of care were maintained.

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 services was safe.

Safe recruitment procedures were followed which meant people were protected from abuse.

Risks to people were assessed and reviewed to ensure the safety and comfort of people living in the service.

Medicines were managed safely and a procedure was in place to ensure the competency of staff administering medicines.

Risk assessments related to glass fronted furniture had not been carried out, but the manager told us they would immediately address this.

Is the service effective?

Good

The service was effective.

People's capacity levels had been considered and the Mental Capacity Act (2005) (MCA) was applied appropriately.

Staff had received regular training and supervision and nurses were supported to meet the requirements of their registration.

People were supported with eating and drinking and received specialist dietary support when necessary.

Is the service caring?

Good

The service was caring.

Staff were caring and compassionate and relatives also told us they felt well cared for and supported.

People were not all able to communicate with us verbally, but there were many examples of psychological well being displayed by people throughout the inspection.

Staff were skilled in their approach to people which meant that

distress was minimised and people were supported sensitively.

Is the service responsive?

Good

The service was responsive.

Person centred care plans were in place and these were reviewed and updated regularly.

People were supported to take part in activities which were varied and designed to meet the different abilities and interests of people.

We saw that the personal choices and preferences of people were respected and supported.

Is the service well-led?

Good

The service was well led.

A registered manager was in post. The manager was supported by an experienced clinical lead who was also a nurse. Staff and visitors told us the manager and clinical lead were helpful and approachable.

Regular audits to monitor the quality of the service were carried out.

Feedback systems were in place to obtain people's views such as surveys and meetings.

Thomas Knight Care 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 14 and 18 July 2016 and was unannounced. The inspection was carried out by one inspector.

We spoke with six people who lived at the service during our inspection and four relatives. We spoke with local authority contracts and safeguarding officers. We used the information they provided when planning our inspection.

We spoke with the manager, clinical lead who was a registered nurse, and four care workers during our inspection.

We read four people's care records and three staff recruitment records. We looked at a variety of records which related to the management of the service such as audits and surveys. We also checked records relating to the safety and maintenance of the premises and equipment.

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 to us.

Prior to carrying out the inspection, we reviewed all the information we held about the home. We had not requested a provider information return (PIR). A PIR is a form which asks the provider to give some key information about their service; how it is addressing the five questions and what improvements they plan to make. We also looked at notifications submitted by the provider in line with legal requirements.

Good

Is the service safe?

Our findings

People told us they felt safe living at Thomas Knight care home. One person told us, "I feel well looked after. The staff are nice to me." A relative said they thought their family member was safe and told us, "I think it is marvellous. I am sleeping better now because I know my relative is being well looked after."

A safeguarding policy and procedure, which informed staff how to recognise and report suspected abuse or neglect, was in place. Staff knew what to do in the event of concerns and told us, "I wouldn't jump to conclusions but I would report anything straight away." Training in the safeguarding of vulnerable adults had been provided to staff and was up to date. Where a concern of a safeguarding nature had been raised and investigated, we saw that action had been taken by the provider to avoid a recurrence of the circumstances which led to the allegation. There were two ongoing safeguarding investigations which were being carried out by the local authority. We cannot report on these investigations at the time of this inspection. CQC will monitor the outcome of the safeguarding investigations and actions the provider takes to keep people safe.

The service cared for people with complex needs including those with dementia related symptoms who exhibited signs of behavioural disturbance or distress. We observed that consideration had been given to the layout of the premises and where necessary people were supported in small groups to minimise distress and therefore maintain the safety of people who used the service. Staff demonstrated good skills in de-escalating behaviour, and used diversion and distraction to good effect to diffuse potential distress reactions.

