Knighton Manor Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of the service took place on 15 May 2018 and was unannounced.

Knighton Manor Limited provides residential care for 21 people with a learning disability and/or mental health disorder and a range of complex needs, which included physical disabilities and behaviour that challenges.

Knighton Manor Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Knighton Manor Limited does not conform to Building the Right Support and Registering the Right Support guidance. The service accommodates up to 21 people in one adapted building. At the time of our inspection 15 people were in residence.

At the last inspection on 23 and 24 February 2017 we identified that Knighton Manor Limited did not have a registered manager in post. This was a breach of their condition of registration and a requirement notice was issued. A registered manager is now in post.

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

People's safety was promoted by observant staff that were present in communal areas which enabled them to provide assistance and support when needed. There was a pro-active approach to promoting people's safety and independence which was reflected in people's risk assessments and care plans. People were supported by staff that had been recruited and had checks undertaken to ensure they were suitable for their role. People's medicine was managed safely and people received their medicine on time.

People's needs were assessed to ensure the service and staff could meet their needs before they moved to Knighton Manor Limited. People's needs were met by staff that had the skills and training to provide good quality care. People's health care needs were monitored, which included their dietary needs and people were supported to access health care services within the community. People were supported to have maximum choice and control of their lives and staff support them in the least restrict way possible; the policies and systems in the service supported this practice.

People were supported by staff that were attentive towards their needs. Staff provided the care and support people required and recognised the importance of promoting people's independence. Family members were encouraged to visit their relatives and staff supported people to visit their relatives. The registered

manager and staff had received thank you cards and letters from people's relatives about the support and care provided.

People's views about their care and support were sought and used to develop care plans. A range of documents, including minutes of meetings, fire evacuation plans and the complaints procedure had been produced in easy read, using large prints supported by symbols to assist people in understanding the information. Additional documents detailing people's care, which included health action plans, was also produced in a way to promote people's understanding.

The management team, which included the registered manager and two deputy managers, provided staff with support and guidance they needed. Systems were in place to monitor the quality of the care being provided, which included seeking the views of those using the service and their family members. A range of audits were undertaken to evidence the quality of the care and the accuracy of records used to record people's care and support. There was an open and transparent approach to the management of the service, which included regular team meetings where information was shared and ideas for improvement sought and discussed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remained safe.

Is the service effective?

Good

The service was effective.

People's needs were met by staff that had the necessary skills and knowledge to provide good quality care. People's health was supported through an appropriate diet and with the support of staff by accessing health care services.

People's choices were promoted by both staff and external stakeholders and staff ensured people's rights were promoted and maintained.

Is the service caring?

Good

The service remained caring.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and used to develop care plans, which included people's views or that of family members. People were encouraged and had the opportunity to influence how they spent their time. People accessed a range of social activities both within the service and the community.

People had access to a range of documentation which had been produced to assist them in understanding the information by using large print and symbols.

People's concerns and that of their family members or others were listened to and acted upon.

Is the service well-led?

Good

The service was well-led.

There was an inclusive approach to the management of the service, led by the registered manager and deputy managers.

Opportunities for staff to comment upon and influence the service were provided through questionnaires and staff meetings.

People's views and that of their family members were sought through questionnaires and people using the service attended regular meetings at the service to talk about the service being provided.

Systems were in place to monitor the quality of the service, which included a range of audits of records held within the service and the environment.

Knighton Manor Limited

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 15 May 2018 and was unannounced.

The inspection was carried out by an inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in people with a learning disability.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We looked at the information held about the provider and the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. We used this information to help us plan this inspection.

We spoke with five people and spent time with others who used the service. The information people were able to provide was limited due to their disability. We spoke with the registered manager and four members of care staff.

We looked at the care plans and records, including medicine records of four people. We looked at the recruitment records of three staff. We looked at staff training records and minutes of meetings for staff. We viewed records in relation to the maintenance of the environment and equipment along with quality monitoring audits.

Good

Is the service safe?

