Farnborough (War Memorial) Housing Society Limited

Knellwood

Inspection report

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Ratings

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

Overall summary

The inspection took place on 9 and 10 June 2015 and was unannounced. Knellwood provides residential and nursing care for up to 52 older people, including people living with dementia, and those requiring respite support. At the time of our inspection 49 people were living in the home.

The home consisted of three wings. Two wings had three floors, and the main part of the building had two floors. Lifts and stairs provided access to all floors. People had unrestricted access around the home. The reception area was manned by a receptionist, and included the nurses station.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Summary of findings

At the last inspection on 9 November 2013 we asked the provider to take action to make improvements to ensure people's records were accurate and up to date, and that people were treated respectfully. At this inspection we found these improvements had been made.

People were at risk of potential harm, because the provider's recruitment policy had not been followed. Some checks, such as identity, criminal records checks and registration with professional bodies, had been completed satisfactorily. However, the provider had not ensured that gaps in applicants' employment history had always been identified or investigated, or explanations recorded. Evidence of suitable conduct in previous relevant employment positions had not always been requested. There was a risk that staff employed may not be of suitable character to safely support people.

Staff understood and supported people to make decisions about their health and wellbeing. They understood the process of mental capacity assessment and best interest decision-making if they were concerned that the person lacked capacity to make specific decisions. However, records did not reflect others that had the legal power to make decisions on people's behalf. We have made a recommendation that the provider refers to the principles of the Mental Capacity Act 2005 Code of Practice for guidance in relation to this matter.

Where people's liberty was judged to be restricted, the registered manager had followed the requirements of the Deprivation of Liberty Safeguards to lawfully detain people for their own protection.

People were protected from the risk of abuse. Staff understood and followed guidance to recognise and address safeguarding concerns. Risks that may affect people's or others' safety had been identified, and actions ensured potential hazards were managed to reduce the risk of harm.

People received their prescribed medicines safely. Medicines were stored and administered safely. Medicine administration records were complete, and checks ensured that any errors or gaps were identified and addressed promptly.

There were sufficient staff available to meet people's identified needs. The registered manager reviewed people's needs, and responded to staff comments, to ensure staffing levels were adjusted in accordance with people's changing needs.

People were supported by staff with the appropriate skills and training to meet their needs. Managers reviewed staff understanding of training topics through assessment, discussion and quizzes to ensure training was effective. They reviewed staff performance through an appraisal system.

Staff ensured people received appropriate dietary support. People identified at risk of malnutrition or dehydration were monitored to ensure they maintained a sufficient dietary and fluid intake. Staff liaised effectively with health professionals and community support agencies to promote people's health and wellbeing in the home, on discharge from hospital, and when returning to their own home from respite care.

We found that people's views were mostly respected during our inspection. Staff listened to people's comments, and acted on their requests. Information shared prior to admission was documented to record people's wishes and preferences, and reviewed with them or those they chose to represent them.

Staff acted in a caring manner towards people. They greeted people cheerfully, and reassured people if they were anxious. They promoted people's dignity and independence, and respected their privacy. A range of activities and events in the home and local community ensured people had the opportunity to engage in social activities as they wished.

People's needs were understood and met. Records ensured staff were informed of changes to people's care and support needs. Risks had been identified and appropriate actions taken to promote people's health and wellbeing. Although people's needs and wishes had been assessed with them prior to their admission to the home, people did not always feel involved in reviews of their care needs.

People and those important to them had the opportunity to discuss concerns with staff or management. The

Summary of findings

formal complaints procedure was displayed to ensure people were informed of the process. People and their relatives told us any issues were usually resolved promptly.

People, relatives and staff felt the home was well-led, and lived up to the provider's values. The registered manager was respected and appreciated. They did not always have sufficient time to drive all improvement tasks identified in a timely manner, as the role of deputy manager had not been filled at the time of our inspection. The registered manager had therefore prioritised actions that impacted on people's care needs.

The registered manager, Bursar, and provider's board of trustees completed audits to ensure people experienced quality care. They were supported by the community specialist nurse through monthly monitoring of indicators of care quality factors, such as the number of falls, infections or pressure ulcers people experienced. Any areas of improvement were identified and addressed through planned actions.

