Knowles Care Home Limited

The Knowles

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 10, 12 and 13 April 2017. The visits on 10 and 12 April were unannounced. The visit on 13 April was announced. At our last inspection in January 2015, this service was rated as 'good'

The Knowles is a residential care home which provides accommodation and personal care to older people including those living with dementia. It is registered to accommodate a maximum of 38 people.

On the days of our inspection visits there were 32 people living in the home. There was one person who was in hospital.

There was a new manager in post but they were not registered with us. 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.

The provider had ensured the home was supported by a 'compliance' manager from within the organisation in the absence of a registered manager. The new manager who is referred to throughout this report as the "care manager" had been in post for one week at the time we carried out our inspection.

People living at The Knowles told us they felt safe. Care staff understood their responsibilities in being observant at all times to keep people safe. However, there were periods of time when communal lounges were not occupied because staff were needed to support people elsewhere in the home. This placed some people at increased risk of falling due to them not waiting for staff assistance to walk. There had been a high number of falls in the home and it was not evident these were always effectively managed.

Staff knew how to recognise abuse or poor practice and told us they would report abuse if they observed this happening. We found that not all reportable incidents related to people's health and safety had been reported to us. We found that information related to risks associated with people's care was not always clearly recorded and risks were not consistently managed.

There was a computerised medicine administration system in place. Records related to creams and lotions did not reflect these had always been applied as prescribed.

There were recruitment checks and systems in place to ensure staff were safe to work with people at the home. Staff received an induction to the service when they started work. They also had access to a range of training to maintain and update their skills and knowledge so they could meet people's needs safely and effectively. Staff practice was observed and they had supervision meetings so their competence could be assessed to ensure they worked to the provider's policies and procedures.

Staff had been supported with training to help ensure they understood how people who lacked capacity

could be supported to make decisions. Staff knew they could not undertake care practices against the wishes of people in the home. The management team had a good understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People had been assessed to determine how decisions could be made in their best interests and applications for DoLS had been completed. Authorisations that had expired had been reapplied for.

We observed staff were caring in their approach and people considered staff to be kind and caring. Most of the time, when staff were available in the communal areas, they were responsive to people's needs.

Social activities were provided for people and work was ongoing to ensure these were meaningful activities for the varying needs and dependencies of people at the home. Staff knew about people's wishes and preferences in relation to their care and aimed to support people in accordance with these.

People were provided with a choice of food and drinks. Drinks were regularly provided throughout the day and people were satisfied with the food provided. However, where people had lost weight and there were concerns regarding their health, action taken had not always been sufficient or effective in addressing these concerns.

People had access to health professionals when needed and district nurses visited the home on a regular basis to support people's healthcare needs.

People and their relatives were encouraged to provide feedback about the quality of care and services in the home. Quality satisfaction questionnaires seen showed mostly positive responses. Where negative feedback had been given, this had been acted upon. People and visitors stated they would feel comfortable raising any concerns if they needed to. We saw complaints made had been appropriately responded to.

There were processes and systems to check the care and services provided were in accordance with the provider's policies and procedures. Some of these checks were not sufficient in ensuring safe and effective care was provided.

People and relatives were positive in their comments of the management team and staff told us they enjoyed working at the home.

We found there were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

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.

People told us they felt safe living at the Knowles. However, staffing arrangements were not consistently effective to ensure people were protected from the risk of harm. Potential risks to people's health were assessed and recorded but were not consistently managed. Staff understood how to recognise abuse and how to report it. Systems ensured staff were recruited safely to the home. Medicines were stored safely but systems for managing medicines were not consistently safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received regular training to provide them with the skills and knowledge needed to deliver effective care. Staff ensured people received the support of healthcare professionals when needed. Staff had a working knowledge of the Mental Capacity Act. Where people lacked capacity to make specific decisions, Deprivation of Liberty Safeguard referrals to authorise restrictions to people's care had been made.

Systems to manage people's nutritional needs were not always effective.

Is the service caring?

Good

The service was caring.

People told us staff were friendly and respectful towards them. We observed staff to be kind and caring in their approach to people. People were supported to make choices and staff knew how to ensure people's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were assessed and staff knew about people's individual wishes and preferences but staff were not consistently

responsive to people's needs. People were happy with their care and knew how to raise concerns. Social activities were provided and work was ongoing to ensure these were meaningful and person centred for all people at the home.

People had care plans to support staff in meeting their needs.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a care manager in post but they were not registered with us. People told us they felt the home was well managed. Staff were positive in their comments of working at the home and the support they received with the exception of staffing arrangements.

Systems for monitoring the quality of care and services had not been consistently effective in identifying and acting upon areas needing improvement.

The Knowles

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.

The first day of this inspection was unannounced and was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has experience of using or caring for someone who uses this type of care service. The second day was a night shift visit carried out by one inspector and the third day was announced and carried out by two inspectors.

