Integrated Nursing Homes Limited

The Knolls Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection visit took place on 08 February 2017. The visit was unannounced. When we carried out the last comprehensive inspection in November 2015 we found the service was not meeting the expected standards in relation to the provision of sufficient staff to meet people's needs safely and in notifying the Care Quality Commission (CQC) of significant events as required. At this inspection we found that improvements had been made and the service was now meeting these requirements.

The service provides accommodation and personal or nursing care for up to 56 people with a range of needs including those associated with dementia and with life limiting health conditions. At the time of our inspection there were 45 people living at the home. The service consists of a residential unit for people who do not require nursing care, a nursing unit and a step down (rehabilitation) unit for up to six people working towards going home following a hospital stay. At the time of our inspection, an additional six beds (from the nursing unit) had been commissioned for step down care, bringing the total number for this unit to 12.

The service did not have a registered manager, the previous manager having left the service approximately one year ago. 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. At the time of the inspection a new manager had been appointed but had not taken up their post yet. There was an acting manager in post who was familiar with the service and held a senior management position within the provider organisation.

Staff were aware of the safeguarding process. Personalised risk assessments were in place to reduce the risk of harm to people, as were risk assessments connected to the running of the home. These were reviewed regularly. Accidents and incidents were recorded and there were processes in place to analyse the causes of these to reduce the likelihood of reoccurrence. People received their medicines as they had been prescribed and there were robust procedures in place for the safe management of medicines.

There were enough skilled and qualified staff to provide for people's needs. Robust recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with the people who lived at the home. Staff received training to ensure that they had the necessary skills to care for the people who lived at the home and were supported by way of supervisions and appraisals. Nurses were supported to maintain and update their skills to maintain their registration.

People's needs had been assessed when they moved into the home. They, their relatives and other healthcare professionals had been involved in determining their care needs and the way in which these were to be met. People's consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

A range of activities were provided and people we spoke with reported they had enough to do. People were

supported to have enough to eat and drink although feedback from people about the quality and choice of food was varied.

The provider had systems in place to monitor the quality of the service which identified areas for improvement and suggested remedial actions to be taken. Staff were able to contribute to the development of the service through team meetings and understood the visions and values of the service. People and their relatives had opportunities to share their views and make suggestions about how the service could be improved. Complaints about the service were managed appropriately and in line with the provider's policy.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were aware of the safeguarding process and how to make appropriate referrals to the local authority.

Personalised risk assessments were in place to reduce the risk of harm to people.

There were enough skilled and qualified staff to provide for people's needs

People's medicines were administered safely and as prescribed. Arrangements for the ordering, storage and disposal of medicines were robust.

Is the service effective?

Good

The service was effective.

People had a choice of nutritious food and drink.

Staff were trained and supported by way of supervisions and appraisals.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

Is the service caring?

Good

The service was caring.

Staff were compassionate and caring.

Staff promoted people's dignity and treated them with respect.

Staff encouraged people to maintain their independence.

Is the service responsive?

Good

The service was responsive.

People received person centred care and care plans reflected the care given.

People had enough to do and their social needs were met.

People knew how to make complaints if they needed to and these were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led because there was no registered manager in post.

The acting manager was knowledgeable, approachable and supportive of staff.

People were asked for their views and these were used to support continuous improvement to the service.

There were robust quality monitoring systems in place

The Knolls Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection visit took place on 08 February 2017 and was carried out by two inspectors.

Before the inspection we reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law. We also read the previous inspection report.

During the inspection we spoke with 10 people and two relatives of people who lived at the home, five care workers, one nurse, the acting deputy manager and the acting manager. We reviewed the care records and risk assessments for seven people who lived at the home. We looked at five staff recruitment files and reviewed training and supervision records for all the staff. We also reviewed information on the complaints system and how the quality of the service was monitored and managed.

Good

Is the service safe?