Our findings

We arrived at Knighton Manor Limited unannounced. The door was answered by a member of staff. We informed the member of staff who were and the purpose of our visit. They asked to see our I.D. before letting us into the service. We were then asked to sign in the visitor's book. This showed staff's understanding of the need to promote the safety of people living at the home, staff and visitors.

Monthly meetings involving people who used the service were used as an opportunity to raise awareness of what people should do if they were unhappy about anything or if they didn't feel safe. Minutes of these meetings recorded that people were confident to talk with staff about any concerns they had.

The registered manager responded appropriately when areas of concern were brought to their attention to ensure people's safety and welfare was promoted. Notifications were submitted to the Care Quality Commission (CQC) about potential abuse and safeguarding referrals made to the local authority. The registered manager provided information required to the local authority and other agencies involved in the investigation of safeguarding concerns. This was to assist them with their investigations and had attended meetings where required.

Staff had received safeguarding training and other training relating to safety. For example, what action to take in relation to incidents or accidents, such as people having a fall. They understood what procedures should be taken if they suspected or witnessed abuse. This included contacting outside agencies such as the police, CQC and local authority safeguarding teams. Safeguarding was also included as an agenda item in staff supervisions.

Staff had a positive approach to risk taking and enabled people to live as full lives as possible yet understood how to balance this with people's safety. Risks to people's personal safety had been assessed and plans were in place to minimise these risks. There were a range of risks assessments in people's care records. These included going out into the community and support to help the person manage behaviour that may be seen as challenging.

We saw staff supporting people to stay safe, whilst supporting them to maintain independence and choice. For example, a person using a mobility aid walked from the lounge, along a ramp, into the side garden, a member of staff assisted them offering encouragement by saying "take your time, concentrate please, take your time."

We noted two staff remained in the lounge at all times, if a member of staff had to leave the lounge, then another member of staff replaced them so that people always had staff close by. Staff were seen to observe people, without being intrusive. For example, whilst supporting someone with their lunchtime meal, the same member of staff kept a watchful eye on someone who was playing with the service's cat in the garden.

Risk assessments were regularly reviewed to ensure they contained up to date and accurate information. The registered manager and staff we spoke with had a good understanding as to the needs of people and

how to support them, which recognised the need to promote people's safety and independent with consideration to their rights and choices. For example, one person's risk assessment required staff to make a judgement as to the level of support a person needed to safely transfer between a wheelchair and comfortable chair or bed on each occasion. The emphasis was on supporting the person's independence by enabling them to support themselves as much as possible without the use of equipment.

The provider engaged external contractors to maintain and service equipment, which included electrical and gas systems, the fire system, passenger lift and equipment used to support people in the delivery of their personal care, such as hoists and other mobility aids. All systems had a certificate to evidence they had been assessed as safe at the time of the inspection. Individual personal emergency evacuation plans (PEEPS) were in place, which provided guidance on the support people would require should they need to evacuate the service in an emergency.

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for staff. Staff recruited by the provider underwent a robust recruitment and interview process to minimise risks to people's safety and welfare. Prior to being employed, all new staff had an enhanced Disclosure and Barring Service (DBS) check, two valid references and health screening. (A DBS is carried out on an individual to find out if they have a criminal record which may impact on the safety of those using the service).

Staff ensured people were kept safe and their right to make decisions about their day to day lives were respected and their independence and choices promoted. For example, people made decisions as to what time they got up, what they ate and drank and whether they accessed the services within the local community. Staff worked together as a team which enabled them to respond to people in a timely manner, promote their choices and keep them safe.

For some people using the service, additional funding had been made available by commissioners to provide one to one support for specific aspects of their care. The staff rota identified the staff responsible for providing the one to one support and care along with additional staff where activities within the wider community were taking place, for example a trip to the theatre. This showed the service had a flexible approach to staff enabling them to promote people's safety and meet their needs.

We looked at the medication and medicine records of some people who used the service and found that their medicine had been stored and administered safely. This meant people's health was supported by the safe administration of medicine. People's plans of care included information about the medication they were prescribed which included protocols for the use of PRN medicine (medication, which is to be taken as and when required). This ensured people received their medicine consistently. Staff had received training reflective of people's individual needs. For example, where PRN medicine was to be administered to promote people's health and welfare, such as the administration of medicine when people experienced an epileptic seizure.

