

Knowles Care Home Limited

The Knowles

Inspection report

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23 August 2018

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

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 21 and 23 August 2018. The visit on 21 August 2018 was unannounced. The visit on 23 August 2018 was announced.

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 33 people living in the home.

People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The accommodation is set out over two floors, the first floor being reached by a lift. There are three separate lounge/dining areas and an accessible garden.

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 new manager took up their post on 22 August 2018, in between our two inspection visits. The deputy manager had been 'acting manager' and had returned to their original role.

At our previous inspection in April 2017, we rated the service as Requires Improvement. This was because the service was not as consistently safe, effective or as responsive to people's needs as it should have been, and the service was not consistently well led. For example, risks to people's care were not always managed safely. People did not always receive personalised care and at times staff did not respond to people's needs in a timely way. How quality monitoring systems were implemented did not ensure the home was consistently well led.

At this inspection we found some areas of improvement. However, we also identified some issues that meant the service remains rated 'Requires Improvement' overall.

Incidents had not always been appropriately recorded or investigated to identify how safety issues could be resolved. The lack of completed incident reports, meant the manager had not been able to investigate and categorise the incidents to see if a referral to the local safeguarding authority was appropriate. The provider had not notified us of all the safeguarding referrals that had been made to the local authority in accordance with their legislative responsibilities. The provider's quality assurance systems had not identified these issues.

There were enough staff to provide safe care, but staff were very busy and sometimes did not have time to

engage with people as they wished to. The suitability of staff was checked during recruitment procedures to make sure they were safe to work at the home. Staff received an induction and training to ensure they had the knowledge and skills to meet people's needs effectively.

The provider used a range of recognised risk assessment tools to identify people's individual risks, but there was inconsistency in the level of information staff had to manage risks. Records to evidence risk management needed to be improved.

People had an assessment completed before moving to the home to make sure staff could meet their care and support needs. People's healthcare needs were monitored by staff and any concerns were referred to other healthcare professionals. People's medicines were managed, stored and administered safely.

Since our last inspection the provider had reviewed the nutritional support people received and introduced some initiatives to ensure people had enough to eat and drink and had a more enjoyable lunchtime experience.

People appeared to be happy living at the home and during our visit we saw some genuine, empathetic and kindly interactions between staff, people and relatives. Staff treated people with dignity and respect and were helpful towards each other in completing their care duties and supporting people.

Staff and managers worked within the principles of the MCA (Mental Capacity Act 2005) and DoLS (Deprivation of Liberty Safeguards) legislation. People's capacity to make decisions had been assessed, and DoLS applications made as required.

The new manager had experience of providing dementia care and was keen to provide a homely environment where people experienced high standards of care. They explained the importance of staff spending quality time with people by making care tasks more interactive.

The provider had an action plan to improve the quality of care provided within the home. They planned to introduce an electronic care planning system so staff had immediate access to information about people and could record care interventions at the time of delivery. A refurbishment was planned to address cleanliness issues and improve the environment for people living with dementia.

There were three breaches of the regulations. You can see what action we told the provider to 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?

The service was not consistently safe.

Incidents had not always been appropriately recorded or investigated to identify how safety issues could be resolved or whether a safeguarding referral needed to be made. Plans to manage risks were not consistently detailed. There were enough staff to keep people safe, but staff were very busy and records to evidence risk management were not always completed in a timely way. The provider checked the suitability of staff before they were able to work in the home. Medicines were stored and managed safely and people received their medicines as prescribed.

Requires Improvement ●

Is the service effective?

The service was effective.

Staff received induction and training that supported them to meet the assessed needs of people effectively. People's health and appetites were monitored by staff and referrals to other healthcare professionals were made when a need was identified. Staff offered people choice and sought their consent before providing care or support. The provider had plans to improve the environment so it was more supportive of people living with dementia.

Good ●

Is the service caring?

The service was caring.

Staff were kind and thoughtful towards people and respected people's privacy, dignity and confidentiality. Staff had received training in equality and diversity and respected people's individuality. People were supported to choose how they spent their day and supported to see their visitors when they wished to.

Good ●

Is the service responsive?

The service was responsive.

Staff were responsive to people's needs, although some

Requires Improvement ●

improvements were required in how information was used to develop care plans for people new to the home. People were offered opportunities to engage in activities. Staff worked with other healthcare professionals to meet people's needs at the end of their life.

Is the service well-led?

The service was not consistently well-led.

The provider had made improvements since our last inspection visit. However, quality assurance checks had not always identified areas that needed further improvement or action had not always been taken in response to issues identified. Staff felt valued and supported by the provider and enjoyed working at the home.

Requires 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 inspection visit took place on 21 August 2018. The inspection visit was fully comprehensive and was unannounced. The inspection team consisted of two inspectors, a specialist advisor and an expert-by-experience. A specialist advisor is a qualified health professional. The specialist advisor who supported this visit had experience in providing care to people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. As the manager and deputy manager were unavailable on the first day of our visit, one inspector returned on 23 August 2018 to speak with them about their management of the service. This visit was announced.