Records were securely stored. Staff access to electronic records was controlled according to role and responsibility. Only those authorised to do so could access confidential records.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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?

Requires Improvement

The service was not always safe.

People were not protected from potential harm, as the provider did not complete all the recruitment checks required for new staff.

People were protected from the risks of abuse, as staff understood how to identify potential abuse, and the steps to take to report concerns.

Sufficient staff were available to meet people's identified care and support needs.

Risks specific to each person had been identified, and appropriate actions taken to reduce the risk of harm. Checks and servicing ensured the environment did not affect people's safety.

People were protected against the risks associated with medicines, because appropriate checks and records ensured they received their prescribed medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff understood and implemented the principles of the Mental Capacity Act 2005. However, for people assessed as lacking capacity to make a specific decision for themselves, their documentation did not record those who had Legal Power of Attorney to make decisions on their behalf. There was a risk that decisions could be made by those without the legal authority to do so.

Staff were supported to ensure they had the skills, knowledge and training required to effectively meet people's needs.

People's dietary needs and preferences were met to ensure they were not at risk of poor nutritional health.

People were supported by health professionals to ensure their health needs were effectively met.

Is the service caring?

Good

The service was caring.

Staff listened to people's views, and treated people with compassion and respect.

People's dignity and privacy were respected, as staff took actions to ensure people were not placed in situations that would compromise their dignity.

Is the service responsive?

Good

The service was responsive to people's needs.

Summary of findings

People's needs had been assessed. Changes had been identified, and appropriate measures put into place to ensure people received the care they required and wanted.

People were able to raise concerns, and the provider listened to people's comments.

Is the service well-led?

Good

The service was well-led.

People, relatives and staff described the home as well-led, and most felt the registered manager was caring and knowledgeable. Staff told us they felt included and respected.

Systems were in place to audit and review the quality of care people experienced. Actions identified and addressed trends that may affect people's health or wellbeing.

Records were held securely, and only those authorised to do so had access to them.

Knellwood

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 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 took place on 9 and 10 June 2015 and was unannounced. The inspection team consisted of two inspectors, and an expert by experience with knowledge of 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.

Before the inspection we looked at previous inspection reports and notifications that we had received, and reviewed information shared with the CQC by commissioners of care. A notification is information about important events which the provider is required to tell us about by law. We had not requested a Provider Information Review (PIR) for this inspection. A PIR 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.

During our inspection we spoke with nine people and three relatives of people living in the home. Some people living with dementia were unable to tell us about their experience of the care they received. We observed the care and support these and other people received throughout the day to inform our views of the home. We spoke with the registered manager and Bursar, as well as five care workers and nurses. Following our inspection we spoke with a specialist community nurse to understand their view of people's care at Knellwood.

We reviewed six people's care plans, including daily care records, and charts documenting their specific care and support needs, such as maintaining hydration and re-positioning. We also reviewed 14 medicines administration records (MAR). We looked at five staff files, including recruitment, training and supervision documentation. We looked at the working staff roster for four weeks from 10 May to 16 June 2015. We reviewed policies, procedures and records relating to the management of the service. We considered how people's and staff's comments and quality assurance audits were used to drive improvements in the service.

Requires Improvement

Is the service safe?

Our findings

One person told us "I feel safe here, absolutely". None of the people or relatives, we spoke with, had any concerns regarding people's safety. However, we did not find that all the provider's processes promoted people's safety.

The provider had not ensured that their recruitment procedures met the requirements of the Regulations. Three of the five recruitment files we reviewed did not show evidence of full employment history. There were gaps in employment history, or dates of previous employment only stated the year of employment, which meant months may be unaccounted for. The provider's recruitment policy stated that any employment gaps should be discussed with the applicant, but there was no evidence that these gaps had been identified or explained. Evidence of character references had not always been sought from all relevant previous employment positions in health and social care. There was a risk that staff of an unsuitable character could be employed, as the provider had not completed robust recruitment checks.