Before the inspection we reviewed the information we held about the service. We looked at information received from agencies involved in people's care. We also looked at the statutory notifications the care manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We spoke with the local authority and asked them if they had information or concerns. They shared information about staffing arrangements and safeguarding notifications which was confirmed during our visit.

We reviewed the information in the provider's information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Not all the people living in the home were able to share their views and opinions about how they were cared for. This was because some people had varying levels of memory loss or dementia. We spent time observing care in the communal areas. We also 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. We spoke with six people who lived at The Knowles and two visitors. We also spoke with nine care staff, the cook, the operations director, the wellbeing manager, training manager, compliance manager and the new care manager.

We looked at a range of records including six care plans, three recruitment records, complaints and

medicine records. We also looked at the provider's quality monitoring records including quality audits, meeting notes, safeguarding records and incident and accidents at the home.

Requires Improvement

Is the service safe?

Our findings

People gave us mixed feedback about staffing levels and whether there was enough staff to support them safely. One person told us, "Occasionally they are short staffed, some evenings and weekends they have agency staff." A relative told us, "There always seems to be enough staff around although staff are always leaving, there is no consistency."

We found staffing arrangements were not consistently effective to keep people safe. Staff explained this was due to the time they needed to spend supporting people with high dependency needs as well as continuing to maintain a staff presence in the three communal lounge areas. They told us this was challenging particularly because some people were identified to be at high risk of falling. Staff told us two staff members were allocated to support people in each lounge but we saw there were no staff available in lounges for periods of time during the morning of 10 April 2017 and evening of 12 April 2017. We asked a staff member in one lounge why there was a lack of staff presence. They told us, "[Staff name] and [Staff name] were upstairs getting people up that's why they were not in the lounge. They should have somebody (staff member) who just sits."

We asked staff if there were enough of them to keep people safe. One staff member told us, "We could do with four on nights because if we have got four we have one on each section and one in the lounge in case there are any falls." Another staff member told us, "It is so busy; we have a few residents that don't sleep. We have to share ourselves between the three lounges and if we have three call bells going at the same time and others are busy in their own section, we struggle to have someone on the floor." Another described staffing levels as 'inadequate'.

We asked staff how they managed people at risk of falls. One staff member told us, "Make sure there are no dangers and always make sure there is a member of staff in the care lounge where they are and there are no obstacles in the way." We asked if there was always someone in the lounge and they told us, "We do try but we don't always manage." One staff member told us they struggled to manage the risk of people falling, "Due to inadequate staffing". They said if someone needed two staff to support them to the toilet there was nobody, "Looking after the lounge". They explained one person who was at high risk of falling was, "Getting up every five minutes" and had recently fallen three times in one night.

Staff supported people without rushing them but they found this challenging during the busy period in the morning. The staff member completing the medication round was alone in one lounge area for a period of time prior to breakfast as other staff allocated to this lounge were getting people up and dressed. People seated at the dining room tables frequently made requests of the staff member administering medicines. The staff member told us, "This morning I had to leave the trolley to get a cup of tea and get [Person] a jumper. [Person] takes a while to take their medication, today they would not take it at all." At this time we observed one person was shouting out "Oh please, please can you take me to the toilet please." No staff were available to support them and it was 20 minutes later when the person received help. We were told the person did not remember they had been taken to the toilet and would ask again, however it was of concern that staff were not available to provide assurance.

We discussed staffing arrangements for the home with management staff and were told the number of staff on duty had been determined in accordance with people's needs. We were told there was minimal use of agency staff and they aimed to "over recruit" staff so they could cover any staff absence without using agency staff. They advised those people who had high needs were in the process of being reassessed to help ensure their needs could be met effectively. The compliance manager and care manager also told us, "We do have some very busy times during the day. We may look at how to manage time. The morning is quite hectic. Staff come on at 7am and are getting people up and giving medication. There are residents in lounges and medication staff need to focus on medication. It may be we can look at how we can rearrange that."

The care manager told us, "We have asked staff to start in one lounge (so that all people for a period of time were together in one lounge for staff to monitor as opposed to three)." However, we noted in practice this was not happening. The care manager accepted this could place people who needed more supervision at risk, and said going forward they would need to look closer at people's dependency levels and staffing arrangements. The care manager told us they used a 'dependency tool' to calculate whether there were sufficient numbers of staff to support people at the required times.

We asked the care manager how staff knew about risks associated with people's care. The care manager told us, "We assess them when they first come in, it's part of the preadmission assessment. We put them into the care plan and do separate risk assessments for them." We saw detailed pre-admission assessments had been completed and risk assessments were available in people's care plans. However, staff did not always put their skills and knowledge into practice. For example, we saw when staff used the hoist to transfer people into wheelchairs; this was not always done in a safe manner. On several occasions the brakes on wheelchairs were not secured and on one of these occasions the wheelchair jolted back and caught the foot of a person sitting behind the wheelchair.