Our findings

At the last inspection in November 2015 we found there were insufficient staff on duty to meet people's needs safely and in a timely manner. The service relied on high numbers of agency staff in order to fill vacancies in the team. At this inspection we found that the numbers of staff on duty had improved and that, although the service still made use of agency staff, the number of hours had significantly decreased due to the successful recruitment of permanent staff. Where agency staff were used the manager confirmed that, where possible, only those who were familiar with the service worked at the home to support the consistency of care.

When asked if staff came in good time if they needed assistance, one person said, "Well, let's see shall we?" and pressed the call bell. A member of staff arrived within one minute to check that the person was okay and then offered them a drink. They returned with it within a further couple of minutes. Most people we spoke with told us that staff were usually able to attend to them quickly if they used their call bells. One person said, "They can usually come. Sometimes there's a delay but I always know it's for a good reason. I rarely wait more than a few minutes." Another person said, "If I need help they do usually come in good time." However, a third person said, "I press the call bell and they say they will be back in a minute, but it always seems much longer." We noted that there were risk assessments in place for people who were unable to use their call bells, and that appropriate control measures had been put into place to mitigate for the risk associated with this. These included more regular checks throughout the day and night.

Whilst staff were busy and occupied, we observed that they were generally able to spend time with the people using the service and respond to them if they needed something. There was a relaxed, friendly atmosphere and staff did not report feeling rushed or under pressure.

The staff we spoke with felt that there were enough staff to keep people safe and meet their needs. However, they told usthat there had previously been issues with short staffing and the use of agency staff. One member of staff said, "We have enough staff, but sometimes staff go off sick and we have to use the agency staff. It's not the same, although we do try and use the same agency staff wherever we can and some of them are good. It's just that sometimes we have to make do."

The provider had effective recruitment processes and systems to complete all the relevant pre-employment checks, including requesting references from previous employers, proof of the applicants' identity, confirmation of their right to work in this country, and Disclosure and Barring Service (DBS) reports for all the staff. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed.

The people we spoke with told us they felt safe living at the service. One person said, "I feel safe living here. It's a nice home and good staff."

Staff were able to describe some of the ways in which they kept people safe, and the process they would follow if they were concerned that a person might be at risk. One member of staff said, "I would always make

sure I understood the facts and then report anything that concerned me. If I couldn't go to my manager then social services or the safeguarding team. But I can't say I've ever seen anything like that here." Another member of staff said, "It's a safe home and we do all we can to make sure that people are being looked after properly. But we can also use the whistle-blowing [policy] if we need to." Whistleblowing is a way of staff reporting concerns anonymously without fear of the consequences of doing so.

We saw that there were detailed risk assessments in place including for people's mobility and the risk of them falling. A member of staff told us that they had been working to reduce the number of falls in the home through more robust and detailed recording and follow-up from incidents. We saw that appropriate referrals had been made to support people who had difficulties with mobility. Instructions from occupational therapists or physiotherapists were embedded into people's care plans for staff to support them. For example, we saw that one person had been identified as being able to stand gradually with support. The staff recorded in detail the successes and challenges with this each day.

There were general risk assessments completed which identified any risks to the environment. Regular maintenance checks were being carried out including portable appliance testing (PAT), gas safety checks and fire equipment checks. Equipment, including hoists, was serviced regularly. There was a contingency plan in place which detailed the steps the service would follow in case of an emergency and each person had an personal emergency evacuation plan (PEEP) included within their care records. We noted that, where incidents or accidents took place in the home these were appropriately recorded and processes were in place to enable the manager to analyse the records to establish patterns and trends. This enabled action to be identified to reduce the risk of further occurrences.

Medicines were administered safely by staff who had received training and observations of their competency. We observed the lunchtime medicines round and saw that the correct procedures were being followed by the nurse on duty. Each person had an information sheet which detailed the medicines they took, their preferred method of administration and any conditions or allergies that staff needed to be aware of. For people who had been prescribed medicines to be taken 'as required (PRN)) there were clear protocols in place to advise staff on when it was appropriate to administer these. We looked at the medicines administration record (MAR) charts for six people and saw that these were completed correctly with no unexplained gaps.