The provider's recruitment procedure did not ensure that staff employed were of good character. This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other recruitment checks, such as proof of applicants' identity, investigation of any criminal record, declaration of fitness to work, and registration with professional bodies, such as the Nursing and Midwifery Council, had been satisfactorily investigated and documented.

Staff understood and followed the provider's safeguarding policy. This was in accordance with local authority guidance. They were able to recognise indicators of abuse, and the appropriate actions to address and report concerns. Staff were confident that any safeguarding issues would be dealt with appropriately by management, but were aware of the provider's whistle blowing policy. Staff stated they would use this if necessary. Safeguarding notifications had been submitted to appropriate authorities as required. The local authority told us they had no concerns regarding people's safety or care at Knellwood.

People were protected from identified risks to their health and wellbeing. Specific risks to individuals, such as the risks of falling or choking, had been identified. Appropriate actions, such as staff monitoring and sensor mats, changes to people's diets or regular health checks, ensured the risk of harm had been reduced.

Risks were managed safely in the home. Generic risks had been identified and assessed. Appropriate actions were in place to protect people and others from risks such as scalding from hot water and electrical hazards. Fire safety was promoted through staff training, and checks and servicing of fire fighting equipment, such as extinguishers and emergency lights. Emergency telephone numbers for utility companies and contractors were displayed in reception for ease of access to call in the event of an emergency.

There was a programme of safety checks and servicing to ensure equipment and facilities in the home were safe. The home held a certification of water safety, and Legionella checks were undertaken, including regular flushing and cleaning of water systems and showerheads. Legionella is a water borne disease that can adversely affect people's health. Contractors had completed identified tasks to reduce the risk of harm, such as removal of water pipe 'deadlegs' that may harbour bacteria. These actions ensured people were protected from the identified risks.

There were enough staff on duty to answer call bells. People told us they did not have to wait long for help when they requested this. People had call bells positioned near them when alone in their rooms, and portable call bells ensured they could summon help if they were in the garden. We did not observe delays in response to call bells during our inspection.

We observed that staff took time to chat with people as they passed them in corridors. Although staff were busy, staff numbers appeared sufficient to respond to people's requests for help. We reviewed a staff roster for a four week period in May and June 2015. During this time there had been four shifts when one care worker had not been sourced to provide the provider's identified required staffing levels. Staff told us that when staff numbers were reduced, they were able to meet people's physical health needs, but had less time to sit and chat with people, and so promote their emotional wellbeing.

The registered manager considered people's changing needs and listened to staff comments when planning staff levels. They had identified that people's needs had

Requires Improvement

Is the service safe?

increased, as more people required two staff to assist them. Staff had reported to the registered manager that this impacted on their workload, particularly in the mornings. The registered manager had added an additional care worker to the morning shift to increase support for people at the busiest time of day. Some care staff provided activities or undertook cooking duties. Their care role was back-filled by other care workers to ensure this did not impact on people's care and support. The provider ensured there were sufficient staff available to meet people's identified needs.

Nurses administered people's medicines safely. Medicines were stored and disposed of safely. Medicines records, including administration and balance checks of remaining drugs, had been completed appropriately. Opened boxes of medicines were labelled with the name of the person they were prescribed for, and indicated when the box was opened. This ensured that medicines were used within a period of time that ensured their effectiveness.

Medicines administration was appropriately recorded. The administration of medicines was recorded within the Medicines Administration Records (MAR). Colour coded storage promoted safe administration of medicines. Nurses observed people swallowed their medicines before signing off the MAR record, and noted any medicines declined. One MAR record had not been signed from the previous night. The nurse on duty was aware of this, as they were required to check each others' records on a daily basis. They had called the night nurse to check that the medicine had been taken, and told us the night nurse would update the MAR when they next returned to work. This demonstrated that internal checks effectively identified errors and gaps, and staff took appropriate actions to protect people from potential harm. The registered manager completed weekly medicines records checks. They reviewed the competency of nurses whilst working with them, to ensure they followed the provider's and NHS guidance. These actions protected people from unsafe administration of medicines, and the potential misuse of medicines.

Requires Improvement

Is the service effective?