Prior to our inspection visit, we reviewed the information we held about the service. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law. We looked at information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. The local authority shared information about recent monitoring visits they had carried out at the home.

Before the inspection visit, the provider completed a Provider Information Collection (PIC). 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. We checked whether the PIC accurately reflected the service during our inspection.

Some people living at the home were not able to tell us about their experiences of living at the home due to their complex health conditions. We spent a significant period of time observing the communal areas. This helped us judge whether people's needs were appropriately met and to identify if people experienced good standards of care.

During our inspection visit we spoke with five people and six relatives about what it was like to live at the home. We spoke with staff on duty including six care staff, the cook and two non-care staff about what it was like to work at the home. We spoke with the new manager and deputy manager about their management of the home. We spoke with the provider's operations director, compliance manager, home support manager, training manager and hospitality manager about the provider's oversight and management of the home. We also spoke with a visiting healthcare professional.

We reviewed a range of records; these included four care plans in detail. We looked at daily records, food and fluid charts and medicine administration records. We checked whether staff were trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Is the service safe?

Our findings

At our last inspection in April 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements to ensure risks to the ongoing health and safety of people were effectively managed. At this inspection we checked whether the provider had made the required improvements. Whilst the provider had made some improvements in these areas, we found further improvements were still required and the provider remains in breach of Regulation 12.

Safeguarding training was made available to staff and they had access to information about how to identify abuse and the process for raising concerns. Staff told us they would not hesitate to share any concerns about people's wellbeing or poor practice by other staff with the management team. One staff member described poor practice as 'neglect' and said, "That would be reported."

However, we found that incidents had not always been appropriately recorded or investigated to identify how safety issues could be resolved. For example, we reviewed one person's ABC charts and daily records over a period of six weeks and found a number of significant events had occurred. ABC charts are where staff record incidents when people display behaviour that can challenge themselves, staff or other people and could potentially cause harm. No incident forms had been completed in relation to any of these events and they had not been reported to the management team for further investigation. We reviewed this person's care plan and found the only risk assessment for behaviours that could challenge advised staff to, "Monitor and distract". There was no information about distraction techniques known to be effective for this person. There was no other guidance within this person's care plan on how to support the person when they were at risk of hurting or causing distress to other people or how staff should approach this person to keep themselves safe.

The lack of completion of incident reports in respect of this person's behaviour meant the manager had not been able to investigate and categorise the incidents to see if a referral to the local safeguarding authority was appropriate. A further incident of significance had occurred a couple of days before our inspection and a safeguarding referral was submitted to the local authority on the day of our inspection visit. We were concerned that a lack of action when these behaviours started to emerge meant appropriate action had not been taken to prevent them escalating. The safeguarding authority had subsequently asked the provider to make individual referrals for every person who had been identified as 'at risk of abuse' by this person's behaviours. We looked at the provider's safeguarding records and found that other safeguarding incidents had been appropriately referred to the safeguarding authority.

At our last inspection we found improvements were required in the management of risks associated with people's health. At this inspection we found the provider used a range of recognised risk assessment tools to identify people's individual risks, but there was inconsistency in the level of information staff had to manage risks. For example, one person had a catheter and there was a very detailed care plan for staff to follow to minimise the risks associated with catheter care. However, another person had diabetes and their daily records also indicated they had a seizure in July 2018 and emergency services were called. No further

information had been recorded in either the form of a care plan or risk management plan for either the diabetes or the risks of another seizure. Another person's mental health care plan had not been updated to reflect that their level of observation had been increased following a recent incident in the home. Despite this, staff were aware of the observation frequency for this person and recorded their checks to confirm they had been completed.

We found other records to evidence risk management needed to be further improved. For example, one person at 'high risk' of skin damage due to poor mobility needed the support of staff to relieve pressure on their vulnerable areas when sitting in their chair. Records did not evidence that this was being done consistently. This person also needed to be encouraged to elevate their legs when sitting. On the second day of our visit we spent nearly three hours sitting in the lounge and did not see staff encourage this person to elevate their legs.

We also found records that evidenced whether people who were at risk of malnutrition had taken enough food and fluids to maintain their health needed to be improved. For example, staff were recording people had eaten all their 'pureed chicken dinner' but not recording the size of the meal. One member of staff told us, "We try to fill the charts in at the time, but in reality it doesn't often happen. Paperwork here is a bit of an issue." They gave an example of when a person was unwell and an ambulance was called. They told us, "The ambulance crew asked if the person had eaten or drank but the paperwork had not been filled in so we were unable to tell them."