When we looked at how risks were managed for people with swollen feet, it was not evident instructions in care plans were consistently followed to meet their needs. For example, there were instructions in one care plan for staff to ensure a person with swollen feet and ankles had their feet elevated during the day. We did not observe this being done each time we checked. A care plan for a second person stated "Staff should check condition of skin on lower legs, needs encouragement to elevate legs, staff to elevate on foot stool and cushion." We did not see this person's feet elevated when we checked during each of our visits. The person's personal hygiene plan stated they were to have cream applied twice daily to their legs but there was no record of cream being applied to this frequency. We noted the skin on this person's legs looked red and very dry. Concerns regarding the application of creams were reported to the care manager so they could ensure this was addressed.

We checked the 'accident and incident log' from December 2016 to April 2017. These records showed there had been a high number of accidents and incidents with some people having repeated falls and injuries. One person had experienced multiple falls so we looked at their care plan to see how the risk of them falling was managed. We saw contact had been made with all relevant health professionals and a request had been made by the care manager for the person to be reassessed as it was identified it was a challenge for staff to meet this person's needs safely and effectively. However, during the time the service were awaiting this assessment, the person had continued to have multiple falls. A staff member told us, "Turn your back for two seconds and they can be up and you can't run to them, you have to go to them carefully as they will lose balance and fall. They need one to one; we have said it all along." Action taken to manage the risk of the person falling had not been sufficient to maintain the person's safety during the time a reassessment was pending. We noted a care professional had given advice to the home during April 2017 to make a safeguarding referral if the person continued to fall because they were known to be at risk. This had not

happened. The person had fallen again during the time of our inspection which had resulted in an injury. We have subsequently been informed one to one staff support was now being provided.

To enable us to carry out the required checks of medicines, we checked copies of the Medicine Administration Records (MAR's) for three people. There were no clear medicine records to show creams and soap substitutes prescribed for people were being used. The care manager told us there was no detailed record that showed each prescribed cream or lotion was applied. Care plan records only contained a tick sheet for staff to indicate all creams had been applied. When we checked people's bedrooms we found creams in use that were out of date. One of these, was dated 2014 and another dated April 2015 should have been used within three months of opening. The expiry date of the cream had passed. This meant any creams applied may not be effective in managing people's health conditions because their expiry date for safe application had expired. In some cases, bathroom cabinets had excess amounts of the cream or lotion suggesting staff may not be using them as prescribed. For example, there were four unopened lotions and the one that was in use was dated January 2016.

One person had been prescribed a time critical medicine which meant it was important they received this at set times. This person was at risk of falls and therefore failure to ensure this happened presented an additional and unnecessary risk to the person. When we reviewed the medicine records showing the 'history' of when this medicine was administered, it had not been given consistently on time to manage their health condition.

The same person had been prescribed eye drops on an "as required" basis. This medicine was prescribed for dry eyes. Whilst the provider confirmed that instructions were in place for staff as to when to administer the eye drops, when we saw the person, their eyes were red and sore. It was confirmed by the care manager the eye drops had not been administered that day. It was accepted by the care manager that there needed to be clearer information available to staff about how these needed to be used.

Another person had been prescribed pain relief to be used prior to any wound dressing changes to ensure they were not subjected to any additional discomfort. However, we noted this was not being given prior to all dressing changes. One staff member told us, "We have to sit with the district nurse" (when they applied dressings). We asked if the person was in pain when this was done and they said "Yes." Another staff member told us the person became, "Very anxious" when receiving personal care because they thought staff would touch the wound area which suggested the person continued to experience pain. We saw when the person was moved they became anxious during the process; they called out when staff lifted their feet onto the wheelchair footplates. They were clearly in some discomfort. The medicine had been prescribed to be given on a regular basis prior to wound dressing changes. The care manager told us they would liaise with the district nurse to check if they felt it needed to be given prior to all dressing changes. We were subsequently informed that this discussion had taken place.

There was insufficient action taken to ensure risks to the ongoing health and safety of people were effectively managed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Despite our findings, people told us they received their medicines when required. One told us, "I am given medication regularly; they never miss giving it to me." We observed how people's medicines were managed and saw a computerised system was in use. Staff used a laptop directly connected to a medicine management system to register medicines administered to people and to log any refusals. This information

could then be checked by management at any time to make sure medicines were managed effectively. We observed a staff member administering medicines, they did not rush people and waited with them to make sure they swallowed them.

People who lived at The Knowles had varying levels of confusion and dementia. This meant they could not always respond in detail to the questions we asked about their care. However, people we spoke with told us they felt safe living at the home. They told us, "I feel safe, I have nothing to worry about" and "I feel safe and comfortable." A relative told us, "I feel that [Person] is absolutely safe here."