Medicines were stored and accounted for as required, including controlled drugs, and there were regular audits to ensure that stock levels were correct. Most people had their medicines provided in blister packs, but separate medicines were appropriately labelled and stored in lockable trolleys. The service had recently received an audit from the local pharmacy and had acted upon the few minor issues raised. The manager told us that the service had been identified by the local Clinical Commissioning Group (CCG) as a home which could be used to advise other services in the area on the correct management of medicines.

Good

Is the service effective?

Our findings

People told us they believed that staff were trained to enable them to provide effective care. One person said, "There's not one [staff] you wouldn't have faith in here." A relative told us, "They're really on-the-ball, all of them."

The staff we spoke with told us they received training that was relevant to their role and helped them to carry out their duties effectively. One member of staff said, "I've done all the essential training and then also courses like DoLS, nutrition and dementia. The trainer we have is really good. Really engaging. There's no online training- it's all face-to-face. [Trainer] explains everything and answers all of our questions." The staff training matrix confirmed that training compliance levels were good, and that most staff had received training throughout November 2016.
The staff we spoke with told us they received regular supervision and appraisal. One member of staff said, "We have really very regular supervision. Daily in terms of being spoken to about our work and guided if we need to do something differently. But formal supervisions are usually once every couple of months." Another member of staff said, "I have three or four supervisions a year but more if I need them." People were therefore cared for and supported by staff who were encouraged to maintain and develop the appropriate skiills.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The managers and staff demonstrated an understanding of the MCA and associated DoLS and recent training had been provided. Where appropriate we saw that capacity assessments had been completed, and best interest decisions had been made on people's behalf appropriately. We saw that DoLS applications had been made where it was deemed that a person lacked capacity and where their liberty was restricted. People's rights were therefore protected.

Staff were able to describe the ways in which they gained consent from people to provide care. One member of staff said, "The most important thing is to speak to the person and understand them. Obviously if they can't make it known to us that they're happy then we would read their care plan to see if they've got capacity." They went on to explain that when a person was deemed to lack capacity to make a particular decision, it would be made in their best interests. They were clear that complex decisions would require a formal best interests meeting to be convened and the decision to be recorded.

We received some mixed views on the quality of the food provided. While people told us they had enough to eat and drink, some people felt that the food lacked variety and that choices were sometimes limited. One person said, "The food is quite bland and could use some spices or seasoning. There are usually two choices for lunch but not always for tea- it tends to be the same sandwiches over and over again." A second person

said, "The choice of food is rather limited, especially for vegetarians." However another person said, "We get a menu every day with choices of what to eat. I'm a vegetarian and there's always an alternative available for me." A relative told us, "[Person] has a softened diet and they give them the right food but it always seems to be the same thing."

At lunchtime tables were attractively laid with small vases of flowers and up to date menus were clearly on display. We observed that the meal provided was well presented and served hot. There was a choice of both main meal and dessert, and we saw that one person, who did not want either of the options, was offered and provided with an alternative meal of their choosing. We observed that staff offered skilled support and encouragement to people who required assistance to eat their meal. They noticed when people were not eating well, checked if they wanted different food or any assistance to eat. We saw that risk assessments had been completed in relation to nutrition and hydration needs and that people's weights were monitored appropriately. Where necessary, referral to dietitians and speech therapists were made to ensure people's needs were met in relation to eating safely.

