Alan Coggins Limited

Knyveton Hall Rest Home

Inspection report

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Website: N/A

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This was an unannounced comprehensive inspection carried out on 1 and 2 and 3 December 2014. At the last inspection in August 2014 we found a breach of regulations relating to consent to care and treatment, the care and welfare of people, management of medicines, safety and suitability of premises and assessing and monitoring the quality of service and records.

Knyveton Hall Rest Home is registered to provide personal care for up to 39 people. Nursing care is not provided. There were 34 people living at the home when we inspected. There was a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

An action plan was received from the provider which stated they would meet the legal requirements relating to consent to care and treatment, management of medicines and assessing and monitoring the quality of service provision by 12 November 2014. The provider told

Summary of findings

us that they would meet the requirement relating to the care and welfare of people by 10 January 2015. The provider did not send us an action plan detailing when they would meet the legal requirements for records.

At this inspection we found there were shortfalls in a number of areas. We found that the provider had not made the necessary improvements following our last visit in August 2014. Improvements were needed to ensure the service kept people safe and their rights were protected. Although people's needs were being assessed, their care plans lacked detail about the support they should receive. This meant people were at risk of receiving unsafe care. There were other failings in relation to care planning. The information in people's care records was not always up to date and there was a risk that people's plans did not reflect their current needs.

People's medicines were not safely managed, stored and recorded. Staff did not have clear instructions when they needed to give people 'as needed' medicines. There were no pain assessment tools in place. This placed some people at risk of harm and not receiving the treatment they needed.

Some people, who needed support to eat and drink, did not get the help they needed so they could do this safely and receive the food and drink they needed to keep them well.

The provider did not always comply with the Mental Capacity Act 2005, which included how to assess people's capacity to make specific decisions.

Policies about keeping people safe and reporting allegations of abuse were in place. However, these were generic and did not reflect local guidance. We found one instance where the safeguarding policy had not been followed. Staff training records indicated that most staff received training in how to protect people from abuse and report it should they suspect abuse had occurred.

Staff were not always recruited safely to make sure they were suitable to work with older people.

Some areas of the home had not been cleaned thoroughly. Infection prevention and control procedures were poor and this put people at risk.

Many of the staff had worked in the home for several years and this provided continuity of care for people at the home. People spoke positively about the kindness of staff and how they were treated.

Most staff treated people with dignity and respect. However we witnessed an incident where one member of staff did not. Staff knew people's care needs and some personal information about them. We saw good relationships and interactions between most staff and people.

There was little organised activity taking place in the home. People's need for social stimulation, occupation and activities were not consistently met.

People's care and monitoring records were not properly maintained and we could not be sure they accurately reflected the care and support that people needed and was provided to people.

Staff did not have the right skills and knowledge to provide personalised care for people who had specialist needs such as epilepsy, diabetes and stoma care. This was because they did not have the right training, regular support and development sessions with their manager.

The systems and culture of the home did not ensure the service was well-led. This was because people were not encouraged to be involved in the home, and they were not regularly consulted. The quality assurance systems in place were not effective, and did not identify shortfalls in the service. Staff told us that there was a blame culture in the home and the management structure was unclear.

We have taken enforcement action against Knyveton Hall Rest Home to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe.

Care was not always planned and delivered in a way which protected people from the risk of harm. One person was observed with bedrails down on their bed contrary to their care plan.

Systems for the management of medicines were unsafe and did not protect people using the service.

Safeguarding procedures were not always followed which put people at risk of harm.

Staff were not always recruited safely to make sure they were suitable to work with older people.

Is the service effective?

Inadequate 

The service was not effective

Staff did not have the right skills and knowledge, training and support to care for people safely and using best practice methods

People's rights were not protected because staff did not understand the implications of the Mental Capacity Act 2005.

People were not always supported to eat and drink enough to meet their needs.

Is the service caring?

Requires Improvement 

People told us they liked the staff who had got to know them and understood their needs. They said staff respected their privacy and dignity. We observed that most staff interacted with people in a polite and friendly way.

People were not routinely consulted or involved in developing their care plans.

Is the service responsive?

Inadequate 

The service was not responsive.

People's need to be kept occupied and stimulated was not consistently met. Very little information had been obtained about people's likes, dislikes and interests. Consequently people were not supported to pursue activities and interests that were important to them.

People needs were not reassessed when these had changed and their care plans did not include sufficient information about their care and support needs. This meant staff did not have up to date information to tell them about people's individual needs and how to provide personalised care.