Staff had completed safeguarding training so that they knew what signs to look for that people may be subject to potential abuse. They were able to tell us about the different types of abuse. One staff member told us, "Well if they had bruises, if they were wary of someone, I would assume something was not quite right. I would let a senior know my concerns." Staff told us they would report any concerns to their manager. One staff member told us, "Report it to the manager straight away and write an incident form." Staff knew about 'whistleblowing' if they felt concerns they had reported had not been taken seriously. One staff member said, "I would go to head office".

We were told staff communicated any concerns regarding risks to people at staff handover meetings at the beginning of each shift. We attended one of the meetings and saw this happened. Staff advised of a health concern regarding one person and told staff coming onto the shift the GP had been contacted.

There was an evacuation plan for people who lived in the home in the event of an emergency and we were told arrangements would be made to ensure this was in a central location so that it was easily accessible to the emergency services. Each person had a personal evacuation plan on their care file so staff would know how they needed to be supported safely out of the building if necessary.

Staff recruited to the home went through a series of recruitment checks which included a Disclosure and Barring (DBS) check and reference checks. The DBS is a national agency that keeps records of criminal convictions. Staff told us recruitment checks were made before they started work. One staff member told us, "I had to go through a DBS check and they checked all my references." We checked the recruitment records for two staff and these confirmed necessary checks had been undertaken to ensure staff were safe to work with people who lived in the home. We questioned a potential discrepancy in one of the checks on the staff files and were advised by the operations director this had been identified by them and addressed to ensure this did not happen again.

Requires Improvement

Is the service effective?

Our findings

People told us they felt their needs were met by staff. One person told us, "Some residents need special care, but they are well looked after." A relative told us, "I definitely think that they know what they are doing when they are looking after [Person]." Another told us, "I like the fact that they wear uniforms, and there seem to be enough skilled people here."

Staff told us when they started work at the home they had an induction to the service and worked alongside more experienced staff so they gained an understanding of what was expected of them. One staff member told us, "I had to have induction days here …. to see how I worked. I had two shadow shifts then worked alongside more experienced staff in the numbers (as part of the shift)." Another told us, "I shadowed a senior member of staff…. I shadowed for a week and senior staff watched me." We asked them if they felt this had been long enough and they responded, "Yes that was long enough. After that, every other shift I worked alongside a senior member of staff. If I needed to ask a question that helped."

Staff benefited from having access to a training manager employed by the provider. The training manager ensured staff had access to the training they needed. They told us they assessed staff after they had completed their training to make sure they followed the correct procedures. We saw the training manager observing staff when hoisting people to assess if they understood how to do this in a safe way. When they identified an issue needing improvement, they told us this had been shared with the staff concerned. Staff told us they felt supported by the training manager and could approach them if there was something they were unsure about. New staff told us they had been completing training to achieve the 'Care Certificate'. To obtain this, staff are assessed against a specific set of standards. Staff have to demonstrate they have the skills, knowledge, and behaviours to ensure they provide high quality care and support. One staff member told us, "The training lady sets you up for online training and we have set dates we have to do them by. She will bring us in for training too. If we have any problems we message [training manager]."

The Provider Information Return received prior to our visit stated that ten staff had achieved a National Vocational Qualification (NVQ) in care. This showed staff were supported to gain further qualifications in health and social care to further develop their skills so they could carry out their roles effectively.

Staff told us their training was up-to-date and a training matrix was used by management staff to ensure training was completed. One staff member told us, "I am up-to-date with my training like fire, manual handling, infection control, yes, I have done dementia care and a refresher, I did all of that." Another told us "It is good (the training) and listed the training they had completed.

We saw staff put into practice what they had learnt from their dementia care training. For example, one person became agitated and uncooperative in the lounge. They grabbed a staff member's hand. The staff member remained calm and started to use distraction techniques. They started talking about where the person used to live and although the person was clearly squeezing their hand, they remained calm throughout. The person refused to speak so a member of the management team went to get them a piece of paper so they could write down what they wanted. They wrote they wanted the doctor so staff gave visual

signs they were going to telephone the doctor.

Staff told us they had supervision meetings with their manager where they could talk about any training or staff development needs. One staff member told us, "They ask about your training and the job, if you are happy, the residents and anything you want the management to do or change or if I am doing something wrong. Management always tell you 'you are welcome' and their door is always open." Another told us, "[Ex Manager] did bring me in the office once to see how I was getting on and asked if I had any concerns. Not had another meeting since."

A member of the management team told us new staff had more regular supervision meetings and once their probation period was over these took place on a quarterly basis. They told us supervisions were used to support staff if they were having difficulties carrying out their role. They explained how more support had been given to one staff member who felt they needed this which had resulted in them feeling more valued.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The care manager and staff team had a working knowledge of the MCA and DoLS. The MCA and Deprivations of Liberty Safeguards (DoLS) require providers to submit applications to a supervisory body for authority to deprive a person of their liberty. We saw applications had been made, and where they had expired, new applications had been made. Staff were aware people lacking capacity should not be subject to restrictions regarding their care unless these had been authorised and were in their best interests. One staff member told us, "Yes I understand it. I understand about knowing when someone has capacity and knowing you cannot deprive them of their freedom, their liberty, and not assuming they do not have capacity." Members of the management team told us this was an area they wanted to further develop staff knowledge.