People's healthcare conditions were listed in their care plans and both nursing and care staff were provided with detailed instructions to enable them to understand how to support people with their health and well-being. We noted in one person's care plan that they required Percutaneous endoscopic gastrostomy (PEG) feeding. PEG feeding is a procedure in which a flexible feeding tube is put into a person's stomach to feed them when they are unable to take food by mouth. We checked their daily records and confirmed that the correct amount of food and fluids were being given and that the PEG tube was being correctly cleaned and maintained. People's care plans included details of any referrals to external healthcare services and involvement from professionals. People we spoke with confirmed they were able to access healthcare professionals such as Opticians, Chiropodists, and GPs should they need to and records confirmed this.

Good

Is the service caring?

Our findings

The people we spoke with told us they had a good relationship with staff. One person said, "They're all wonderful [staff] here." Another person said, "It's been excellent living here. No complaints at all. The staff are all very conscientious and caring and very patient too. There isn't one of them that isn't thoughtful and gentle and doesn't treat me like a human being." The interactions we observed between people and staff were very positive and the atmosphere in the home was friendly. Staff appeared to know people well and took time to chat amiably with them between and during tasks.

The people we spoke with felt that they were treated with dignity and respect. One person said, "I'm definitely treated respectfully and my dignity has never been an issue. I trust them to know what I need and to handle it appropriately." Another person said, "They [staff] listen to us. We have a good relationship and yes I would say I'm treated well." We saw that staff took care to protect people's privacy, knocking on the door before entering a person's room and keeping doors closed when giving assistance with personal care.

Staff supported people to make choices about their care, gave them good information to support their choice and respected the decisions they made. For example, at lunchtime, a person was feeling unwell and became distressed. Staff responded quickly and discretely to find out what was wrong. The person wished to leave the dining room and was finding it difficult to mobilise. They took time to find out how the person wished to be supported and followed their wishes swiftly and with skill, explaining all the while what they were doing and why.

People, especially those supported by the rehabilitation unit, were supported to regain and maintain their independence. One person said, "They are supporting me to be more independent so I can go home again. I don't feel I have made enough progress yet but they are really helping me get there." Nurses and care staff worked closely with occupational therapists and physiotherapists to support people who were recovering from illnesses or injuries following a stay in hospital. Robust support plans, including exercise regimes and life skills confidence building were in place to support people to regain skills that may have been lost due to a prolonged hospital stay.

An internal newsletter had been created called "The Plantation Post" which was distributed to staff and people. This included updates on events and activities in the service and a profile of a different member of staff each month. This enabled more person-centred communication in the service and showed a commitment to further developing relationships between people and staff.

Good

Is the service responsive?

Our findings

Most of the people we spoke with knew they had a care plan and said they had been involved in discussions about what care they needed and how they preferred it to be delivered. One person said, "Yes, they wrote down all my needs and they ask often how it is going and if they need to change anything." Two of the people we spoke with did not know whether they had care plans in place but one relative said they had been involved in the initial care planning process for their family member. They said, "I was involved at the beginning and they do call if anything changes." The staff we spoke with told us they were involved in the care planning and reviews of people's care plans, whilst also helping them worked towards their desired outcomes. One member of staff said, "Each person has their own needs and we have monthly reviews to consider how we're meeting their choices and preferences. All the staff get involved with care plans but each person has a key worker."

An initial assessment was carried out when people first came to the service to determine their level of need and from this a care plan was developed. The care plans we looked at were detailed and person centred, giving staff sufficient information to understand the individual's needs and preferences. Care plans were in place to cover identified needs in relation to in areas such as eating and drinking, personal care, sleeping, pain management, skincare, mobility communication and activities of living. In addition to the full care plan, a two page profile had been developed for each person that identified the key information about the person's needs and preferences, This was sent with the person if they were admitted to hospital to ensure continuity of care. It was also used to brief agency staff to enable them to work effectively with people.

The people we spoke with told us there were activities available for them to participate in if they wished. One person said, "I prefer to be in my room but I do go down and see what's happening sometimes. There's always the option of something going on." Another person said, "They have lots of activities and some good ones. Not always the sort of thing I like but I suppose they can't always cater for everyone. What's nice is that they don't leave out the older ones who can't join in when everybody's in the lounge. They'll bring things to them to enjoy. Nobody gets forgotten about here."