Our findings

Staff had attended training about the Mental Capacity Act (MCA) 2005, and understood how to apply the principles of the Act. They explained how they supported people to make choices over diet, clothing and other aspects of their care. They explained how they offered information to guide people's decision-making, but understood that people retained the right to make unwise decisions if they wished.

We observed staff supported people with decision-making during our inspection. They listened carefully to people's responses to ensure they provided care in accordance with people's consent and wishes. When people refused medicines or care, staff accepted the person's decision. Records demonstrated that staff documented when people declined their planned care.

Where people were assessed as lacking the mental capacity to make specific decisions, staff were aware of the process to support them through decision-making in the person's best interests. The registered manager informed us that they planned to seek support from a dementia nurse specialist to complete and document mental capacity assessments.

A lasting power of attorney (LPA) for health and welfare means the holder can legally make decisions about people's health and wellbeing on behalf of the named individual when they have been assessed as lacking capacity to make that decision for themselves. The provider did not hold a copy of relevant LPAs, and so staff were not aware of those that should be legally consulted in these instances.

We recommend that the provider refers to the principles of the of the Mental Capacity Act 2005 Code of Practice for guidance in relation to this matter.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive a person of their liberty where this is a necessity to promote their safety. The DoLS are part of the MCA 2005 and are designed to protect the interests of people living in a care home to ensure they receive the care they need in the least restrictive way. The registered manager understood and followed the process to review and apply for DoLS. This had been granted for one person at Knellwood.

Staff were well supported. The registered manager and Bursar operated an 'open door' policy. One care worker told us "We can raise and discuss any concerns". The Bursar held annual appraisal meetings and six monthly reviews with staff to discuss concerns and career development, and showed us a plan to ensure these were delivered regularly. One care worker told us that these were very useful. A nurse told us they discussed clinical development with the registered manager.

Training topics identified as mandatory by the provider were refreshed to ensure staff retained the skills and learning required to support people effectively. Topics included fire safety, safeguarding people vulnerable to abuse, and equality and diversity. Staff files contained copies of training certificates, and evidence of quizzes used to ensure staff understood the content of delivered training. Care workers told us nurses discussed their training with them to ensure knowledge was embedded into practice. Practical training sessions ensured staff understood how to use hoists safely, and experienced what it felt like to be hoisted. Competency checks ensured staff were able to use equipment safely. Staff told us they were supported to attend additional training to develop their skills to support people, for example in end of life care. Nurses completed additional training to demonstrate continuing development in their nursing role.

Effective handovers between shifts ensured all staff understood their roles and responsibilities, and any changes to people's support or care needs. Staff told us teams worked well together, and we observed staff communicated effectively, listening to and acting on each other's comments. The electronic records system used in the home enabled staff to share information easily with staff who were off duty. This ensured that all staff were notified and reminded of training events, meetings and planned appraisal dates.

Drinks and snacks were offered throughout the day. Staff were aware of people requiring support to maintain their weight, and ensured these people received fortified meals and drinks to protect them from the risks of malnutrition or dehydration. The cook explained that they met with people when they were first admitted to the home, to understand their dietary needs, preferences and dislikes. The registered manager ensured they were aware of any dietary changes. Some people had diabetes that was controlled through

Requires Improvement

Is the service effective?

diet. The cook provided sugar-free desserts to ensure everyone could enjoy the same meals together. Moulds were used to ensure pureed meals, provided for people with swallowing difficulties, looked similar to other's meals.

People's care plans identified those that may be at risk of malnutrition or dehydration. Appropriate actions were in place to promote sufficient food and fluid intake, including regular weighing and charts recording daily intake for those identified at risk. Nurses reviewed records at least monthly to ensure the care provided effectively managed people's identified risks.

A specialist community nurse who supported the home told us staff liaised effectively with health professionals to ensure people's identified health needs were met. Information was prepared on people's records to share should people require emergency admittance to hospital. This included their prescribed medicines, known health conditions and allergies. The registered manager visited people in hospital to ensure their discharge was managed effectively. The manager liaised with community support agencies, such as meal providers, and health professionals such as occupational therapists, on behalf of one person planning to go home following respite care. This ensured their continuing safety and wellbeing would be supported when they left the home.