We saw staff usually asked people for their consent before giving care. For example, one staff member asked a person "Can you stand up for me?" Another asked, "Do you want to sit next to [Person]." We asked staff what they would do if someone refused care. Staff knew to ask the person again a short time later so that their needs were met. One staff member told us, "We would give them five minutes and then go back. We will keep trying and try different care workers to try and encourage the person to accept personal care." They told us if the person continued to refuse they would report it to their manager. A staff member knew that not all people had capacity and told us, "What they do and don't like is in their care plans so we have to read through their care plans to see what they like and don't like." This showed staff understood it was important to know what people's wishes were when providing care so they did not support them in ways they may not consent to.

People told us they were given choices about their daily care and how they spent their day. One person told us, "I choose how I spend my day." Another told us, "I can have a shower when I want, there are no restrictions, I can go out at any time, I don't have to ask or tell them"

People were not always given choice at meal times throughout the day. For example, during the morning we

observed breakfast in one of the three lounge/dining areas and saw people were sat at the dining room table for 45 minutes before breakfast was served. Some people were not given a choice of drink whilst others were not offered the full choice of breakfast options. One staff member told us they knew what people liked so did not always ask.

At lunchtime, people were provided with a choice of meals which were served from a hot trolley. People told us they were satisfied with the food which met their dietary preferences. One person told us, "At mealtimes the food is good, we get a choice of two dishes. If you don't want what is cooked, they would do you something else. I have enough to eat and drink, I am never hungry." People who needed a soft diet had meat pureed and vegetables mashed. We were told there were no people with any cultural needs in regards to their food.

Consideration had been given to providing special cutlery to those people who needed it to eat independently. However, people who needed support to eat had varying experiences of support. For example, staff spoke with two people who were being assisted to eat to enhance their enjoyment of the mealtime experience. Two other people were not spoken with and one person was left waiting for around half an hour after everyone else for their food. When the person was given their food they were not offered a drink. A staff member was approached by us to advise them of this so they were given one. We also noted a staff member who was supporting a person to eat frequently got up from their seat. Each time this happened, they either gave others their food or spoke with staff. This meant the person's mealtime experience was not positive for them.

We asked the cook how they knew people's likes and dislikes. They told us they closely monitored what people ate or left so they knew what not to order again. They also told us, "Every now and again they (company who provided meals) will do a tasting with a selection of new dishes, we will have that for lunchtime and let them taste different ones." This then helped to decide what meals were chosen for the menu. The cook said, "We try to have a variety of things on every day so that everybody gets a choice. If they don't like choices, we usually have things like soup, spaghetti or ravioli and sandwiches available."

Care plans contained risk assessments where people were at risk of poor nutrition. These showed that food and drink for people at risk needed to be monitored and recorded. The Speech and Language Therapist (SALT) had been involved where people had swallowing problems so they could be assessed and advice given to staff.

We looked at people's weight charts and found a number of people losing weight each month. Most of these were small amounts, however, weight charts showed from September 2016 to March 2017 the number of people losing weight each month ranged from 12 to 20 people. We saw some people's weight was monitored by the completion of food and fluid charts. On viewing these charts we saw snacks were not always recorded and the amount of drinks they consumed were not always totalled and checked to make sure they were drinking enough. Records also did not show if food was fortified (adding calories to food such as cream, butter etc) so that those people with reduced appetites, who may not feel like eating, may benefit from this. The provider told us a risk assessment process was used to determine people at risk of poor nutrition and the GP called when a specified amount of weight has been lost. They told us weight losses were monitored in line with risks although actions taken were not always effective in managing risks.

When we looked at the weight chart, one person had lost a significant amount of weight since October 2016. The "Action Plan Monthly Weight Audit's" completed by the registered manager during January 2017 did not list this person as being of concern. The action plan for February 2017 did not reflect the overall weight loss for this person despite them having lost a significant amount of weight. The eating and drinking care plan

for the person had last been reviewed in December 2016 when staff were advised to encourage the person to finish their meals. No further reviews had been completed to reflect the weight loss or the actions staff needed to take to manage risks of malnutrition. For example, a fortified diet. Whilst positive action had been taken for the person's weight concerns to be reviewed by health professionals in January 2017 and again in March 2017, (when food supplements were prescribed), the person had continued to lose weight. The provider told us that the cook had a list of those people who needed to have a fortified diet to ensure this was done.

People told us they had access to health professionals when they needed them. One person told us, "The doctor will visit if needed and we don't have to wait long, we also have opticians, chiropodist and hairdresser." Another person told us, "I developed a sore on my leg; they acted promptly and called in the doctor to look at it. They are now treating my leg."