We walked around the service with the registered manager, which included looking at a majority of the bedrooms. We identified some rooms required cleaning, as there was significant dust on lampshades and cobwebs in some of the rooms. The registered manager said they would take action and have the rooms cleaned.

Inspections carried out by external stakeholders had taken place. This included a health and safety audit, which had identified minor areas for improvement. Records showed that the improvements required had been made. An inspection as to food hygiene arrangements had been carried out and the service had been awarded a good hygiene rating of 5, which is the highest rating that can be awarded.

Audits were regularly undertaken of accidents and incidents within the service and the analysis of these was used to make changes to promote people's safety and welfare. For example, in consultation, a person had moved to another bedroom, following two recent falls. The person had become anxious about falling again. It was suggested they move to an alternative bedroom, which was larger and had the benefit of the passenger lift close by to support their independence and safety enabling them to move around the service.

Our findings of the inspection visit were an accurate reflection of information provided by the registered manager in the PIR. The PIR reflected the policies and procedures of the service and how they were implemented to ensure people's safety was promoted.

Good

Is the service effective?

Our findings

People's needs were initially assessed by the funding authority, who shared their assessment with the registered manager. The registered manager or a member of the management team upon receipt of the assessment reviewed the information to decide whether they could meet the person's needs. On the day of the inspection the registered manager was contacted by a commissioner, who made a referral for someone to move into the service for respite care (short term care). The registered manger viewed the assessment and spoke with the person's social worker to gain additional information. The registered manager determined that the person's needs could be met.

The registered manager, along with the person's social worker agreed the period of respite care and care plans were put into place, which provided staff with information as to how the person's needs were to be met. The person arrived at the service and was greeted by staff, who spent time with them on a one to one basis to help them settle in and become familiar with their surroundings. The registered manager later spoke on the telephone with the person's family member to reassure them of their relative's care and well-being.

A range of assessments were regularly reviewed, which included topics related to the promotion of people's health and well-being. These included an assessment to review the condition of people's teeth, dentures, gums etc. Where concerns or changes were noted people were supported to access a dentist. Other areas that would routinely assessed included people's nutritional intake so that appropriate action could be taken where concerns were identified.

A programme of induction, which included training, was in place. Staff new to the field of caring for people were enrolled to undertake The Care Certificate. This is a set of standards for staff that upon completion should provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support.

The provider was committed to staff development and training, and had a programme of training in place for staff. Records showed staff had received training in a range of topics to support the health, safety and well-being of people, which included attaining qualifications in health and social care. Staff had received training for 'delegated health care tasks' and was provided by an external health care professional who had assessed staff's competency. The training was specific to people's individual health care needs, for example the administration of medicine via an injection.

Staff were regularly supervised and had an annual appraisal with a member of the management team. Staff had their competency to provide care and support assessed by a member of the management team in a range of topics, to ensure the care and support people received was of a good quality and reflective of staff training and the policy and procedures of the provider.

People's records and leaflets stored in the office contained information about specific health care related conditions, such as epilepsy and diabetes and could be accessed by staff. The information provided staff

with an insight and awareness as to how specific health issues affected people's health and welfare and the use of instruments and devices to manage their condition. For example, this information had been used to develop a person's care plan, which provided guidance for staff on how to respond and support the person when they had a seizure and included the use of a Vagus Nerve Stimulator. (This sends electrical stimulation through a nerve to help irregular electrical brain activity that leads to seizures).

A person told us that the cook provided fresh food daily, they told us their favourite meals saying, "corned beef hash or cottage pie." We spoke with the cook who told us the person had not been eating well, and that they added extra protein to their meals. A second spoke of their favourite food. "My favourite food is chicken and rice and sausages." They went onto say. "Yes, I get a choice in what food I want." Staff offered choice, where people could not verbally express their views, we saw a member of staff hold both a yoghurt and ice-cream so that a person could indicate their preferred dessert. Staff regularly offered drinks to people throughout the day and responded quickly to requests for drinks.