The provider had failed to ensure that care was provided in a safe way to service users. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection visit we found staffing arrangements were not consistently effective to keep people safe. At the time of this inspection, the provider had identified staffing levels as seven members of care staff during the morning, six in the afternoon and three at night. Although the service was short staffed at the time of our inspection, the planned staffing levels had been achieved through the use of agency staff and permanent staff covering extra shifts. However, our conversations with staff showed that some staff were working 14 hour shifts to ensure staffing levels were maintained. The deputy manager told us that whilst staff were happy to work longer shifts, they would monitor staff practice through observations and staff supervision to ensure it was not affecting the health or performance of staff.

On the day of our inspection visit we saw sufficient numbers of staff to provide safe care to people, although they were very busy. Staff were available in communal lounges most of the time to respond to people's needs and keep them safe. Overall, staff felt there were enough of them to meet people's needs safely. However, they explained it was a challenge to ensure a staff presence was maintained in lounges during the morning and evening when they were helping people to get up and go to bed. They also told us they were not able to spend quality time with people. One staff member explained, "I feel we are safe, but I also feel it would be nice to have more time with the residents." Another said, "One thing we are told is not to leave the lounges unattended. In the morning and evening when doing personal care, we can't always be in the lounges."

We received mixed feedback from people and their relatives about whether staff were quick to respond to their needs. One person told us, "On occasions there has been only one (staff member) on each end of the ground floor and they struggle with some people's personal care." Another person told us, "I don't think it's too long really, they are always very busy."

On the first day of our inspection visit, we saw a person who could demonstrate behaviour that challenged

others, spent most of their time walking around the home. Staff maintained regular observations of this person, but it clearly impacted on their working day. On the second day of our visit, the provider had implemented one to one care for this person to ensure their safety and that of the others who lived in the home. Staff confirmed that an extra member of staff was added to the rota if people needed one to one care.

We asked the deputy manager how they assured themselves staffing levels supported staff to provide safe care. They told us staffing levels were based on people's dependency levels which were reviewed monthly. They told us they also worked alongside staff and completed regular observations. The deputy manager was confident that based on the dependency levels of the people currently living at The Knowles, together with the one to one care implemented for one person, the identified staffing levels ensured people were kept as safe as possible.

People were cared for by staff who were suitable to work in a caring environment. Before staff were employed, the provider carried out checks to determine if staff were of good character. These included criminal record checks through the Disclosure and Barring Service (DBS) and obtaining references from previous employers. This showed the provider followed recruitment procedures which minimised risks to people's safety.

Some people required equipment to help them stand or transfer. During our inspection visit care staff used equipment confidently and safely. For example, we observed staff on two occasions using equipment to transfer people into chairs. During the procedures they reassured the person they were safe and continually explained what they were doing. Staff remained with the person throughout, although on one occasion they failed to put the brakes on the wheelchair which could have compromised the person's safety if the wheelchair had rolled backwards.

At our last inspection we found improvements were needed in the management of medicines. At this inspection we found medicines were managed, stored, administered and disposed of safely. Medicines that required extra checks and special storage arrangements because of their potential for misuse, were stored correctly. The administration of these medicines was recorded accurately and showed they were being given as prescribed.

Staff who gave people their medicines had received training and regularly had their competency checked to ensure medicines were managed in accordance with best practice. Staff wore a red 'do not disturb' tabard when they gave people their medicines and made sure people had swallowed their tablets before they moved away and signed the electronic Medicines Administration Record (MAR). The electronic system enabled staff to identify which medicines people needed and the correct time to give them. Staff knew which medicines were 'time critical' and used an alarm system to ensure they were given as prescribed.

A visiting healthcare professional told us staff always asked them to sign any changes in medicines to ensure they were accurate. However, the daily records for one person showed they were often awake and restless at night despite being prescribed medicine to help them sleep. There was nothing to show that staff had considered why this was happening or if the person required a medication review.

At our last inspection we found creams and soap substitutes prescribed for people at risk of dry or sore skin were not being used by staff. At this inspection we found there was still a lack of consistent recording to demonstrate staff had applied creams and soap substitutes as prescribed. For example, over a period of 22 days, staff had only recorded they had applied one person's topical cream on seven occasions. However, we were assured this was more of a recording issue because when we checked these items in people's bedrooms, the content levels indicated they were being used as prescribed.

Staff sought advice from other health professionals when people were at risk of not taking their medicines regularly. When people lacked capacity to understand the benefits of their prescribed medicine, they were referred to their GP. Records showed the GP had authorised staff to administer some people's medicines covertly in their best interests, that is, without their knowledge, if they declined to take them. However, there was no evidence the advice of the pharmacist had been sought as to the safe administration of crushed medicines in respect of one person. The manager assured us this would be checked with the pharmacist as a matter of urgency.

The provider's compliance manager told us the electronic medicines management system enabled managers to check medicines records daily so any errors could be quickly identified. They were confident the management of medicines in the home had improved greatly over the last 12 months and told us this had been recognised by the local clinical commissioning group after a recent medicines audit. People confirmed they had their medicines when they needed them. One person told us staff giving medicines were, "Extremely good now, and make sure you take it too."