Care files showed people's health care needs were being addressed by regular involvement of professionals such as, doctors, a dentist, chiropodist, optician and speech and language therapists. A staff member told us the GP visited the home every Tuesday but people were given the choice to retain their own GP.

Good

Is the service caring?

Our findings

People told us all the staff were caring and respectful, despite staff having time constraints during certain times of the day which meant people had to wait for assistance. When people did receive staff support, staff were kind, caring and friendly. One person told us, "The staff speak nicely to us and treat us with respect." Another told us, "The staff are very caring, they pop in and ask if you are ok, they will also sit and have a chat." Relatives were positive about the staff, one told us, "The staff are brilliant, they seem to be happy and this brings happiness to the rest of the residents."

Staff were cheerful and friendly in their approach to people. Staff showed their respect towards people by ensuring they were at eye level when communicating and talking with them. Staff spoke clearly to people and when they were talking about personal issues, did this discreetly.

We observed one person was anxious and stated they were cold. In response, a staff member went to the person's room and brought them a cardigan which helped to calm them. We saw examples of staff taking time with people when delivering care so they did not feel rushed such as when providing them with assistance to move from one area of the home to another.

One person kept saying they were frightened and a member of the management team gave them assurance by speaking with them and stroking their arm. They asked, "What are you frightened of? Can I do anything to help? We all get frightened sometimes. Do you want to hold my hand?" The person repeated they were frightened again and were told, "That's why I'm staying with you." The person was not left until they had calmed and were settled.

We asked staff how they built relationships with people so that people felt at ease with them. One staff member told us, "With some of the residents it takes time, some have travelled and that helps a lot and we have sat talking about it. We try to talk to them about what they did (as a job), where they have been, and family, that kind of helps to build the relationship." Another staff member told us, "I think for me, it's the fact that when I come in, in the morning, I feed this person here, I need to give her a drink, if I don't feed that person they won't have anything to eat today. It's not just a job, it's somebody's life and wellbeing is in my hands. I have to feel, 'yes I have done enough today'. I didn't know anything about the 40's I just ask the residents and they tell me and I have learnt a lot from them…. It's the best job to have."

We found staff had taken the time to get to know people to help them build relationships with them. Staff knew about people's backgrounds and their family members and spoke with people about them. For example, one person was initially reluctant to have their hair done and was told, "[Name of family member] would like to see it done." The person then responded positively by agreeing to have it done. The person's care plan said that [family name] was their daughter who was very important to them and they liked talking about them. This showed staff were aware of this.

People were seen to be well presented and wearing clean clothes. The Provider Information Return (PIR) completed by the service prior to our inspection visit told us, "Care staff are also trained in MCA, DOLS,

dignity, equality and diversity, confidentiality and data protection. We saw staff understood their role in supporting people's privacy and dignity and most of the time this was maintained. On one occasion when a person was not appropriately covered when hoisted, this was corrected when the staff member did it for a second time to maintain the person's dignity. Staff knocked doors before entering rooms and addressed people by their preferred names.

We were told there were no restrictions on visiting times and saw visitors arriving at the home during the day.

Requires Improvement

Is the service responsive?

Our findings

Overall, people told us their needs were met in accordance with their wishes and preferences. However, we found staff were not consistently responsive to people's needs. For example, sometimes people waited to be served their meals or to go to the toilet. Some of the social activities were not person centred to ensure all people benefitted from them. There were people falling when staff were not around to support them.

People told us they liked living in the home, one person told us, "I like living here; I am glad that I am living here." Another told us, "Very good atmosphere, I don't get the feeling that you are in a home." People said staff knew about their likes and dislikes.

People's needs were assessed by the service before they came to live at The Knowles to make sure their needs could be met. Assessment records showed there had been involvement of family members so they could be involved in decisions about the care of their relative. We saw information obtained from assessments was used to formulate care plans for people so that staff knew how to support people's needs.

Overall care staff were knowledgeable about people's needs and how to address them. We spoke with a staff member about a person who could be challenging in their behaviours towards them. The staff member told us, "[Person] can be challenging and aggressive to staff, not to residents, just when they have personal care and hoisting. You just have to keep reassuring. I have found that because they can't hear very well, if you tell them what you are doing, sometimes they are less aggressive. [Person's] hearing has almost gone, they do not wear aids."

Staff knew about people's individual preferences and explained how they made sure these were considered when providing care. For example, one staff member told us, "[Person] is very particular, they have to have their wash the way they want it done. [Person] will tell you how they want the water, they will feel it, then they like their face done first. [Person] takes their time to do it. That's their routine and how they like it." They went on to tell us about another person, "[Person] likes to take their tablet before their breakfast so the minute they come in, I pop the tablet for them and they take it." We saw this happened.

Care records confirmed family members were involved in people's care, for example, one person's relative had been told when the GP had been contacted and had participated in care reviews of their family member. We noted in some care files there was a summary sheet giving an overview of the person's needs and preferences to help staff access some information quickly to support people. For example, in one care plan there was information about how the person liked to be addressed, special dates, their preference of social activities, times they like to get up and go to bed and some food and drink preferences.