The dining room had a menu board, which detailed the menu options for the day. The dining room was decorated with pictures of different foods and drinks to help people show staff what their choice of meal was. Tables were set at mealtimes with condiments and cutlery.

People ate their lunchtime meal in the main dining room, whilst a small number of people remained in the lounge. People who remained in the lounge required assistance with eating, which was provided in a sensitive and caring manner.

People shared their views about the lunchtime meal. One person said. "I had corned beef hash." When asked if they liked the food they replied. "Oh yes its lovely."

People's dietary needs were met. People had a care plan which detailed their individual dietary requirements, which included supporting people who had diabetes, or those whose diet supported their cultural or religious values and beliefs. We also found a care plan that provided clear information and guidance where people received their nutrition via an alternative method, known as a PEG (percutaneous endoscopic gastrostomy). This means their nutrition was passed via a tube directly into the stomach. Staff had received training and had their competence assessed in the use of PEG equipment.

People's record we looked at included a nutritional assessment which had identified where people were at risk of choking. A Speech and Language Therapists (SALT) had been contacted who had assessed people's needs and had provided a care plan for the staff to follow. Care plans reflected the support people required, which included guidance on the texture of people's food, along with the prescribing of nutritional supplements, this ensured people's dietary needs were met to promote their health. We saw the cook at lunchtime putting additional gravy onto a person's meal to keep the meal moist, as the person was at risk of choking. People's food intake where required was monitored, and people had their weight regularly checked. This meant concerns relating to people's weight were referred to the appropriate health care professional for advice and investigation.

Each person had a 'health action plan', which held information about people's health needs, the professionals involved in their support, along with a record of appointments attended for the promotion of their health and well-being. Information about people's medicine, their likes and dislikes along with communication needs, for example, which included how a person expressed they were in pain, were also documented. A quick reference 'accident and emergency grab sheet' was in place that contained essential information to be shared for the benefit of the person should they have to access health care services in an emergency.

On the day of the inspection a number of people were supported to attend health care related appointments, which included a visit to the dentist for one person and a hospital appointment for another person. A person using the service told us. "I've seen the dentist; he gave me some white toothpaste." Specialist services such as diabetic health screening and neurological appointments supported people within the service in the assessment and development of plans to enable staff to provide good and safe care. Records showed people were supported to attend routine screening appointments, which included screening for a range of cancers and the reviewing of ongoing health conditions, which included both mental and physical health.

Knighton Manor consists in part as a converted private dwelling which has an extension to the rear of the original property. Bedrooms within the service have en-suite facilities and there is a courtyard garden to the side of the property. There is a large dining room and lounge on the ground floor, and an additional communal room on the first floor. We looked at a majority of the bedrooms when we inspected the service and found those in the original part of the service were in need of some decoration. The registered manager said that rooms for decoration had been identified and the information shared with the person employed to maintain the property.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. Whey they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation process for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found six people had a DoLS authorisation in place, of which some had conditions attached. We found the conditions were being met by the provider, which required the recording of incidents where people's behaviour was challenging and accessing the wider community for recreational and social activities.

The records we looked at where people had a DoLS in place recorded the involvement of a 'paid person's representative' (PPR). The PPR's role was to monitor the implementation of the DoLS and as part of their role to speak with staff and view the person's records which recorded how staff implemented the DoLS. The information recorded by the PPR's reflected the service was meeting the condition of people's DoLS.

People's rights had been championed by the registered manager who had supported family members in challenging DNAR decisions put into place when their relative had been in hospital. People's capacity to make informed decisions about their day to day lives had been undertaken. Where assessments had not identified people were able to make informed decisions, then a best interest decision was made as specified in the MCA.

Our findings of the inspection visit were an accurate reflection of information provided by the registered manager in the PIR. The PIR had referenced key changes to policies and procedures that under pin equality, diversity and human rights. The PIR referred to policies and procedures supporting and following the FREDA principles, (freedom, respect, equality, dignity and autonomy).