Summary of findings

Information about complaints was displayed and people knew how to make a complaint. People and their relatives knew how to complain or raise a concern at the home.

Is the service well-led?

Inadequate 

The service was not well led.

There was a blame culture in the home. The manager and registered manager blamed each other for the failings that we identified during the inspection.

Systems for checking and monitoring the service were poor. This meant shortcomings in the home and the service people received were not always identified and responded to promptly.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

Knyveton Hall Rest Home

Detailed findings

Background to this inspection

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

This inspection took place on 1, 2 and 3 December 2014 and was unannounced. There were two inspectors in the inspection team. We spoke with and met seven people living in the home, one relative and a visiting professional. Because some people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with one visiting relative during the inspection. We also spoke with the registered manager, manager, a visiting professional and four staff.

We looked at seven people's care and support records, an additional two people's care monitoring records, medication administration records and documents about how the service was managed. This included staffing records, audits, meeting minutes, training records, maintenance records and quality assurance records.

Before our inspection, we reviewed the information we held about the service. This included information about incidents the provider had notified us of. We also contacted one commissioner and three health care professionals involved with people to obtain their views.

We did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give us some key information about the service, what the service does well and the improvements they planned to make. This was because we had previously inspected the service and issued a warning notice relating to the safety and suitability of premises. This meant we needed to return to the service within a short timescale to ensure that the required action had been taken.

Inadequate

Is the service safe?

Our findings

People who were able to tell us about their experience of the home, told us they felt safe at Knyveton Hall Rest Home. One person said: “It’s perfectly alright as far as I am concerned.” Another person told us, “I feel absolutely safe, I can go out when I want to go out. It’s so nice here, I don’t push myself. I am very happy.”

However we found that there were not appropriate systems in place to identify, assess and monitor risks to health and safety of people living at the home.

Regular fire drills took place, the last of which was recorded on the 20 April 2014. The fire alarm system and emergency lighting had been maintained by a qualified contractor every three months. The home’s fire records log book and recommended that it is good practice is to carry out a monthly check of the emergency lighting system and this can be done by someone within the home with the necessary training. There were no records in the log book to show that this was being done. The log book and recommended good practice is also that firefighting equipment and fire doors are also checked monthly. There were no records in the log book to show that this was being done. We found that the fire door to the laundry room had part of the intumescent smoke seal missing which meant that the door would have been less effective in preventing the spread of smoke in the event of a fire. We also found that the first floor bathroom door was broken. The bathroom contained an electric bath seat and other combustible items. Again, this door would not have been effective in preventing the spread of smoke in the event of a fire.

Cleaning chemicals including toilet cleaner, stain remover and fabric conditioner that had been decanted into a water bottle had been left unsecured in the downstairs staff toilet and the laundry room. People living in the home could have easily accessed these areas and had therefore been put at risk. The home had a generic Control of Substances Hazardous to Health policy which stated that chemicals should be kept securely. This policy had not been amended to reflect the needs of people living at Knyveton Hall.

We saw that there were broken windows in the downstairs toilet and kitchen. The broken window had been identified by an Environmental Health Officer some months previously and the home had been given a notice to repair this. This may have posed a risk to staff who accessed these areas.

At our previous inspection in August 2014 we found that people were not protected against the risks of unsafe or unsuitable premises. At this inspection we found that all but two of the windows on the first and second floor of the home had been restricted in order to prevent people from falling from them. We saw that two radiators still did not have covers on them to prevent people from the risk of burns from hot surfaces. The provider has taken action to address most of these areas, but had not fully responded to the areas outlined in our previous inspection report.

This was a breach of regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as there were not effective systems to identify, assess and monitor risks to health and safety of people living at the home.

At our previous visit in August 2014 we found that people were not protected against the risks associated with the management of medicines. At this visit we found further issues with how medicines were managed.

We looked at the medication administration records (MAR) for two people who lived in the home. We saw that there was an up-to-date photograph and details of any known allergies on people's MAR. We saw that all medicines had been signed for when given. We found two instances where medicines had been carried over from the previous month; the number of tablets that remained in the boxes had not been recorded. This meant that the staff could not be sure how many tablets were in the boxes and therefore whether there was enough stock or whether any had gone missing. We also found other discrepancies where medicines stock did not match the amount signed for on the MAR.