We found sometimes information in care plans was conflicting. For example, in a care plan for personal care, it stated the person had no preference for a bath or shower but the front sheet in their care file stated their preference was for a shower. A sleep care plan stated the person preferred two pillows but the front sheet in their care plan stated one pillow. Whilst staff usually asked people what their preferences were,

there was a risk of inconsistent care being provided.

People had access to some social activities both in and outside of the home environment and we saw some people engaged in social activities. Some people chose not to participate. One person told us, "My hobbies were different sports; I have a television in my room to watch sports." Another told us, "I sit here all day and do nothing; there are activities but mainly skittles and things like that (which they chose not to do)."

Staff told us social activities were provided regularly. One told us, "Yes, we have two (activities) a day in the morning and afternoon. We always have music on and they sing along to songs… we have bingo and tea parties." They told us some activities were scheduled each day and sometimes they did whatever people wanted to do. For example, they said. "You can just pick up a ball and they will want to throw it to you."

We observed a carpet bowls activity in one lounge. Two people participated in this activity and enjoyed it. In the afternoon the 'Wellbeing Manager' sang with people in a second lounge where four people joined in and two people observed. People who participated responded very positively to this activity.

During the day we saw the wellbeing manager spent time with people individually, discussing their past, where they lived and other things of interest to them. They showed people internet based video clips of things of interest such as the removal of the bridge from the Council House in Coventry. We were told the wellbeing officer visited the home three to four times a month to support people with activities and care staff provided activities to people at other times.

Although staff had good intentions in regards to carrying out activities with people, we could not be confident that everyone in the home was benefitting from meaningful activities suited to their needs. For example, one person wanted to do some knitting and seemed happy that staff were going to support them with this activity. Staff put a box containing balls of wool and knitting needles on a table next to the person but then disappeared. The person said "Where have they gone now?" and became frustrated no staff were around to help them. When a staff member came into the lounge, rather than support them with some knitting, they attempted to engage them in a different writing activity which they were not interested in.

The wellbeing manager recognised that meaningful activities were not being provided for people all of the time. They said staff would be supported with the 'tools' required to help them engage more effectively with people and told us about plans to introduce themed activities based on five key areas including sensory, physical and emotional activities. They told us, "Within the structure of the day, carers are allocated to activities, with regards to dementia, they have higher needs, that is an area I need to concentrate on more."

People told us if they were not happy with the care or service they received, they knew who to raise concerns with. One person told us, "I would be happy to raise concerns, if I had any, to anyone in charge. A relative told us, "If I had any concerns, I would go to the office."

Staff knew how to respond to complaints, one told us they would, "See what the problem was and ask them to speak to the manager."

There was a complaints procedure on display in the home for people and visitors to access if they needed. Complaints records showed those received had been investigated and responded to. Records showed people who had complained were satisfied their concerns had been addressed. They also showed actions taken to help prevent the complaints happening again which demonstrated lessons had been learnt. For example, in one case the main learning point was 'communication' and staff had been reminded of the importance of regular communication with family members and the next of kin.

Requires Improvement

Is the service well-led?

Our findings

Staff knew what was expected of them in regards to carrying out their roles although they told us they sometimes found it a challenge to carry out all that was expected of them in a timely manner. Staff told us they didn't always have time to read care plans, speak with people or write up the care notes for people within their shift times. One staff member told us, "They have got care plans, we don't get time to read them but if we need to know something, we will be told to read them." Another told us, "I used to come in early …. to read the care plans so I knew the residents. New residents… I go through their care plan before I start my shift." One staff member told us they often stayed after the end of their shift to write up their notes. Another told us, "Ninety per cent of time we stay behind to do them." When we arrived at 8am on the first day, we were greeted by a member of night staff who told us they should have left at 7am but they were still writing the notes up as there had been "a couple of falls" in the night. They advised the night had been "very busy" with the call bells going off "all the time".

We found staffing arrangements were not always effective to ensure risks were managed. For example, we identified that a number of accidents and incidents had occurred at night. Night staff told us they felt very pressured at times in particular in trying to help prevent people from falling. One staff member told us, "At night …. some residents need one to one, as soon as you leave them they fall."

Night staff told us it was a challenge for them to complete all of the "night tasks", some of which were ancillary tasks such as cleaning and laundry, in addition to their care duties. This meant staff may not always be able to focus their time on managing risks during the night. One staff member told us, "They expect everything to be done."

We found that although systems and processes for managing risks were in place, including managing risks of falls, these had not proved to be effective in reducing or managing the number of falls people experienced each month. Some of these falls had resulted in serious injuries. We saw the provider had taken action to give notice to some people whose needs had increased where they felt the service could no longer effectively manage their care. Whilst this demonstrated actions were taken to try and minimise risks, these people continued to be at high risk until alternative placements were found. Following our inspection visit the provider confirmed that further actions had been taken and alternative care homes found.