Good

Is the service caring?

Our findings

There were no restrictions on family members and friends visiting. A person told us about a recent visit from family members. One person said "My brother came to my birthday party the other week." A second person told us they had a birthday cake, watched a film, as well as visiting the pub with the support of staff for their birthday.

People's records contained information about their lives prior to moving into the service. They included information about their family members and friends, as well as information as to their hobbies and interests. This information was used to develop care plans to support people's likes and dislikes. For example a person who attended Church was supported to do so, whilst others continued to maintain links with friends, which included their friends visiting them at the service. Information about people's hobbies and interests, such as taking part in board games, arts and crafts, and accessing the community for recreations were recorded.

As part of people's initial and ongoing assessment, information had been gathered and reviewed as to people's communication style and needs. The information had been used to develop a range of documents. For example, a communication passport detailing how staff should communicate and encourage communication to ensure people could express their views and have their needs met.

We saw examples of staff providing sensitive care and support. We noted a person with limited movement supported by staff. The person could play a soft musical toy by holding it between their feet, and we saw the enjoyment in their face and eyes when they got it to play a tune. We saw staff pick up the toy and reposition it for them so they could continue to enjoy the music. Staff were aware of the need to promote people's independence. A member of staff told us. "If you take the little independence that they have got, what have they left, that's why it's important to encourage their independence." Staff told us how they encouraged independence. "I encourage [person's name] to wash themselves when they can, I will ask them what they want to wear. I will get two pairs of trousers and hold then up and ask which one, or get them to point to the one they want to wear."

Staff were seen to talk to people throughout the day, and spoke with people using good eye contact and talking softly. Staff were seen to be very encouraging and were continuously checking people were okay. We saw person being supported to move so as to ensure they were not sitting directly in the sun. After lunch were observed staff supporting people to get to their room for a rest. A staff member was heard saying. "Come on [person's name] I'm going to take you to your room now, I'm taking you to your room for bed rest." Bed rest was an identified need in the person's care plan.

People's views about the menu, activities, and the environment in which they lived were sought through monthly meetings. The minutes of meetings recorded people's comments. When asked about the menu, people had suggested different foods. The next meeting, then sought feedback. For example, rhubarb pie had been suggested as a something different to try, the next meeting recorded that people preferred apple pie instead. Positive comments were recorded about activities within the community for example, the Easter

Vintage Parade, trips to the cinema and bowling.

Recent meetings had been used as an opportunity to talk about those people who had lived at the service that had recently died and to provide support. Staff encouraged people to talk about happy times and to share memories, people using the service and staff had attended the funerals of those who had died.

Sufficient staff on duty, meant staff had time to encourage and provide activities for people. On the day of our inspection a number of activities took place, which included a floor game of 'snakes and ladders' and a game of bingo. Staff encouraged people to move their own 'counter' when playing snakes and ladders. We heard much laughter and enjoyment during the games. Staff rotas were developed to meet the needs of people, with additional staff being on duty to support people to attend community activities, such as disco's, shopping, day trips and short breaks.

A person who had moved from Knighton Manor Limited to other accommodation had written a letter of thanks to the staff for the support they had received in helping to choose furnishings for their new home. A number of family members had written to the registered manager and staff, thanking staff for the care of their relative. A family member had written to staff to thank them for visiting them with their relative and bringing a present on their birthday.

People's individuality and diversity was celebrated, respected and recognised by staff that made every effort to provide people with opportunities to celebrate and take part in a lifestyle of their choosing. People's individual needs were understood relating to their cultural diversity and met by staff. People's care plans reflected the importance of their privacy and dignity and how this was to be supported by staff. The promotion of people's independence and encouragement to make choices was recorded within their care plan.

People accessed their bedrooms when they wanted time alone, this was respected by staff. Staff always knocked on people's door and sought consent before entering their room. People in some instances had a key to their bedroom, which they chose to keep locked.

Good

Is the service responsive?