There were suitable numbers of staff on duty. Staff were effectively deployed to ensure the safety of people who used the service. One staff member old us, "We don't leave the lounge unattended in case anyone falls or tries to stand unaided, or someone might become anxious or upset." We saw that a staff member who needed to attend to a task waited a short time until the other staff member returned to take over from them in supervising the lounge. A visiting professional told us, "There appears to be plenty staff. They are calm and unhurried." A relative told us, "Staff are very visible and available." Staff recruitment procedures were appropriate. Staff records showed that recent applicants had been screened by the Disclosure and Barring Service (DBS) to ensure they were suitable to work with vulnerable people. DBS checks ensure staff working at the home have not been subject to any actions that would bar them from working with vulnerable people. This helped to protect people from abuse. Two references were obtained for each applicant, and there were no unexplained gaps in employment.

Risk assessments and safety checks of the premises and equipment were carried out. These included checks of water temperatures, emergency lighting, fire safety equipment, and gas and electrical checks. A risk assessment was in place for the prevention of infection caused by legionella bacteria, and control measures were in place. Equipment used to help people move safely such as hoists and wheelchairs were checked regularly. Window restrictors were in place and these were checked regularly to ensure they were working effectively. Hazardous substances such as cleaning materials were locked away which meant that people were protected from harm. A business continuity plan was in place for staff to follow in the event of an

emergency such as a gas leak or flood. This outlined action staff would take and described how people would be protected and moved to safety. We noted that there was small number of gaps in the weekly fire alarm test records. We discussed this with the manager who told us that the maintenance staff member had been working at another site on those occasions. They said that they would ensure that this task would be delegated to another staff member in the future to ensure tests were carried out in line with their own policy. There were items of furniture in the home which contained glass such as display cabinets. These included items belonging to people in their own room. While we acknowledged the importance of personalisation of rooms, there were no risk assessments in place related to these or those in communal areas of the home. We spoke with the manager about these and they suggested that where they could not verify whether safety glass was in place, they would risk assess and if necessary apply protective film to minimise the risk of harm to people.

Individual risks to people were assessed and these were reviewed and updated regularly. These included risks related to falls, pressure ulcers and nutritional risks. This meant that information was available to help staff take action to avoid or reduce these risks. We observed safe moving and handling techniques, and individual records of the type of handling equipment such as slings were recorded including the serial number. This meant that staff were clear about the procedure to move people correctly and also the correct equipment to use. This helped to ensure the safety of people and staff. Training in safe moving and handling techniques had been provided.

We checked the management of medicines and found that there were safe procedures in place for the ordering, receipt, storage, administration and return of medicines. We checked the stock balance of a controlled drug (medicine liable to misuse) and found the correct quantity. Fridge temperatures were checked regularly. This is important as some medicines deteriorate if not stored at the correct temperature. The temperature of the room used to store medicines was not checked. The clinical lead told us they would start doing this immediately. Records were kept of medicines ordered and received from the pharmacy. We saw that medicines received were carefully checked and any discrepancies such as missing medicine were picked up by staff members checking the order. Most medicines were administered by qualified nursing staff and some medicine was administered by senior care staff. One of the nursing staff told us, "I have done an online medicine assessment and I always check medicines if I am unsure by consulting the British National Formulary (BNF) online or by contacting the chemist. They are happy for us to ring if we have any queries." The BNF is a resource for clinicians which lists medicines and their side effects and prescribing guidelines. Staff completed formal qualifications related to the safe administration of medicines and an annual competency assessment. The assessment took staff through various scenarios asking what they would do. This meant that the practical knowledge of staff was tested. Audits of medicines were carried out on each floor. This meant that medicines practices were monitored to ensure the safety of people who used the service.

Procedures were in place for the prevention, control and spread of infection. We spoke with a member of domestic staff who told us they had completed training in infection control and knew the correct procedures to follow to keep the service safe and clean. A staff member returned from a trip and we overheard them saying, "I'll come and help with lunch, I'm just going to wash my hands." There were ample supplies of personal protective equipment such as gloves and aprons to help to prevent the spread of infection. There were two pets belonging to people living in the home. We observed a sign next to antibacterial hand gel saying "This is a pet friendly environment, so please use this facility if you touch any of the pets."