General medicines were stored appropriately in secure lockable cupboards. We found that some medicines required storage at a low temperature. The provider had a fridge to keep these medicines at the correct temperature. We examined the fridge in the afternoon of the first day of the inspection; we saw that the fridge was not closed properly and fluid was leaking onto the floor. There was no temperature alarm on the fridge and staff were not conducting regular temperature checks to ensure the

Is the service safe?

medicines were kept at the correct temperature. We raised our concerns with the manager who contacted the local pharmacy to ensure that the medicines required to be kept cool were still safe to use.

The home had the facility to store controlled drugs. We checked the home's controlled drug book and found that it contained several errors. For example, it indicated that for two people, there should have been quantities of a controlled drug in the home. There were no controlled drugs in the controlled drugs cabinet. We also found that a person's name had been recorded in the space for the name of the medicine. The manager and other staff were unable to identify what the medicine was or what had happened to it.

We found that some people living in the home had been prescribed PRN (as required) medicines. However we found that care plans that set out what the medicine was for, when it was to be offered and the dosage were not always in place. There were no pain assessment tools in place to enable staff to assess and provide pain relief for people who were unable to communicate that they were experiencing pain.

Staff who managed medicines had not had their competency assessed to ensure the safe management of medicines. This meant that people living at the home and the provider could not be assured that staff had the necessary skills and knowledge to administer medicines safely.

These shortfalls in the management of medicines were a continued breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our previous visit in August 2014 we found that care was not always planned and delivered in a way which ensured people's welfare and safety. At this visit we identified further shortfalls.

One person had been discharged from hospital and we saw records that said the hospital had advised that the person should receive thickened fluids and a pureed diet. However we saw that the person's care plan stated the person was able to drink normal fluids. There had been no referral to a speech and language therapist to assess the person or provide support and advice. We saw that the person was regularly weighed and since their admission to the home had lost a total of three stone and 13 pounds. The person's Body Mass Index (BMI) had not been calculated which meant it was unclear whether the person was of a healthy weight or that they required input from relevant health professionals regarding their nutritional needs.

People had risk assessments and management plans in place for falls, moving and handling, pressure areas and nutrition. However, risk assessments and management plans were not in place for some areas of risk. For example, one person had epilepsy and was prescribed medicine to help manage this. There was no plan in place to instruct staff how this person's epilepsy was managed, what to do if the person experienced a seizure and when they should call paramedics. Staff were not able to tell us how the person may present when they had an epileptic seizure and what action they needed to take in response to this person having a seizure. This meant that the person may be at risk of not receiving the support they require should they have a seizure.

There were not appropriate plans in place to reduce the risk of people developing a pressure sore. We saw that the person was being cared for in bed on an air mattress. A pressure risk assessment had not been completed. The person's care plan did not state the setting of the air mattress. We looked at the person's air mattress and saw that it was set to "5". We asked the manager what the air mattress should be set to, they did not know. They showed us an "air mattress control book". We saw that the air mattress was set to setting 7 on the 13 October 2014 and then setting 5 on the 17 October 2014. We asked the manager why this was and how they knew this was the correct setting. The manager responded that they did not know. This meant that air mattress may not be fully effective, as there was no assessment or plan in place to ensure that it was programmed to the correct setting to meet the needs of that person.

Another person had been assessed by the provider as requiring bedrails to prevent them falling out of bed. We saw that a risk assessment was in place for the safe use of the bedrails. However on the first day of our inspection we found that the person was asleep in their bedroom and their bedrails were down. This meant that their care was not being delivered in accordance with their care plan and there was a risk they may fall out of bed.

Inadequate

Is the service safe?

This was a continued breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care was not always planned and delivered in a way which ensured people's welfare and safety.

Staff had been trained in safeguarding adults. Three of the staff we spoke with were confident of the types of the abuse and how to report any allegations. The providers safeguarding policy included contact details for reporting any allegations of abuse. However, the provider did not respond appropriately to allegations of abuse. We looked at a selection of staff records and saw that two members of staff had reported an allegation of abuse to the manager in June 2014. We saw that a safeguarding alert had not been raised with the local authority, nor had a notification been made to the Care Quality Commission under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Following our inspection we raised a safeguarding alert with the local authority safeguarding team.

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to safeguarding people who use the service.