The provider had policies and procedures to ensure the home was clean and hygienic. A member of domestic staff told us they had received training in infection control and explained how they used different coloured mops and cloths for different areas of the home. They told us they were informed if anybody had an infection so they could take extra precautions to reduce the risks of the infection spreading. However, the home was not consistently clean because throughout the first day of our inspection visit there was a strong and unpleasant odour in the entrance hall of the home and in one of the lounges. We also found the carpets were sticky in areas, as were some of the lounge chairs. The provider's own records indicated the odour had been identified as far back as April 2018. The provider's operations director assured us various actions had been taken to address the issue, but they had clearly not been effective. On the second day of our visit, the new manager had taken action and the odour had reduced. However, they accepted there needed to be a more permanent solution and carpets and furniture were to be replaced as part of a planned refurbishment scheme.

The provider had systems in place to make sure the premises remained safe for people, visitors and staff. Routine checks were made on the premises, including checks on equipment to make sure it was safe to use and fire safety checks. However, we found some window restrictors did not meet current health and safety standards. During the first day of our visit we found the toilet off one lounge was not working and there was a leak in the hairdressing salon which had made the floor very wet. On the second day of our visit, the maintenance man was on site and we were told these matters were being addressed.

The provider had procedures to keep people safe in the event of an emergency which meant people had to be evacuated out of the home. Each person had a personal emergency evacuation plan (PEEP) which detailed what assistance and equipment they would need to evacuate the building

Is the service effective?

Our findings

At our last inspection visit we found improvements were required to ensure people's nutritional needs were met. At this inspection we found improvements had been made and the rating is now Good.

The provider's operation's director told us they had reviewed the nutritional support people received in the home and introduced some initiatives to ensure people had enough to eat and drink and had a more enjoyable lunchtime experience. For example, the provider had introduced 'snack stations' in communal lounges where people could help themselves to cold drinks, snacks and fruit. They had also introduced brightly coloured crockery to help people living with dementia identify their food and pictorial menu cards as a visual prompt to help people choose what they wanted to eat

The majority of main meals were obtained as frozen, ready prepared meat and fish dishes. The cook explained the choice of meals was based on people's known preferences and a 'taster session' had recently been held for people and their relatives so they could give their opinion of the new meal options that had been introduced. On the day of our visit, people had mixed opinions about the quality of the food. Comments included: "The food is edible, but like anywhere else, it varies from day to day" and, "The pudding was okay, but the cottage pie and mashed potatoes were horrid." The cook told us they monitored what people ate or left so they knew what they liked or disliked.

At meal times people were supported to move from their chairs to the dining areas to improve their mobility and enable them to socialise. People were encouraged to sit in friendship groups to encourage them to enjoy their meal. Some people preferred to remain in their lounge chairs and staff respected their choices.

The cook had information about people's nutritional needs and how they needed their meals to be prepared, for example those people on a puree or soft diet. The cook told us the kitchen was accessible 24 hours a day if people wanted something to eat during the night.

At our last inspection we found the provider had not effectively monitored those people who had lost weight. At this inspection we found staff monitored people's weight and the manager completed a monthly analysis of those people who had suffered significant weight loss or gain, together with any action taken. This was then assessed and reviewed by the provider's compliance manager to ensure staff had sought the advice from healthcare professionals, such as speech and language therapists or dieticians, if there were any concerns about people's nutrition. Where people had refused to be weighed, this had been risk assessed to identify what staff needed to do to monitor for any weight loss.

People's needs were assessed before they moved to the home to ensure they could be met by staff. The assessments included the person's life skills, potential risks to their health and wellbeing, understanding and mobility.

The provider had an induction and probation system to ensure all new staff had a good understanding of the home's policies and procedures and demonstrated the required values and behaviours. This included

training the provider considered essential to providing safe and effective care such as health and safety, safeguarding, infection control and moving people safely. In addition, staff new to the care sector were supported and encouraged to complete the Care Certificate. The Care Certificate is a set of core standards that health and social care workers adhere to in their daily working life. New staff were given a mentor who they 'shadowed' for two shifts so they had the opportunity to get to know people's needs. The mentor then continued to provide support as staff developed into their role.

Staff told us they felt confident in their roles because they received regular training that kept their skills and knowledge up to date. Staff received training from a variety of sources including, on line training and in-house training by suitably qualified managers. The training helped ensure staff had information that reflected current best practice in providing care. One staff member described the training as 'brilliant' and said, "They are constantly updating the training." This member of staff particularly spoke of the value of in house training they had received in supporting people living with dementia. They said the training had made them think about what it might feel like to have dementia and explained, "It was good see it through the eyes of a person with dementia. If they are confused or agitated, I think what is going on here, what has caused it." The provider's training manager confirmed this training was very well received and increased staff confidence because it empowered them to share ideas and suggestions as to how their practice could be improved. A visiting healthcare professional told us, "I think they do understand dementia and some of the senior staff are very good with how they manage it. They look at the reasons for any behaviours."

Staff received regular supervision meetings to discuss their role, and managers carried out observations to make sure they put their learning into practice.