A record of accidents and incidents was maintained. This included a detailed accident checklist for staff to complete to ensure they had recorded all of the necessary information including adding the information to a

body map. Body maps are drawings of bodies which staff use to indicate where injuries or marks were located. Accidents and incidents were reviewed to identify any patterns or trends. Monthly health and safety audits were carried out. Actions we saw included the removal of rubbish from the garden, and the replacement of a carpet. The action also detailed who was accountable for ensuring work was carried out. This meant that the provider sought to maintain the health and safety of people staff and visitors to the service.

Good

Is the service effective?

Our findings

A relative told us they were very happy with the care provided at Thomas Knight, they said, "My relative is very complex. There is no blame when anything goes wrong, they are so accepting, the staff say, 'Things happen, we'll sort it.' It's such a relief."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager had submitted DoLS applications to the local authority for approval in line with legal requirements. Capacity assessments had been carried out, and where people lacked capacity, decisions made in their best interests were appropriately recorded and included who had been involved in the decision making process.

Staff received regular training. We viewed the training matrix and found that training in key areas such as those related to safety and safeguarding were up to date. We saw certificates of training that had been completed in the staff files we read. Where there were gaps we saw that training was booked over the following months to meet these. Nursing staff were supported to meet the requirements of the Nursing and Midwifery Council (NMC) registration requirements. In order to remain on the professional register, nursing staff must go through a process called 'revalidation' which demonstrates they have maintained their skills and knowledge. Each nurse had been provided with a revalidation file and documentation upon which they could gather evidence and witness testimonies to their learning. One nurse told us, "The clinical lead got us all a file and printed off all the things we need. We need to get feedback from professionals when they visit." They asked us and we recorded on a form that they had been interviewed as part of a CQC inspection.

Staff also received regular supervision and appraisals. We looked at the supervision files and found that care staff received supervision every eight weeks, nursing staff had monthly supervision. We also saw that group supervision sessions were held where staff were reminded of the importance of taking their breaks, and were thanked for their hard work. This meant there was a system in place to support staff and ensure effective communication across the staff team was in place.

People were supported with eating and drinking. We joined people for lunch on the first day of the inspection. A six weekly menu cycle was in place. A staff member told us, "We used to try to ask people what they wanted the day before, but people sometimes forgot or changed their mind. We just offer people choices at the time of the meal now and there is always enough food for them to choose either choice. If they don't like something, there are always alternatives available such as omelette or sandwiches." We

observed that staff supported people well during the meal. They sat at the same level as people, and were observant and noticed when people needed support. One staff member offered to turn the plate around for one person as they had eaten all the food on one side of their plate. Another staff member asked, "Can I please wipe your mouth?" Another person was restless and found it difficult to sit still at the table. Staff appropriately tried to encourage them to stay at the table, including bringing food and drinks, but they did not force the issue and had appropriate plans in place to support the person to eat in the way that they preferred. One person had a sloped bowl filled with warm water to help to keep their meal warm. We checked their care plan and found that this was recorded, including the level of support they needed. This meant that people were provided support to maintain their independence and staff intervened only when appropriate in order that they did not de-skill people. Special diets were catered for and staff were aware of people with swallowing difficulties and knew, when we asked, whether they needed anything added to their food to aid safe swallowing. Nutritional needs were assessed and specialist dietary advice had been sought when necessary.

The health needs of people were assessed and we saw that care plans were in place to meet the physical and psychological needs of people. Additional support from visiting professionals had been sought, where necessary. Care plans relating to specific ailments or conditions were available, including how the person was affected for example due to Alzheimer's Disease. We spoke with a district nurse who visited the service, they told us, "I find the service very organised and helpful. Staff do what I ask them and I have no concerns about the care." People had access to a number of health professionals including GP's and chiropody. We overheard and member of staff calling the doctor because they had noticed that someone appeared 'chesty'. This meant that staff had followed up health concerns about the person and sought appropriate advice.