Our findings

People had a key worker (named member of staff who provides additional support). One person said of their keyworker. "They (keyworker) buy a birthday present and Christmas present. They take me shopping for anything I need like clothes and they take me on medical appointments and ensure my bedroom is kept nice and tidy." The person said they were going away at the weekend so they had taken a shopping list to get some holiday clothes.

We observed staff leading activities, which included bingo, and a floor game of snakes and ladders. Staff encouraged a person to move the counter themselves when playing snakes and ladders, saying. "Come on [person's name] I know you can count to three show me how you move the counter." A person told us they went to the day centre saying "I can go when I want. They told us what they enjoyed. "To play pool." We saw another person doing puzzles.

People told us about the activities they took part in. One person said. "I like going to garden centres, I like gardening. And, I chat to my friends." After lunch people were able to walk outside. One person said. "I'm going to outside now for the afternoon I've decided."

Information about activities was displayed on a poster which included pictures of community events. Planned activities included a Plan Fair, a 1940's war time weekend, a trip to Foxton Locks for a picnic. Photographs showed people's participation in activities, which included celebrations for Halloween, Diwali and the Leicester Caribbean carnival. Weekly activities also took place, which included arts and crafts, movies, music to relax, table top activities, karaoke, quiz time and sensory time. A person told us they had colouring items in their bedroom. They told us. "I like to go upstairs, I do drawing and I like colouring."

Two people told us they were going away for the weekend to Skegness, both looked very happy when staff talked to them about their holiday.

People's care plans were developed with their involvement and regularly reviewed. Reviews of people's needs were held with the commissioning authority to ensure the service was meeting people's needs. People's care plans focused on all aspects of their lives and contained the views of the person or their representative. Each aspect of a person's life was considered, which included their personal care, social activities, physical and mental health needs, dietary needs and relationships. Care plans were reviewed monthly and any changes and updates were clearly evidenced to ensure staff continued to support people to achieve the best outcome for the person.

Organisations that provide publicly-fund adult social care are legally required to follow the Accessible Information Standard (AIS) which says services should identify record, flag, share and meet information and communication support needs of people with a disability, impairment or sensory loss. We found information had been made available to people using the service to meet their communication needs. This included a number of documents, including key policies and procedures and the minutes of meetings being produced in large print, using easy read words supported by symbols and pictures to assist people's

understanding.

People's records contained a 'communication passport' which described how staff were to communicate with people. For example, a person's records included key phrases to be used by staff to encourage the person to take part in everyday activities, such as cleaning their teeth, along with detailing the person liked to greet people by the use of 'high five'. Key words were also included to reflect the person's first language to be used by staff to encourage communication.

The registered manager and staff supported people to maintain relationships with their relatives and friends, in addition to people seeing each other in person, staff ensured people sent their relatives and friends cards to signify special events such as birthdays.

People were encouraged to discuss their views about their wishes with regards to death and dying in a document 'advanced care planning making choices' handbook. People in some instances had recorded their wishes within the document, which included their preferences and made reference to what was important to them. There were a number of 'thank you' cards and letters from family members whose relatives had recently died, thanking staff for the care of their relative.

In some instances people had made an advanced decision about their care with regards to emergency treatment and resuscitation, which meant they had a DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) in place. This had been put into place with the involvement of the person, their relative or representative and health care professionals. This showed that people's choices and decisions were supported and would be acted upon when needed as agreed by all parties involved.

People's concerns and complaints were recorded by the registered manager, along with the action taken as a result of complaints or concerns. We found concerns were used to further develop the service. For example, a concern had been raised by an external organisation to commissioners. Commissioners had visited the service and looked at the person's records connected with the concern and spoke with the registered manager. The registered manager informed all staff as to the nature of the concern and advised staff that improvements were needed. Additional documentation was put into place to record the additional checks and care provided.

Good

Is the service well-led?

Our findings

At our previous inspection of 23 and 24 February 2017 we found the provider to be in breach of their condition of registration as a registered manager was not in post. We issued a requirement notice for a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009.