People in the home were supported to attend planned health appointments, or to see their GP when they were unwell. Staff were prompt to identify changes to people's health and wellbeing, and nurses told us GPs trusted their judgement and acted promptly when they raised concerns. People's health needs were supported through effective liaison with health professionals.

Good

Is the service caring?

Our findings

The provider had taken actions to address the concerns identified at our previous inspection in November 2013 regarding respecting and involving people.

Although some people told us that they sometimes felt rushed to get up in the morning, this was not most people's experience. People's care records noted their preferred routines, including the times they wished to rise or go to bed. During our inspection people indicated to staff whether they wished to get up or stay in bed when staff greeted them in their rooms in the morning, and staff respected their wishes when they wanted a lie in.

Staff encouraged people to maintain their independence. They monitored people's safety, but did not prevent them from walking independently unless they were at risk of falling. They allowed people to undertake tasks at their own pace. One relative told us "Staff have the patience of saints".

People were reminded that call bells should be used if they required support. One person was anxious about using their call bell to ask for a cup of tea, but staff reassured them that staff were on duty during the night, and happy to assist. Staff chatted with people, explained their planned actions, and apologised if they had to leave someone to attend to a pressing matter whilst talking with them.

Nurses sat and chatted with people whilst administering their medicines. They were patient, and ensured they put people at ease. One person was on the last dose of a prescribed antibiotic. The nurse asked them how they felt, to ensure that the required improvements had been met. Staff listened to people's comments, and shared information appropriately with other staff and health professionals. One person had requested a visit from care workers at a specific time that evening. This information was shared with staff at handover, and one care worker was tasked to meet this request. These actions ensured that people's views, requests and wishes were respected.

The registered manager showed us a pre-admission assessment form that was completed with people and others they wished to be involved, such as relatives. Information documented included their care needs, wishes and preferences, and any known health concerns. This demonstrated that people had been involved in their care planning.

People's records were held electronically. They did not always record how people had been involved in creating or updating personal records. The registered manager explained how they had printed off a copy of one person's care plan for relatives involved in their care decisions to review prior to a planned meeting. People had a named keyworker. This staff member was responsible for reviewing the person's care with them or their nominated representative. We spoke with one care worker who was the keyworker for three people. The care worker spoke regularly with these people to understand their current needs and wishes. People and others important to them had been involved in their planned care.

A relative told us "Staff ring me at home if they have any concerns" about their loved one. They said staff were caring, and interacted well with people. Another relative told us they couldn't find fault with any of staff or their care for people. All staff greeted people with a smile and by name when they passed them in the corridor. One care worker told us "I love my job, I love the residents". Staff took time to stop and interact with people throughout the day, and joined in with activities, such as an exercise session, as time allowed. They encouraged people to join in and praised their endeavours.

Staff proudly showed us people's craft creations. This demonstrated that people's achievements were valued and appreciated. The care worker leading an arts and crafts session had changed out of their uniform, to indicate that their time now was to be spent supporting activities rather than providing personal care. They joined in with a knitting group, and chatted amicably with the people knitting with them.

People's privacy was respected. One person told us "They don't intrude". We observed staff knocked on people's doors and waited to be invited in. Personal care was provided behind closed doors to protect people's dignity. When one person was settled into a chair using a hoist, staff ensured their clothing was adjusted to promote their comfort and dignity.

People's dignity and privacy were respected by caring staff. People were able to receive visitors in the privacy of their own room, or in one of several meeting rooms within the home. People were provided with their own phone with a direct dial into their room. This meant people could make and receive private calls without having to go through reception or chat in communal areas.

Good

Is the service responsive?

Our findings

The provider had taken actions to address the concerns identified at our previous inspection in November 2013 regarding maintaining and updating people's records.

A specialist community nurse told us they had confidence that staff provided people with care that was responsive to their changing needs, including end of life care. They told us staff were quick to seek referral to health professionals when people required additional support, and ensured guidance from health professionals was followed appropriately. They described the registered manager as tenacious to ensure people received the care and support they required.