Recruitment practices were not safe. We looked at four staff recruitment records and found that not all of the relevant safety checks had been completed before staff commenced work. We saw evidence of enhanced checks with the Disclosure and Barring Service being carried out for all four members of staff. For two members of staff recruited, there were no employment histories, application forms or declarations that they were mentally and physically fit to work. We also saw that each member of staff only had one reference on file and with the lack of employment history, it was not clear if the references were from their previous employer. Paragraph 6 of Schedule 3 to the Health and Social Care Act 2008 (Regulated Activities) regulations 2010 states the requirement as: "A full employment history, together with satisfactory written explanation of any gaps in employment." This meant the provider could not be sure of the suitability of staff as they had not gained satisfactory evidence that applicants were of good character.

The shortfall in obtaining references from previous health and care sector employers and a full employment history put people at risk from staff who may be unsuitable. This was a breach in Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not protected by effective systems for the prevention and control of infection. Areas of the home such as kitchen, lounge, bathrooms and bedrooms had not been cleaned thoroughly. We found that items of furniture such as tables, armchairs and bedside cabinets were soiled and there was debris behind people's bedroom furniture. Equipment including hoists and commodes were also not clean. We found dried faeces on the seat of one commode.

We spoke with the cook who told us that the kitchen was cleaned but there was no plan to identify the frequency that each area of the kitchen should be cleaned. We found that the home had been given advice by the Environmental Health Officer and an Infection Prevention and Control Specialist in December 2012. Both professionals had also identified that various work surfaces in the kitchen, preparation area and serving hatch to the dining area had worn and damaged surfaces that were no longer properly sealed and therefore could not be cleaned properly. No action had been taken to address this. In addition, we found that the cook had not undertaken basic food hygiene training in more than 10 years. The recommended frequency and period of validity for this training is three years. The Environmental Health Officer had advised the cook to undertake this training. We asked the registered manager about these issues. They told us that they thought that the issues raised by visiting professionals were only recommendations so they did not need to take action.

We looked at food within the fridge and saw that some foods were not covered and other items were not properly labelled and dated. This meant that there was the risk that people could be given food after its use by date. The cook removed these food items when we raised this with them.

Within the laundry there was no clear segregation of soiled laundry from the clean laundry and very little work space to sort items. The sink in the laundry room was dirty and stained. When the washing machine was on the rinse cycle we noted that the foul water came up through the drain and into the sink.

There were not appropriate hand washing facilities in place. There were no paper towels in the downstairs toilet but there was a stained hand towel hanging on a hook. We pointed this out on the first day of the inspection and in addition noted on the second day that the liquid soap was almost finished. The paper towels were not been replenished throughout the three days of our inspection. A communal hand towel would not be effective in preventing

Inadequate

Is the service safe?

the spread of any infection. We also found that there were no hand wash facilities consisting of liquid soap and paper towels for staff in any of the bedrooms. This was of concern because staff should wash their hands before and after providing personal care.

The extractor fans in en suite bathrooms were dusty and required cleaning. There were also toiletries left in the upstairs bathroom which included wash cream, talcum powder, shaving foam and antiperspirant. None of these items were named. This posed a risk of cross infection as they could be used by more than one person.

There were no cleaning schedules to instruct cleaning staff on the frequencies that areas of the home or items of furniture and equipment should be cleaned and how they should be cleaned. Wheelchairs and hoists were soiled. Slings did not have people's names on them, and some were stained and there was no system in place to ensure that they were cleaned. We spoke with one healthcare professional who told us they felt the home was not kept clean. Infection control audits were not completed, which meant that shortfalls were not identified and acted upon.

These shortfalls in the cleanliness, prevention and control infection placed people at risk. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our previous inspection in August 2014 we found that people were not protected against the risks of unsafe or unsuitable premises. At this visit we found that the provider had taken action to address most of these areas, with some work still to be completed in relation to restricting all window openings and covering all radiators.

We saw that the provider had a Legionella risk assessment in place and improvement works had commenced. Legionella are water-borne bacteria that can cause serious illness. Health and safety regulations require persons responsible for premises to identify, assess, manage and prevent and control risks, and to keep the correct records.

The provider had purchased an electric wheelchair and a purpose built mental ramp in order to assist staff when moving people from one part of the home to another. We saw that a risk assessment was in place for the ramp. Three members of staff told us that the electric wheelchair was useful when assisting people in wheelchairs to move.

The provider had completed work to the front entrance of the home which eliminated the trip hazards we found at our last inspection. Fire exits were clear and free from trip hazards. We saw records that showed that the passenger lifts in the home were regularly serviced.