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 people lack mental capacity to make particular decisions, any decisions made on their behalf must be in their best interests. 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 2005. The application procedures for this in care home are called Deprivation of Liberty Safeguards (DoLS). We checked that the service was working within the principles of the MCA 2005 and found that they were.

Where it was considered people may lack capacity to make a decision, a mental capacity assessment had been completed to ensure staff knew when and how to support people in their best interests. However, we found the capacity assessments would benefit from more information as they did not always show how decisions and assessments were undertaken for people, or what communication aids were used to assess people's capacity or help them to understand the decision that needed to be made.

The provider had identified some people were unable to leave the home without support from staff and other people had restrictions within their care plans to keep them safe which deprived them of their liberty. Appropriate applications had been made for the legal authorisation of these restrictive care plans.

Staff had received training in the Mental Capacity Act 2005 and we saw that where possible, they invited people to make their own decisions about how they were cared for and supported. Staff routinely asked people for their consent before they carried out any tasks or care. For example, staff asked people where they wanted to sit and who they wanted to sit with. At lunch time they asked people whether they wanted to have a clothes protector on and did not just assume they did. One person was walking around without any shoes on. A member of staff encouraged the person to put some shoes on, but respected their decision when they declined the assistance offered.

People's healthcare needs continued to be met by staff and any concerns were referred to the doctor. The doctor visited the home every week to see people who had requested a visit or who were unwell. We saw from people's records that they had regular appointments with other health professionals too. For example, where people experienced changes in their behaviours, they had been referred to the mental health team for ongoing support.

We spoke with a visiting healthcare care professional. They told us staff contacted them if they had any concerns about a person's health and were good at following advice. This joint working ensured people received effective care. Relatives told us staff were good at communicating about their family member's health and informing them of any medical advice given.

People could choose to sit in one of three different lounges or in a seating area in the entrance to the home. There was also an accessible garden with places for people to sit and enjoy the warm weather. However, there was a lack of stimulus within the environment of the home for people living with dementia, and there was little to stimulate people's memories and provide opportunities for interaction. The new manager acknowledged that more could be done to provide a more suitable environment and told us improvements were planned to help people orientate and find their way around the home independently. They explained the new colour schemes would take into consideration the needs of people living with dementia and provide them with items of interest relevant to them. They said, "We can make the corridors more dementia friendly based on what people did for a living and introduce things on the wall that are meaningful to them."

Is the service caring?

Our findings

At our last inspection we rated caring as 'Good'. At this inspection people at The Knowles continued to receive a good caring service.

People appeared to be happy living at the home and during our visit we saw some genuine, empathetic and kindly interactions between staff, people and relatives. People appeared content and relaxed in their surroundings and approached staff for support and reassurance without hesitation. One person enjoyed sitting with staff and spent time engaging with a manager whilst they were working on their computer. Another person reached out and gave a member of staff a kiss after they had supported them to transfer from their wheelchair into a lounge chair. The staff member responded positively to this spontaneous demonstration of affection.

People told us staff were friendly and thoughtful. One person told us the staff were, "Always very nice and willing to make you comfortable and happy." This person went on to tell us, "The care staff are very good, they would do anything for you. If you want a cup of tea upstairs in your room, they will bring you one."

Staff spoke positively about working at the home. One staff member told us they enjoyed working in the home because, "It is a lovely place to work. I've always felt it is like one big family." We saw staff were kind and compassionate in the way they interacted with people and frequently reassured people, by touching their arms and hands. Permanent staff had a good understanding of the various needs of people and were attentive in their manner. When staff supported people, they worked at the person's pace and did not rush them.

Staff treated people with dignity and respect. All the people looked well presented, and were observed to be wearing clean and well-fitting clothes. When supporting people, staff spoke kindly and gently to them and informed them of what they were going to do. Staff used people's names when talking to them to reinforce their sense of identity and self-worth.

Staff were also respectful of people's privacy. One person had one to one support from a staff member. This staff member withdrew when the person's family arrived so they could have privacy during their visit.

Most people were able to choose where they wanted to spend their time and moved between the communal areas as they wished to. People chose what time they got up in the morning and what time they went to bed. We spoke to one person who was sitting in a lounge at 7.30am. This person confirmed they liked to get up at that time and told us, "We can do what we like normally. It has to be your own choice."

Where people were able to, they were encouraged to take an active part in the home and complete tasks within their capabilities. The home's administrator told us about one person who liked to help them in the office. They told us, "[Name] will help me sort out the envelopes." Another person told us how they were particularly pleased to be involved in interviewing potential new staff, especially as the managers were making them their own 'staff badge' to wear. When talking about this person a staff member said, "Her

words were that it has given her a sense of purpose."

The provider had an equality and diversity policy and staff had also received training in this area. Our conversations with staff demonstrated they respected people as individuals and were keen to understand what was important to them. Staff understood how to protect people's confidentiality. Care records were stored securely and staff ensured conversations involving people's personal information were held in private.