The electronic records system was used effectively by staff to ensure people's records were regularly reviewed and updated. It included messaging and monitoring facilities. The managers and nurses were able to monitor calendars and review records to ensure planned appointments were attended, and updates such as weight checks and care plan reviews were completed. Monthly checks and reviews had been mostly completed, although several of the care plans we reviewed noted delays of between one and 20 days on some reviews. Managers were alerted to delays to planned reviews by the system's monitoring facility. The registered manager was aware of people's needs and the urgency of these reviews, and ensured that people's health and wellbeing were not adversely affected by these delays.

People's changing needs had been identified and documented. Their support and care had been adjusted in response to these changes. One person had experienced falls and reduced mobility. Their care plan documented their falls, and the actions taken to reduce the risk of further falls. This included positioning a sensor mat by their bed to alert staff if the person got out of bed during the night. The care plan guided staff to support this person with two care workers and use of a standing aid, and to transport them in a wheel chair. Risks affecting people's safety or wellbeing had been identified, and had been responded to appropriately by incorporating measures to reduce the risk of harm.

People identified at risk of malnutrition, dehydration or developing pressure ulcers had their daily care documented on hand-written charts. These recorded daily intake of food and fluids, and regular turning to promote skin integrity. We observed a care worker alert a nurse to one person's pain when they had attended them to support their pressure care needs. The nurse immediately visited the person and took appropriate actions to reduce their pain. This indicated that people's changing needs were promptly identified and addressed.

One care worker told us "We know our residents well". They told us the records system was useful to understand people's preferred routines. They explained that the registered manager shared information from the pre-admission assessment with staff though the electronic records system. The registered manager was knowledgeable of the needs and wishes of each person living at Knellwood. They understood factors affecting each person's care. For example, they were aware that one person's weight had reduced slightly, due to their increased mobility following discharge from hospital. Continuity of staff ensured people's current and changing needs were understood by those supporting them. Effective handovers between shifts meant staff were alerted to any current changes, planned appointments, and follow up actions required to promote people's health and safety.

Information was inputted onto the electronic system promptly. Staff selected information from a range of 'tick boxes', describing different levels of care or support that may be required. This meant information was not always personalised for the individual, as the same phrases were used across care plans. However, some information was specific to the individual, such as descriptions on how to communicate effectively, and staff provided people with personalised care. People's individual wishes were documented in their preferred routines. The registered manager explained that they were still in the process of inputting information into the system, and had prioritised people's care needs and staff training.

People and their relatives told us that concerns raised were usually dealt with promptly. The provider's complaints procedure was included in the statement of purpose, which was displayed in the reception area. The registered manager told us "It's been a long time since our last complaint". We did not see any complaints logged in 2015. Staff confirmed that they were usually able to deal with concerns informally. They were aware of the provider's policy, and understood the requirement to document formal complaints and issues they were unable to address immediately.

Good

Is the service responsive?

The provider had not conducted surveys or held meetings to seek people's or their relatives' feedback on the quality of care provided. They told us that they had not had a representative response when they had last sent a survey out. We saw a staff survey sent in November 2014 had only received two responses, despite requests for responses raised with staff. This did not provide a sufficiently representative base line to identify issues or plan changes required. People's feedback on specific issues, such as discussion of the menu, had been sought.

People's opinions on the menu were diverse. One person told us their meal was delicious, and another said the food and choice was good, but others said meat was sometimes tough and the food was poor. One person told us their complaint about a meal had been addressed when they raised it with the registered manager. The manager confirmed that they were able to make changes when people raised concerns with them, but similar comments had not been raised with the staff or managers.

The registered manager and Bursar were in attendance daily, and operated an 'open door' policy for people, relatives and staff to raise concerns or discuss issues. The provider's board of trustees spoke with people and relatives when conducting visits in the home. This helped them to capture feedback informally. The registered manager engaged with people and visitors when they walked around the home throughout the day. We observed people, visitors and staff appeared at ease when chatting with the registered manager. This indicated that they would be able to raise any concerns should they wish to do so.

The reception area was manned daily. It included a post box for people's use, and daily papers. One person told us they enjoyed sitting here with their magazine, and watching the activity. A large lounge area and quiet room ensured people could sit together in a setting of their choice. When people wished to remain in their rooms, their choice was respected. Staff reminded them when planned activities or meals were due, to ensure they had the opportunity to join in if they wished.