People and relatives said there were enough staff. We looked at the staff rotas covering a period of three weeks and saw that there was a minimum of eight staff on duty in the morning and the evening which were the busier times of the day. However, the manager was not able to evidence how staffing levels were calculated and whether it was based on people's individual needs. This meant that there was no system in place to ensure that staffing levels were reviewed and adjusted to meet people's needs.

We saw that people living in the home had a personal evacuation plan so that staff and emergency services knew how to safely support the person in an emergency.

Inadequate

Is the service effective?

Our findings

Not all staff received adequate supervision, appraisal and training to enable them to fulfil their roles effectively. We looked at the training records for the 36 members of staff employed. Staff had received training including moving and handling and safeguarding adults. However three members of staff had not received infection control training since their employment with the home and four members of staff had not received this training since 2012. Following the inspection we asked the provider to send us a copy of their training plan, however this was not received.

One person required stoma care. We looked at staff training records and found that staff had not received stoma care training. That meant that there was a risk of the person receiving unsafe or inappropriate care as staff may not have the necessary skills, knowledge and experience to meet this person's needs safely.

One member of staff was unable to recall the last supervision meeting that they had with their manager. We looked at five staff files and saw that for one member of staff had not received supervision since January 2014. Another member of staff who commenced employment in February 2014 had not received supervision. A third member of staff had not received supervision since April 2014. The manager told us that all staff should receive formal supervision at least six times per year.

This was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as staff did not receive adequate supervision, appraisal and training to enable them to fulfil their roles effectively.

People told us they were satisfied with the food at the home. One person said, "The food is excellent, there is plenty". Another person said, "We get a choice of food and it's very good." People were given a choice of meals the day before. People told us that if they didn't like the two choices the cook would make them something different. However, we saw people were not offered a visual or verbal choice of food and drink at the time of their meal. This meant for some people living with dementia, they may not recall what they had ordered the day before or understand what was being offered to them.

The records for some people stated that they had specific dietary and nutritional needs. We saw that the provider had not worked with health professionals such as dieticians and speech and language therapists to meet these needs. Two people living in the home were receiving their food pureed. There was no information in these people's care plans contained information to support why this decision was made. Neither people had a safe swallow plan in their care plan or in their bedrooms.

We spoke with the cook and asked them which people in the home were at risk of malnutrition. They told us that there was no one living in the home who they understood was malnourished and they were not fortifying people's food. However this contradicted some of the care plans we had looked at. We looked at the list of people's dietary requirements in the kitchen of the home. We found that this had not been updated since April 2014. We saw that one person, who was receiving a pureed diet due to swallowing difficulties, was recorded as receiving a normal diet. This meant that the person may be receiving the wrong type of food and be at risk choking. The list contained no likes or dislikes and there was no record of any allergies. We asked the cook if they were aware of any people living in the home with an allergy. They told us that one person had a cheese allergy. This meant that there was a risk that people may have been given foods that they did not like or that they were allergic to.

A malnutrition risk assessment for one person had identified that they were at risk of malnutrition and were underweight. They had not been referred to a dietician so that their nutritional needs could be assessed. Their care plan highlighted that the person was at risk and contained guidance on the types of foods the person enjoyed and prompted staff to be creative when offering food and prompt the person to eat regularly. However, their food chart was incomplete. For example, on the 23, 24, 25 and 26 November 2014, we saw that the person was only recorded as being offered breakfast and lunch. It was not clear whether this person had declined their evening meal or whether this was an omission in records. We saw on one occasion the person had refused their lunchtime meal, but there was no record of any alternative offered or action taken. On the day of the inspection we visited this person in their room at 15:00. They had their lunchtime meal and drink in front of them untouched. We raised our concerns with staff who arranged for an alternative meal as specified in the person's care plan to be taken to them. We returned to the person's room at 15:15 and saw that the person was eating the replacement meal. Staff had not identified that this person had not wanted their meal, and had not sought

to bring an alternative until this was raised with them. This meant that the person was not receiving a choice of suitable and nutritious food and they were not receiving adequate support to enable them to eat and drink sufficient amounts to meet their needs.