The environment had been improved and adapted since the last inspection. The top floor unit, which cared for people experiencing behavioural disturbance and distress, had been opened up with the removal of a wall, and was a bright, calm and airy space. Signage was in place which was supportive to the needs of people with dementia. Toilet signs had a picture of a toilet and the word to support people who may have difficulties understanding the written word. Items of interest were attached to walls for people to explore, and handbags hung from hooks provided opportunities to explore the surroundings. Exits had been disguised by bookcase wallpaper as some people had a tendency to wish to leave the building and became distressed. Staff told us that the wallpaper had significantly reduced these incidents. LED lights to mimic sunlight had been placed in corridors. A staff member told us, "It was quite dark and this is more like natural sunlight. It is supposed to help with sundowning syndrome." The Alzheimer's Society explains that sometimes a person with dementia will exhibit an increase in certain behaviours in the late afternoon or early evening. For example, people may become more agitated, aggressive or confused. This is often referred to as 'sundowning'.

Bedrooms were homely and nicely personalised. One relative told us, "I am very happy with the facilities and the en suite room. They told us we could put picture up and said 'It's their home now'. We had an appointment with a professional and were offered a private room to speak in." Another relative told us, "In other homes you find the TV on all day. In here they think about what they put on. It might be the music channel or not at all. It isn't on all day every day." This was important because managing excess noise in the environment is an important feature of caring for people with dementia related symptoms which can include hyper sensitivity to noise.

Good

Is the service caring?

Our findings

People were not all able to speak with us to tell us their experience of care due to dementia related symptoms. We observed, however, that people exhibited positive signs of psychological well-being throughout the inspection. These included being bright and reactive, displaying warmth, affection and humour, and engaging with the environment and people around them. One person told us, "It's fine here, it's okay. The staff are friendly, they are nice." Another person beckoned us over and said, "Can I help you with anything?"

Family carers were also supported by staff. One relative told us, "The reception when you come in is marvellous. I asked if I could pay for a meal and they said no, that I was welcome to stay and eat. I make things for them because when they got my family member they also got me. We are so well cared for, I am like a different person." Another relative told us, "The staff are all very good and good at cajoling people. Personal care is good and my relative is always clean and tidy." A third relative said, "The care is out of the ordinary here, they know what they are doing and the atmosphere is good."

Staff were caring, and we saw kind and compassionate care and positive interactions throughout the inspection. One person was shouting in their bedroom, and a staff member went straight away to see if they were okay. We were shown around the home, and introduced to people by staff which was respectful and polite. One person held the hands of a staff member who said, "Your hands are cold, I'll hold them." People were supported to keep their own pets and this provided them with great comfort.

We observed a person who required attention with personal care. Staff supported the person sensitively and discreetly, and there was the potential for the person to become distressed and embarrassed. Following the staff intervention, the person returned calmly to the lounge with a member of staff. The staff member asked if they would like to have a seat, and the person said, "No, I'll just wait here for you." They stood in the doorway waiting for the staff member. This demonstrated that staff were skilled in putting people at ease and supporting people with sensitivity and a minimum of fuss.

Staff took care when assisting people, not to cause alarm. At lunch time, we saw that people were warned before staff helped them to move, a staff member said, "I'm just going to move you back a bit." Another staff member said, "Are you ready? We are going to move this way." People responded warmly to staff. A staff member asked someone if they would like to join in an activity and the person answered, "I'll do my best for you." Another person was concerned when a staff member moved a small piece of furniture and said, "That's heavy for you to move pet." The staff member replied, "Don't worry, I'm a big lass." The person laughed.

End of life wishes were recorded where appropriate and care plans were in place to support people nearing the end of life. Anticipatory medicines had been prescribed which meant they were prescribed in advance should people nearing the end of life experience discomfort or distress. This meant that they could be administered without delay.

Good

Is the service responsive?

Our findings

Relatives told us their family members' needs were responded to. Two relatives told us that their family member had stayed in other care settings that had struggled to meet their needs. They were complimentary about the culture of the service which they found to be optimistic and accepting. Staff were observed responding to the needs of people. One person was shifting in their seat and a staff member went to ask, "Do you need something?"