Staff spoke with one another in a respectful way and were helpful towards each other in completing their care duties and supporting people. The new manager told us they planned to build on these foundations to develop a service where people felt they mattered and were put at the centre of the home. They explained, "I want everybody to come into work and have a lovely day with the residents. Everything has to be person centred. The day I don't know I have made a difference to somebody's life, I won't do care anymore."

There were no restrictions on visiting times and we saw visitors arriving at the home throughout both days of our inspection visit. Staff were welcoming to visitors and supportive of them being with people in communal areas of the home or in quieter areas or bedrooms if they wanted more privacy.

Is the service responsive?

Our findings

At our last inspection we found staff were not consistently responsive to people's needs. At this inspection we found improvements had been made, especially in respect of the provision of social activities in the home. However, there were other areas that still required improvement to ensure people consistently received a service that was responsive to their individual needs.

People's needs were assessed before they moved to the home which formed the basis of a care plan which was then developed over the next twelve weeks as people settled into the home and staff began to have a better understanding of people's individual abilities and preferences.

We looked at four people's care plans. For people who had been in the home for some time, there were care plans for all aspects of their care and support. Such as personal care, mobility, skin care, nutrition, continence and health. These care plans promoted independence because they informed staff what people could do for themselves and when they might need prompting or support. They also contained some information about people's preferences, for example, how many pillows they liked and what they preferred to wear when sleeping.

However, we found that for people who were new to the home, the information captured within their daily and other records was not always being used effectively to inform the development of their care plan. Whilst we acknowledged these care plans were a 'work in progress', it meant there was limited guidance for staff about how to support people with complex dementia care needs so they could respond to people in a positive and consistent manner. We particularly identified one person who had recently moved to the home who was demonstrating behaviour that put themselves and others at risk. We fed this back to the provider's operations director who agreed this person's care plan did not contain the level of information and guidance they would expect for someone with such complex needs and risks. On the second day of our visit, this person's support needs had been reviewed and as a result, the provider had made a referral to the funding authority for the person to receive one to one support.

Each person had a 'snap shot' of their needs on a 'This is Me' sheet in their bedroom, which was a prompt and guide to ensure people received safe and appropriate support. The 'snap shot' listed the equipment people required when being supported to transfer or mobilise and information about their dietary requirements and the level of assistance they needed. This meant staff had access to information to quickly respond to people's basic support needs. They also contained some information about people's family and what was important to them so staff had a source of reference to start meaningful conversations with people.

Each person had a 'My Life Story' in their care plans which captured current information about the person, their life history, important relationships and key events in the person's life they would like to remember and celebrate. We found some 'stories' needed further work so staff had more information to inform their understanding of who the person was and their life experiences.

Care plans included details of the support people needed with communication and to understand information. When staff spoke with people, we saw they ensured they were on the same level so people could hear what they had to say and staff could understand the person's physical responses if they had limited verbal communication. Some information was in a pictorial format to help people understand their choices and options. For example, menus were pictorial and staff said this was particularly beneficial for those people who had hearing problems.

People had access to an activity programme, referred to as a 'monthly social and wellbeing programme.' There had been an activity co-ordinator who supported people to join in activities in groups or individually. People spoke very highly of the activities co-ordinator, but unfortunately they had recently left the home. The provider had agreed to the recruitment of two new activity co-ordinators so activities could be offered to people seven days a week. The roles were being recruited to at the time of our inspection visit. In the meantime, the provider's hospitality manager had taken on the role of providing activities on two days a week until the positions were recruited to.

On the first day of our inspection visit we saw the hospitality manager sitting with a group of people reading a 'Daily Sparkle' which is a reminiscence newspaper which offers a range of nostalgia topics to promote conversations. In the afternoon they led a craft session which people indicated they enjoyed through their engagement and laughter. We also saw people sitting and chatting with each other, reading newspapers, doing a puzzle and in the morning a member of staff sat with two people and played a board game with them. Doors to the garden were open and we saw people were encouraged to go outside if they wished to. Some people enjoyed sitting in the sunshine.

During our time spent in the communal areas we found permanent staff engaged well in activities and conversation with people who were able to communicate and respond to them. However, staff were too busy to spend the time necessary to encourage those people who lacked motivation or were unable to communicate and engage in activities without more support. Interactions between care staff and these people were mainly task focused. One member of staff told us, "We need somebody to do activities because care staff don't have the time." We shared our feedback with the provider's operations director who acknowledged the time constraints on staff. They instructed the manager to put another member of staff on the rota during the day to provide this engagement until the new activities co-ordinators were in place.

The new manager explained it was important for staff to spend time with people and this could be achieved by making care tasks more interactive. This was understood by permanent staff as one explained, "We do try and sit and talk with people and if I don't have time, I will talk to them as I'm doing my tasks. That way they are aware you are there and not just sitting." The provider's training manager said they would provide more training for staff in sensory and tactile methods for encouraging engagement.