We saw another person who had hardly eaten any of their main course or desert. We asked them about this. They told us that they had liked their meal but their arms had been hurting them and no one had been available to assist them. The person said "I liked the food, the girls are intermittent some do stop and are helpful, some don't care at all". The person also told us that one of the cleaning staff had helped them to eat some of their meal. When we checked the food records for this person it stated that they had eaten all of the main course, coffee and dessert. This placed this person at risk, as they had not received adequate support to eat their meal and records provided inaccurate information on this person's nutritional intake.

These shortfalls in meeting people's nutritional needs were a breach in Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our previous inspection in August 2014 we found before people were not always asked for their consent before they received any care or treatment. We also found where people did not have the capacity to consent; the provider had not acted in accordance with legal requirements. At this inspection we identified further shortfalls.

The provider had not made suitable arrangements to act in accordance with the Mental Capacity Act 2005. Three members of staff told us that they had not received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff training records confirmed this. Where needed, people had not always had their capacity assessed in relation to specific decisions so plans could be made and care could be provided in people's best interests. For example, one person had been diagnosed as having Alzheimer's disease, we saw that their mental capacity assessment was incomplete and there were no best interest decisions recorded. Another person did not have a mental capacity assessment but had a best interest decision in place for having their hair cut. A third person who had a diagnosis of Alzheimer's disease had their care plan signed by their relative; however their relative did not have the legal status to do this and staff had not understood this. There was no mental capacity assessment or best interest decision in place for this person. We also observed two people during our inspection who had bed rails up on their beds without either their consent being sought, or a mental capacity assessment and best interest decision in place. This meant that people may be at risk of receiving care that they had not consented to, or that may not be in their best interest.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the manager understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. Applications had been submitted to the local authority for a number of people and the home was waiting for assessments to be carried out. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

The shortfalls in the staff's understanding of the MCA, implementation of best interest decisions, and those people who were being deprived of their liberty was a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because suitable arrangements were not in place for acting in accordance with the Mental Capacity Act 2005.

At our previous inspection in August 2014 we found people were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. At this inspection we identified further shortfalls.

Care plans prompted staff to record people's weights on a monthly basis, or more frequently if required. However we found that this was not always completed. For example, one person's care plan indicated that they were last weighed on the 31 October 2014 and had lost weight since they were previously weighed on the 20 August 2014, but the frequency for weighing them had not been reviewed and their weight had not been recorded during November 2014.

Some people in the home required their fluid intake to be monitored to prevent dehydration. We looked at a sample of five people's fluid charts and found that none of them contained targets so that staff knew how much people

Inadequate

Is the service effective?

should drink to ensure their health and welfare. None of the fluid charts were totalled. This meant staff would not know whether people had consumed enough fluid to prevent them becoming dehydrated.

We saw that some people required continence aids and care plans specified this. However care plans did not specify the type and size of aids required. This meant that some people were at risk of receiving incorrect care and support

This was a repeated breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

We could see from the care records we looked at that local health care professionals, such as the GP and district nurse, were involved with people when they needed it. During the inspection we spoke with a visiting healthcare professional who told us that they visited the home on a regular basis and were kept informed of people's healthcare needs.

Requires Improvement

Is the service caring?

Our findings

People that used the service were positive about the care and attitude of staff. One person told us, "The staff are nice, I feel safe, I am well looked after." Another person told us, "The staff are nice and they know me well. They bought me a new TV." A relative said, "I feel [person] is getting good care here. There is a low turnover of staff, I have no concerns."

Throughout our observations we found staff were kind, compassionate and caring. Staff used people's preferred names and spoke with people in a respectful and friendly manner. Some people required support with eating and drinking. Staff supported people at the pace the person needed. Some people were cared for in bed. Staff were organised and ensured people were comfortable and had their needs met.

Staff had a good understanding of people's needs, some of their personal preferences and the way they liked to be cared for. For example, staff knew one person enjoyed spending time in their room and reading. In another instance a member of staff recognised that the person did not have their glasses with them. They spoke to the person and went to get their glasses for them. We saw that the member of staff then cleaned the glasses for the person. People's life histories and personal preferences were not recorded. This meant that some staff may not have been aware of people's preferences so would not be able to respect these and ensure that they received personalised care.

We observed that staff respected people's privacy and dignity. We observed that staff knocked on people's doors before entering and that doors were closed when people were assisted with personal care. We spoke with three members of staff to check their understanding of how they treated people with dignity and respect. Staff gave examples of how they worked with the person, to get to know how they liked to be treated. One staff member told us, "We know each person well and share information on handover."