Staff supported people to make choices and we heard staff consulting people throughout the day saying, "Would you like to do this?" and "Can I help you?" People were offered choices where possible and there was recognition that although some people could not always verbalise choices, they could be supported, for example being shown two meals and asked to indicate which they preferred.

Person centred care plans were in place. This meant that people's personality, behaviour, likes, dislikes and previous experiences were taken into account when planning care. Care plans were neat and well organised and were evaluated monthly. Pre admission assessments took place before people moved into the service. This meant that care needs were identified before admission so that appropriate care plans were in place.

A varied activity programme was in place. Two activities coordinators were in post and we spoke with one of them who told us, "We take into account people's past history. For example, a lot of the people enjoyed gardening so we have a gardening club, and music also goes down very well." Staff paid for their lunches, and the money was added to the activities fund. We spoke with one person who told us, "I've been outside to the gardening club, I like gardening." There were strong links with the local church which was across the road, and people visited it regularly for coffee mornings or services. There were good community links and the church staff and other individuals had made tactile aprons, cushions and activities suitable for people with more advanced dementia. Tactile aprons had various items attached including different textures. Tactile activities are suitable for people with more advanced dementia related symptoms, when activities need to be more sensory.

One person told us they were looking for their bag and were worried and upset. A bag was nearby full of items and had been placed in their room within easy reach. They smiled broadly when given their bag and took out the items saying, "Look, these are all my things." This meant that staff were aware of the importance of people having access to their belongings and having these available to enable them to respond to people's needs.

A number of activities were advertised on the notice board and social care plans were in place where participation in activities were recorded. Due to the limited outdoor space, the activities coordinator told us there were plans to convert a small ground floor lounge into a garden room, complete with doors to the garden and synthetic grass for use in the winter or for people who were reluctant to go outside.

A nurse referral book was in use, which enabled care staff to alert nursing staff to any concerns they might have about people's care. This helped to ensure effective communication between care staff and nurses.

Relatives told us that communication was generally good, and that they were contacted if there were any concerns about their family member.

A complaints procedure was in place and a record was maintained of complaints received and the response to these by the manager. Most of these had been addressed immediately by the manager and there was one ongoing complaint at the time of the inspection.

Good

Is the service well-led?

Our findings

A registered manager was in post who was supported by an experienced clinical lead nurse. Staff and relatives spoke highly of the manager and clinical lead. One relative said, "You can't fault the managers, you can go to them for anything, it's run well."

A number of audits were carried out to monitor the quality and safety of the service. These included a housekeeping audit, which checked sheets pillow cases and duvets. A dining experience audit was carried out every three months which included checking that a second course was not put down while people were still eating, that the manager ate with people on a regular basis, and that any music played in dining areas was the choice of people who used the service, and not staff. Food surveys were also carried out.

A staff questionnaire had been completed by staff in April 2016, and questionnaires were also provided to relatives and visiting professionals. Positive comments had been received including about the helpfulness and knowledge of staff, and that the top floor behavioural support unit was well run and led. A number of compliments cards were seen which were dated between February and June 2016.

Staff meetings were held and minutes had a positive and supportive tone. This meant that staff were supported by managers and we saw that they had been reminded that they do a good job and not to worry about any forthcoming inspections. 'Resident and relative' meetings were also held. Minutes showed that people and relatives had been consulted about plans to extend the garden area and to provide raised flower beds. One person had said they really liked being in the home and that staff were nice.

The registered provider visited the service regularly, and provider visits were carried out on their behalf by a care consultancy company. The consultant told us that they had seen a number of improvements in recent months and that they were confident that this would continue.

Staff and visiting professionals told us that the service was more organised and staff and visitors mentioned that the clinical lead had introduced a number of ideas which had improved the quality of the service. There were clear lines of accountability between the clinical lead, nursing staff and care staff.

There were good links with the community, including churches and activities organisations. The service also maintained contact with a local school which was working to become dementia friendly.