Knighton Manor Limited had a registered manager in post following an application to the Care Quality Commission. The registered manager oversees a clear management structure and the registered person regularly visited the service to meet with staff and those using the service. Regularly meetings involving staff had taken place, providing an opportunity for the management team and staff to discuss and review their working practices to ensure people received good quality care.

The registered manager had a good understanding of the requirements of their registration with the Care Quality Commission. All necessary notifications had been made to the CQC and we saw that the duty of candour had been adhered to following any incidents. Where necessary, the registered manager had undertaken investigations into incidents, accidents and complaints.

The open approach by the registered manager ensured staff were kept informed about any changes to practices to enable staff to work collaboratively. Regular staff meetings took place and the minutes of these showed a range of topics were discussed to ensure the people received good quality care. Minutes of meetings had recorded where people's needs had changed. They showed staff reflected upon any changes in the level of support a person required along with the involvement of health care professionals where concerns had been identified. Meetings were also used as an opportunity to comment and influence the day to day running of the service. For example priorities set by the registered manager. Changes to policies and procedures were discussed to ensure staff had up to date information. Staff were provided with feedback from visits by external stakeholders who monitor the service, this information was used to share improvements required and to celebrate good practice.

Staff we spoke with appeared to enjoy working at the service. One member of staff said. "I like it here; the days are different no two days are the same."

Staff spoke positively about the registered manager and the staff team. One member of staff said. "I get help from the manager. They will ask me what training I want." A second member of staff said. "The staff team has been together for a while now so we know each other." A third staff member said. "I have a good relationship with the manager." A fourth staff member said. "There is always support as there are two deputies and a manager."

Strong leadership meant the management team were aware of their responsibilities in ensuring staff received regular supervisions. Staff had their work appraised, which included having their competency assessed to perform specific aspects of their role. For example, the delivery of personal care and the administration of medication. Surveys seeking staff views had been circulated and staff had the option to return these anonymously, no completed staff surveys had been returned at the time of our inspection.

We found that the management team and staff promoted a positive and open culture which provided a range of opportunities for people and those representing them to comment upon and influence the service provided. In addition to meetings, in which people using the service took part, their views and those of their representatives were regularly sought through a questionnaire. The information gathered from questionnaires was shared with those using the service and identified any areas for improvement. The most recent report reflected a high level of satisfaction with the services provided by Knighton Manor Limited.

Questionnaires in some instances contained comments from people's family members expressing their satisfaction with the service. One family member wrote. 'We are very happy with the care the management and staff give to our [relative] and also for their kindness to them. It is so nice to know they are happy and safe.' A second family member stated. 'The staff, although young always seem to be communicative, considerate and understanding and helpful.' A third family member wrote. "It's lovely staff who make Knighton Manor special. The contented and relaxed residents are sufficient proof."

A range of audits were undertaken by the registered manager and member of the management team, who had designated areas of responsibility to ensure the service delivered high quality care. The outcome of audits was a part discussed as part of staff supervision, so that any actions could be undertaken.

The registered manager explained how accidents and incidents were monitored and analysed and learning from these was used to improve the service. We saw records to confirm this. Legal obligations, including conditions of registration from CQC and those placed on them by external organisation were understood and met, such as social care professionals and health and safety organisations. The provider is required to display the rating following CQC inspections, both within the service and where applicable on their web profile, Knighton Manor Limited displayed their rating both within the service and on their webpage.

The Provider Information Return (PIR) reflected on the services participation in a scheme lead by Leicester City Clinical Commissioning (CCG) team, where representatives from the CCG were invited into the service to observe the medication systems, policies and procedures. Part of the involvement of the CCG staff was to look at how medicine waste could be reduced by liaising with people's doctor's and the service. The registered manager stated the scheme allowed the service to get gain advice and valuable information as to the medicine people were prescribed.

The PIR provided information as to how as a service they seek advice and information from outside agencies, particular mention was made of a company who provided the provider and registered manager with up to date information and advises of changes with regards to human resources and data protection. All staff had attended training following recent changes to data protection legislation.