We observed that most staff treated people with respect. However we saw that on one occasion a person who had entered the office was told, "[person] what are you doing in here? This is private". This did not respect the person and was an area for improvement.

During our observations we checked on people who were being cared for in bed so that we could see how their care was being delivered. We saw that people were comfortable and were attended to regularly throughout the day. We saw that call bells both on the ground floor and first floor were responded to quickly when people required support and assistance. One person who lived at the home said, "I have a call bell, but I don't use it often, only in emergencies, I don't have to wait long when I press it."

People were not routinely consulted or involved in reviewing and developing their care plans after the initial assessment on their admission. One person told us that they had not been kept informed or been involved in developing their ongoing care plan. Relatives had been involved in some people's initial assessments and had signed some people's care plans where people were not able to do this themselves. One relative told us that they held power of attorney for health and welfare and had been involved in the person's care planning. This was an area for improvement to involve all people and their relatives where appropriate in the ongoing review of people's care planning.

People were supported to maintain relationships with their families and friends. People told us that their families were able to visit at any time and that staff supported them to go out and visit their friends and family. Care plan records confirmed this and a relative we spoke with said they visited regularly and were always welcomed.

Care files and other confidential information about people were kept in the main office. This ensured that people such as visitors and other people who used the service could not gain access to people's private information without staff being present.

Inadequate

Is the service responsive?

Our findings

People had an assessment of their needs completed prior to moving into the home, from which a plan of care was developed. However, people did not always receive support as described within their care plans. Some care plans were not updated as people's needs changed or were not in sufficient detail for staff to be able to follow them. Two staff told us they had not read people's care plans but were told about people's needs in handover. This placed people at risk of not receiving the care and treatment they needed.

One person was displaying behaviours that challenged others during our inspection. Staff told us that they displayed these behaviours often. We looked at the person's care plan and found no information regarding management of these behaviours and there had been no referral to relevant health professionals to help staff support this person. Failure to assess and plan for this person's need placed the person at risk of being provided with inappropriate or unsafe care.

The manager explained that some people living in the home who were at risk of malnutrition were too frail or became too distressed to be weighed. They explained that in this instance they measured the person's mid upper arm circumference (MUAC). We looked at the records for one person who was having their MUAC measured. We saw that care plans contained no guidance on how staff should complete the measurement. There was no information about to what this meant or if further action as required. We spoke with the manager and a member of staff who told us that they did not know what the measurement meant. This meant that the person may have been at risk of malnutrition as staff did not fully understand the method being used, did not know how to use this measurement to review the care they provided, or when a measurement may mean that specialist advise should be sought.

People did not receive support to meet their social needs. During the three days of our inspection, there were no activities organised for people to participate in. We asked the manager how activities were provided in the home. They told us that they did not employ an activities worker, but sometimes seasonal events were held. They told us that a Christmas fete was being held in December with dog rescue charity also attending. They told us that day to day activities were the responsibility of staff. We spoke with two members of staff who told us that, whilst they knew it was their responsibility to provide activities, they were too busy with their care duties, so they did not take place. They could not recall when activities were last provided in the home. We spoke with two people who could not recall any regular activities that took place in the home; one person told us that they would like to join in if they took place. During the second and third day of the inspection we noted that one person who was cared for in bed was repeatedly calling out. We looked at this person's records which contained no information regarding why they did this or any social activities for this person, other than watching the TV, which may help to reduce their calling out. We found that staff had not explored this person's interests and life history to plan how to provide meaningful activity and occupation.

These shortfalls were a repeated breach in Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not receiving the social stimulation, care, treatment and support they needed to meet their care, support and emotional well-being needs. In addition, people's needs had not been fully assessed and care plans had not been put in place or they had not been followed.

The manager told us no complaints had been received in the last 12 months. We examined the provider's complaints log which corroborated this. A copy of the complaints procedure was on display in people's bedrooms. People we spoke with told us that they no complaints about the service they received. One person told us, "I've not had to complain but if I did I would speak with the manager". We saw that the provider had a complaints policy that was reviewed annually. We saw that the provider kept copies of compliments. One relative wrote, "Thank you for caring for my mother."

People's needs were recognised and shared when they moved between services. The manager told us that when a person was admitted to hospital staff, provided information explaining why they required hospital support, a copy of their medicine administration record (MAR), a contact list of people who are significant in their life and information about their needs.

Inadequate

Is the service well-led?