We saw a weekly chart which listed the activities available for the week of our inspection, which included games, arts and crafts, one to one time and singing. This enabled people to organise how they spent their time. Some residents were baking some scones on the day of our inspection in a specially designated area for them to practice cooking and baking.

The deputy manager told us the service took pride in their rehabilitation work and said, "We really help people to believe in themselves and regain their confidence." People using this part of the service were in agreement with this. One person said, "Yes, I'll soon be home. They are brilliant." There was a gym on site which could be used by people with physiotherapy input to practice mobilising. We saw that people's individual exercise regimes were clearly displayed for staff to follow a consistent guideline to help them with their on-going recovery.

The people we spoke with told us they knew how to make a complaint and would be happy to complain if

they felt it necessary. One person said, "I've never had to make a complaint. But if I have any grumbles about anything then I can call the owner directly and they sort it straight away." There was an up to date complaints policy and we saw that complaints were recorded effectively. Complaints received since the last inspection had been managed in line with the provider's policy and we saw that responses to complaints were appropriate, acknowledged people's concerns and identified action that would be taken to resolve the situation where possible. This showed that the service listened to people.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in post and the previous manager had left the service approximately one year ago. Although the provider had recruited to the post during this time, the appointed candidate turned down the position at short notice. At the time of the inspection, a new manager had been recruited but had not yet taken up the post.. In the meantime a senior manager within the provider organisation was supporting the service as acting manager. This manager knew the service very well having worked there previously. The service also had an acting deputy manager, who had previously been employed as a nurse within the rehabilitation unit.

The people we spoke with told us the managers were visible and approachable. One person said, "The managers are very helpful. They'll come and see me if there's something I need to talk about and they're not afraid to [provide care] if necessary either." Another person said, "They [the managers] will come and see us and spend time with us."

The staff we spoke with told us that they felt the managers were approachable and provided them with a good level of support. One member of staff said, "I have always had a lot of support from the managers." Another member of staff said, "I think working here is great because you get a lot of support. It's very well organised and just a really nice environment to be in." It was apparent that the manager had a person centred and consultative approach to their role. Through clear direction and openness to contributions from people, staff and relatives, they provided good leadership to the service.

The staff we spoke with told us they felt able to contribute to the development of the service through team meetings. One member of staff said, "We have all kinds of meetings; nurses meetings, meetings for each unit and then whole team meetings where we all get together. We get to speak about what's been happening and the managers do listen to our views and what we think." We saw from records that, as well as meetings for care and nursing staff, there were weekly head of department meetings. Processes were in place to cascade information from these meetings to all levels of staff. Residents meetings were also held to discuss recent events and activities.

People and their relatives were encouraged to share their views about the service and to be involved in making decisions about improvements.. Surveys had been carried out with people, relatives and staff in 2016 and a report had been developed to show the results and to identify action to be taken as a result. People told us that they were routinely asked to provide feedback on various aspects of the service such as food. One person said, "They ask us what we think and for any suggestions of different meals we might like."

There was a robust quality assurance system in place to identify improvements and areas for development in the service including regular auditing visits by the provider. Managers within the service carried out audits including medicine administration audits, care plan audits, infection control and health and safety audits. We saw that, where areas for improvement were identified, plans were in place to monitor the actions required to ensure the improvements were made. The manager also completed a daily walk around at 9.00am and recorded any actions required by staff on duty that day. Staff signed the record when the action

was completed and the manager completed a second walk around at the end of the day to check that the work had been completed. This enabled the manager to keep abreast of issues as they arose in the service. The manager also completed regular nightly spot checks to monitor the quality of care provided to people at night.

Care records were stored securely within lockable cabinets at the nurse's stations and within the manager's office. This meant that confidential records about people could only be accessed by those authorised to do so.