Other activities by external providers or entertainers were advertised on the noticeboard in the entrance to the home. These included visits from a pet therapy dog, creative exercise, musical entertainer and a visit from a local children's primary school.

At the time of our visit, no one was in receipt of 'end of life' care. Staff told us they were able to support people to spend their final days at the home, if it was their wish to do so. Arrangements could be made for anticipatory medicines to be available to help manage pain relief and staff worked in partnership with other health professionals to support people to have a pain free and dignified death. However, there was little recorded information in people's care plans about their wishes and expectations for being supported at the end of their life. The manager told us that some people were reluctant to discuss their end of life wishes and it was often a difficult area to approach. They told us this was an area they planned to improve so they could

be sure people's final days were spent as they wished them to be. There was information in people's care plans about any decisions that had been taken about resuscitation should they have a cardiac arrest. A discrete sign on people's doors ensured this information was known to all in a medical emergency.

We looked at how complaints were managed in the home. Complaints information was displayed in the reception area for people and relatives to refer to. No one we spoke with had made a recent complaint. However, when we asked one person who they would talk to if they had any concerns, they responded, "It depends on what your complaint was. You could complain to somebody and it would get passed on."

We looked at the complaints the provider had received in the eight months prior to our visit. We saw there had been three recorded formal complaints and these had been dealt with in accordance with the complaints policy.

Is the service well-led?

Our findings

At the last inspection in April 2017 we found the provider was not meeting all the legal requirements and was rated as 'Requires Improvement' under the key question of 'Is the service well led?' This was because systems and processes for managing nutritional risks were not always effective. The system for recording accident and incidents was not always consistent or clear and some audits had not identified the issues we found or demonstrated what actions had been taken. This meant the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The provider submitted an action plan that detailed the improvements required to meet their legal obligations. At this inspection we found some improvements had been made, however further improvements were still required and we found the provider continued to be in breach of the regulations.

At the last inspection in April 2017 there was no registered manager in post. Part of the provider's registration is that they have a registered manager. At this inspection, there continued to be no registered manager in post. A manager had registered with us in July 2017, but had then left the service in March 2018 and the deputy manager had been promoted as 'acting manager'. Shortly before our visit, the acting manager had decided their competencies and confidence were better suited to being deputy manager and had stepped back down to that role. The provider's quality director told us they were pleased they had offered the deputy manager the opportunity, as the provider liked to encourage personal development in staff and promote internally. However, they acknowledged The Knowles could be a challenging home and had appointed a new manager who had previously worked for the provider and had experience of managing similar services. The new manager started in their role on the day after our first visit. They told us they would submit their application for registration with us in due course.

The provider's compliance manager told us one of their responsibilities was to check the manager completed regular audits and took action to address any improvements that had been identified. The compliance manager told us, "Changes had been made for the better" based on their reflections from our last inspection. They said, "We have made significant changes with more hands-on support" to both the manager, staff and people at the home.

The provider's governance systems meant the manager was required to provide written assurance that actions had been taken from each audit with oversight from the compliance manager. The compliance manager reviewed the manager's response, but in some cases there was no follow up checks and we found some improvements had not been made in line with the manager's identified actions.

At our last inspection we found systems for the oversight of care plans and risk assessments were not always effective. The provider's action plan response to us following that inspection dated 21 July 2017 stated 'Any at risk residents are sent to the operations director to ensure appropriate action is taken'. On the first day of our inspection there was a failure to identify and mitigate risks presented by one person. This included risks relating to their behaviours and meant steps had not been taken promptly to safeguard people and staff. Immediate action was taken to mitigate the risks after we raised them with the management team.

The provider maintained a central record of DoLS applications and authorisations so they could re-apply for DoLS before they were due to expire. However, we identified occasions when DoLS had not been re-applied for before their expiry date. For example, one person's had expired on the 13 February 2018, but it had not been re-applied for until 29 March 2018. We were aware of an occasion earlier in the year when it had been identified that the provider had not adhered to the conditions on a person's DoLS authorisation. The provider's operations director agreed to include any such conditions within the central record so managers could monitor they had been complied with.

Infection control checks were completed, but they continued to record the same concerns with no evidence action had been taken, such as yellow bin bags not being fitted correctly and laundry bags not taken to the laundry. On the first day of our inspection visit, we found red laundry bags were left in communal bathrooms.

The provider's action plan dated 5 April 2018 in response to our last inspection visit stated – 'Environment, the entrance has a distinct unpleasant odour... the entrance lacks the wow factor'. On the first day of our inspection visit, the communal entrance and one of the lounges continued to have an unpleasant odour and action to eradicate the odour had been ineffective. On the second day of our visit the new manager had taken action to clean the carpets and the odour had significantly reduced.

Regular window restrictor checks had been completed, but the window restrictors did not follow health and safety executive advice because the windows could be opened easily, allowing people potential to fall or access external parts of the home which placed them at increased risk.