People participated in a range of activities. People told us of musical events and celebrations they had enjoyed in the home, and a recent canal boat trip. The registered manager told us they arranged visits to a nearby garden centre and local shops. During our inspection a group of twenty people participated in armchair exercises, and a group of six people attended an arts and crafts session. A hairdresser visited the home three times weekly, using a hair salon on site. A regular bridge game was supported for people and visitors. A pet therapy organiser attended the home, and relatives brought people's pets to the home to visit. Local organisations had used facilities at Knellwood for games and storage, and were encouraged to chat with people when they visited. People had the opportunity to engage in a range of activities and access the local community.

Good

Is the service well-led?

Our findings

People spoke positively about the home and registered manager. Some people referred to the manager as "Matron". Comments included "Matron is very nice, she will have fun with you", and "I don't know how you could improve it [the management]. The manager is a dear". One relative described the manager as "Straight to the point and outspoken", and another person stated the manager "Doesn't take any nonsense, she sees both sides of the story".

Staff told us their colleagues and managers were respectful of different cultures in the workforce. They said staff listened to each other, and communicated effectively. The board of trustees promoted the values of the home, such as respecting others, in accordance with the statement of purpose. Actions had been taken when staff raised concerns about staffing levels in the morning. They were confident that the management listened to their comments, and provided feedback on the actions taken when concerns were raised.

Care and nursing staff told us the registered manager was approachable and supportive. Comments included "The manager solves problems immediately. She's fantastic, we couldn't ask for a better person. She's very approachable, so I'm not scared to say anything. She listens to what we say and deals with [things]", and "She is hands on, and knows what's happening". Another care worker told us the managers "Cared" about staff on a personal level.

The registered manager felt supported by the board, stating "The board are there to help". The registered manager had joined a local liaison and support group of senior staff and registered managers from other services in the area. This provided a forum to discuss issues and share learning.

The registered manager's workload had increased because recruitment to replace the previous deputy manager had not yet been successful. Nurses tried to alleviate the manager's workload by taking on some additional tasks. The registered manager had not been able to proactively progress some lower priority planned actions to improve the quality of care people experienced. This had not impacted on people's care needs, but meant some identified requirements, such as bathroom décor, had been delayed.

Staff meetings were held to provide an opportunity for staff to raise any concerns or discuss plans to develop the home. Minutes from a meeting held in February 2015 documented discussion of topics including quality of care and infection control management. There was evidence that concerns raised, such as a requirement to re-design bathrooms to permit ease of access for wheelchairs and hoists, had been addressed.

Board members conducted monthly visits to review the quality of care people experienced. They reviewed cleanliness and availability of equipment in the home, spoke with people, visitors and staff, and reviewed records. There was evidence that issues identified had been addressed, such as reviewing the menu and reducing reliance on agency staff. The board reviewed and updated policies and procedures, and authorised external support where required, for example in human resourcing advice.

The managers were able to review and audit actions through the electronic records system, as this flagged up any delays to actions required, such as care plan updates. Trends were identified, and information was shared with the specialist community nurse to ensure appropriate actions had been taken to reduce identified risks. A specialist community nurse visited the home regularly to support actions to promote the quality of care people experienced. They spoke positively about the quality of care provided at Knellwood.

Records were mostly stored electronically, and access was restricted according to staff role. Passwords were required to access information. This ensured that confidential records could only be reviewed by those authorised to do so. The registered manager and Bursar were able to track and review staff entries for audit and performance purposes. The system used provided managers with information required to drive improvements to the quality of records and documentation. There were appropriate systems in place to review the quality of care people experienced, and this information was used to consider and implement improvements identified.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 (2)(a)(3)(a) HSCA 2008 (Regulated Activities) 2014 People had not been protected from the risks of inappropriate care and support, because the provider's recruitment procedures did not effectively ensure applicants were of good character. Satisfactory evidence of conduct in previous employment positions in health and social care, or supporting people vulnerable to abuse, had not always been identified or verified, and a full employment history, with explanation of gaps, was not always documented.