Our findings

The systems that were in place to monitor the quality of the service and drive forward improvements were inadequate. We found the home was poorly organised and although staff responded to people's needs as they arose, care delivery was reactive rather than proactive and planned.

The service has a registered manager, who was also the provider. However they told us that they were not in charge of the day to day running of the service, and were unaware of many of the incidents and shortfalls that we raised with them during the inspection. They told us that they had employed a manager who was responsible for the running of the home. They also employed a member of staff who was responsible for some of the quality assurance work.

Staff members' view of the of the management team were mixed. Some said they were approachable, whilst others told us that it "depended on the day" and which manager they approached. Others told us that they were shouted following the findings of our last inspection. We were told that both the registered manager and manager had "favourites", which caused conflict. Staff told us that the home had a blame culture. Throughout the inspection both the manager and the registered manager each attributed responsibility to the other person for the shortfalls we identified.

We found substantial failures in the leadership and management of Knyveton Hall rest Home. Several serious and widespread concerns referred to throughout this inspection report had not been identified and been allowed to continue unchecked. Some of these issues had been identified at previous inspections had subsequently been remedied and then allowed to reoccur. The service had been unable to sustain or build upon progress made.

Where concerns were known about, for example failing to report allegations of abuse, poor record keeping and supervising staff, effective action had not been taken. The registered manager told us that they had relied on the actions taken by the manager. The manager told us that they did not receive adequate support from the registered manager to complete these tasks.

At our previous inspection of the home in August 2014 we found that the provider had breached Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to assessing and monitoring the quality of service provision. At this inspection we found additional breaches of this regulation.

We looked at the systems in place for monitoring the quality of the service that was provided. There were blank audit forms available in the office for staff to assess a number of areas. These included the premises, recruitment, record keeping and consent. However we found that none of these audits had been completed. The last infection control audit had taken place in 2012 and the recommendations had not been completed.

We found that other audits completed by the provider, such as care planning or the management of medicines, were ineffective because they had failed to identify or address any of the concerns we had identified during our inspection. Therefore the health, welfare and safety of people who used the service and others had been put at risk.

People, relatives and staff were not regularly consulted about the quality of the service and they did not have the opportunity to be involved in the development of the home. We saw that the last residents meeting had taken place in July 2014.

Within their action plan from the last inspection, the provider told us that a staff meeting would be held. However we saw that the last staff meeting took place in March 2013. The manager told us that they planned to place a suggestions box in the hallway of the home so that people could provide feedback about the service.

These shortfalls were a repeated breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, as there were not effective systems in place to assess and monitor the quality of service provision.

The manager was not reporting all incidents to us as required by regulations. Certain incidents which affected people's welfare, safety or health needed to be reported to us so that action could be taken if necessary. For example, we saw records of a safeguarding incident that had taken place in June 2014 that had not been reported to the local authority safeguarding team, which should have also resulted in a formal notification to the CQC.

Inadequate

Is the service well-led?

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider's policies and procedures had been recently reviewed. We found that some of the provider's policies, such as provider's control of hazardous substances, training and development and safeguarding and whistleblowing policies were generic and had not been adapted to reflect the service being provided at Knyveton Hall Rest Home. The safeguarding and whistleblowing policy also did not contain contact details for the relevant local authority.

This was a repeated breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider did not respond appropriately to allegations of abuse. Regulation 11.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **People and others were not protected from the risk of infection because appropriate guidance had not been followed. Regulation 12.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **People were not always supported to be able to eat and drink sufficient amounts to meet their needs. Regulation 14.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Appropriate checks were not undertaken before staff began work. Regulation 21.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Action we have told the provider to take

People who use services and others were not protected against the risks associated with unsafe or inappropriate care because staff had not received adequate training or supervision. Regulation 23.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider had not taken proper steps to ensure each service user received care that was appropriate and safe. Regulation 9.

The enforcement action we took:
We have issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use services and others were not protected against the risks associated with unsafe or inappropriate care because the registered person did not have effective systems in place to monitor the quality of the service delivery. Regulation 10.

The enforcement action we took:
We have served a warning notice.

Regulated activity	Regulation
	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and storage of medicines. Regulation 13.

The enforcement action we took:
We have served a warning notice.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. Regulation 18.

The enforcement action we took:
We have served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People who use services and others were not protected against the risks associated unsafe or inappropriate care because records did not contain up to date and appropriate information. Regulation 20.

The enforcement action we took:
We have served a warning notice.