At the last inspection we identified records to evidence risk management were not always completed accurately. For example, topical cream applications charts and food and fluid records were not always completed with important information. At this inspection, we identified there were still issues with the accuracy and consistency of how staff recorded this information.

At this inspection we found staff had not formally been recording all incidents that occurred in the home in accordance with the provider's accidents and incidents procedure. This meant the manager had not been aware of the incidents so they could decide whether a referral to the local safeguarding authority was required. In some cases, the incidents had reached the safeguarding threshold.

The provider did not have effective arrangements in place to monitor, improve and sustain the quality, safety and welfare of people using the service. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The compliance manager had introduced a 'CQC notifications log' to give them assurance the manager and provider complied with their legal responsibilities to tell us about notifiable incidents. During our inspection visit, we identified that we had not been informed about all safeguarding incidents that occurred in the home. There had been a number of recent safeguarding incidents the deputy manager had only notified us (CQC) about when they made a referral to the local safeguarding authority which had been substantiated and action taken. They had not realised they needed to notify us as soon as they made a referral, without waiting for the outcome of the local authority investigation.

The provider had not notified us of safeguarding incidents which was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We discussed this with the new manager who was aware of their legal obligations. They told us they would

notify us at the same time as they made any safeguarding referrals in future.

Whilst we were concerned the provider's own checks had not identified the issues we found on the first day of our inspection visit, on the second day we were assured immediate action had been taken in response to some of the concerns raised. Incidents had been reviewed and where necessary referred to the local safeguarding team. Notifications about all safeguarding incidents had been submitted to us retrospectively. Window restrictors had been put in place to meet health and safety requirements.

The provider also had plans to address some of the other areas of concern we had identified. For example, in October 2018 they planned to introduce an electronic care planning system. Staff would have immediate access to care plans on handheld devices and record any care interventions as soon as they were completed. The provider's quality director said they were confident this would ensure there were accurate records of the application of people's topical medicines and how much they had to eat and drink. The system would also have a list of 'must do' actions in respect of each person's care. For example, pressure relief, time critical medicines or prompting people to elevate their legs. If these were missed, a report would go directly to the manager who could investigate and ensure the actions were completed in line with people's care and risk management plans.

The provider had planned a refurbishment of communal areas of the home to address issues around cleanliness and to make the environment more suitable for people living with dementia.

Staff told us 'lessons learned' had been shared with them at staff meetings on the day after our first visit. Staff told us and records showed they had been reminded of the importance of recording incidents on formal accident/incident forms to ensure the manager had oversight of events within the home.

Staff told us there had been significant improvements since our last inspection visit and spoke particularly of the introduction of the 'snack stations' and that there was more for people to do. However, some felt further improvements were still required. One member of staff told us, "There have been a lot of changes (in the management team)." Another said that whilst progress had been made it had 'slipped a little' recently. We asked staff if there was anything that could be improved. All said that more staff would provide them with the opportunity to spend more time with people and be more responsive to their social and emotional needs. One staff member told us, "The carers are sometimes run ragged" and another commented, "It would be handy to have another person. We have requested it, but it has never happened."

We shared this with the new manager who told us, "I think there are enough staff, but I need to ensure the skill mix is right because of the use of agency." They went on to explain that ensuring the right number of staff with the appropriate knowledge and experience was central to their vision of providing person-centred care at The Knowles. They told us, "I want people to be safe and well cared for and I want them to have an interesting home, and I want the home to become a little bit more inviting and homely."

All the staff we spoke with particularly spoke highly of the support from the provider and the senior management team. One staff member told us, "They are very supportive and you can pick up the phone and talk to someone. There is a good support network there to get things right." Another member of staff commented, "The head office and the group Adept (provider), I can't fault them. The support you get." This staff member went on to explain, "When it is 'Carers Week' we get a card and a bottle of wine so we are recognised for the work we do." One of the senior management team said, "I think highly of the company. They are very proactive. The company's policy is a good place to live and a good place to work and they really adhere to that."

The provider sought views from relatives, people and staff. Relatives were always welcome at the service and regularly visited their family members. They were invited to meetings and on the first Saturday of each month there was a 'relatives support surgery' held by the manager. People and relatives were sent annual questionnaires and there was a 'You said, We did' board in reception detailing the action taken in response to any suggestions or concerns raised. The results from the last survey indicated people were happy with the care provided with comments including: "Carers are very kind and helpful" and, "Our families are made welcome at all times."

Managers and staff worked in partnership with others to meet people's needs. This included working with health and social care professionals such as GPs, mental health teams and relevant others, such as family members.

Providers are legally required to display their CQC rating. The ratings from the last inspection were prominently displayed in the reception area at the service and they were available on the provider's website.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission of all allegations of abuse that had been referred to the local safeguarding authority.
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not consistently been assessed or recognised so action could be taken in a timely way to mitigate the risks. Records did not evidence that staff consistently followed risk management plans.
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes had not consistently identified where quality and/or safety were being compromised and actions to address issues had not always been effective.