Similarly, systems and process for managing nutritional risks were not always effective. We were unable to confirm from staff knowledge and records that sufficient actions were always taken to address risks.

The system for recording accident and incidents was not always consistent or clear. Where people were found on floor' this was listed either as an 'accident' or 'incident'. This inconsistency meant the number of accidents recorded in the accident analysis submitted to the provider was not always consistent to give an accurate reflection of all accidents. The 'accident logs' were not always sufficiently detailed to use for monitoring purposes. We also found incidents between people that were linked to behaviours that challenged were not consistently reported to us in line with safeguarding procedures.

The 'provider information return' received prior to our visit told us, "We strive to continually improve the service we deliver and therefore take an active approach to seeking feedback from individuals who use our service. Feedback is obtained through meetings, day to day discussions and quality questionnaires and acted upon accordingly. The home has a range of quality assurance systems in place to monitor, manage risk and take appropriate action to improve the service." We found there were systems in place to obtain feedback from people to help improve the ongoing quality of care and services people received.

'Resident' meetings took place periodically. One person told us, "They do ask for my opinions and there are meetings." A meeting had taken place in February 2017 where items discussed included acknowledgement of some of the concerns raised in quality surveys, the social activities provided, and food. We saw there were action points but it was not clear whether individual requests had been acted upon. There was no reference to issues from the previous meeting having been addressed.

Staff meetings had taken place so that issues relating to the home could be discussed. We noted some of the issues raised at the last meeting in September 2016, were as a result of complaints received at the home. It was not clear from the notes of the meetings that staff had been given the opportunity to raise issues themselves or discuss them. One staff member said staff meetings "always get cancelled." The care manager told us that they aimed to have staff meetings bi monthly and a staff meeting was in the process of being planned.

Quality satisfaction surveys had recently been forwarded to relatives and professionals who visited the home. These contained both positive and negative responses. Positive feedback included, "The staff generally are very caring." The negative responses were in regards to personal care not being sufficiently attended to.

The provider had a system of internal checks to ensure the quality of service was maintained and the home ran in line with the provider's policies and procedures. This included audit checks of care plans, medication and moving and handling equipment being available for people. However, we found audits for medication had not been effective in identifying areas needing improvement such as those we had found.

The provider's audit system required further improvement because they had not identified some of the concerns we found. The lack of provider oversight before and during managerial change meant effective governance systems were not always maintained to drive improvements and to ensure their governance systems were effective.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

People were positive about The Knowles and their experiences of living at the home. One person told us, "On the whole, it is a pretty good atmosphere here." Another told us, "All of the staff here are caring, this place is homelier than I expected."

Since the last inspection the registered manager had left and a new care manager appointed. During the interim period, a compliance manager, appointed by the provider, had provided management cover within the home. The new care manager had been in post for one week when we visited and we were told about plans for the care manager to be registered with us.

The management team consisted of a manager and a deputy manager. In addition to these managers,' staff received frequent support from the provider's other management staff. This included a training manager,

wellbeing manager, compliance manager and the operations director.

Staff told us they enjoyed working at the home and felt they worked well with one another and the management team. One staff member told us, "The staff are nice, very welcoming, once you get to know the residents, it can be a pleasure to be here." Another said, "The staff are really good, if I have any problems I speak to [deputy manager], if I ever need to know anything, they will always let me know. [Name] training lady is always on my case (indicating they are supported by the training manager)."

Staff were still getting to know the new care manager but were positive in their comments of them. One staff member told us, "[Manager] is very nice; he likes to know what is going on." Another told us, "He is lovely. If you have any questions, he will answer them. He is a really helpful manager and he interacts a lot with the residents too."

The notice boards in the home showed that a 'Relatives Support Surgery' was to be held on the first Sunday of every month between 5.30pm and 7.30pm with the care manager. This showed the provider's commitment to ensure relatives' were given opportunities to discuss anything they might want further information about or any potential concerns.

There was also a "What you said", "What we did" and "What we learnt" board which demonstrated the service had listened to people and learning points had been identified and addressed.

We saw an 'Activities Social Wellbeing Observation' audit had been carried out in January 2017. This showed checks had been made whether there were magazines and books around for people and whether staff encouraged conversations between people and carried on conversations. There were also detailed records of observations of staff practice to make sure they were following the provider's policies and procedures. For example, observations of staff using the hoist and checks staff made sure people had their pressure cushions in place. We noted that where it had been identified a pressure cushion had not been put in place; this was addressed with staff during the handover meeting. This demonstrated areas of concern identified were being acted upon.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from risks associated with their health, safety and welfare because risks were not effectively managed to ensure care and treatment was always provided in a safe way. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to monitor the quality of service were not operated effectively to ensure people received safe and effective care that consistently met their needs. Regulation 17 (1)(2)(a)(b)(c)