Ashdown Care Limited

Knappe Cross Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 31 May and 2 June 2016. We brought forward this comprehensive inspection because we received concerns regarding people's care and welfare at the service. The service was the subject of a whole home multiagency safeguarding investigation at the time of our inspection. These concerns related to poor pressure care management, poor communication and records not demonstrating that people's care and welfare needs were always being met. At our inspection we found the provider had been responsive and taken action regarding the concerns identified. Improvements had been made and people's needs were being met.

Knappe Cross Care Centre provides care and accommodation for up to 42 people. On the first day of the inspection there were 30 people staying at the service.

We carried out an unannounced comprehensive inspection of this service on 16 and 20 July 2015. Two breaches of legal requirements were found. This was because people's medicines were not being safely managed. People were not always receiving care that was person centred and reflected their personal preferences. At the last inspection, we asked the provider to take action to make improvements and this action has been completed.

The service is required to have 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. The registered manager had changed their registration with The Care Quality Commission (CQC) to manage another service belonging to the provider. A new manager had been appointed and was in the process of completing their application with CQC to become the registered manager at the service. The manager had been at the service for five months at the time of our visit. Staff were positive about the manager and said they were approachable.

Medicines were safely managed. There had been improvements made for the monitoring of medicines stock at the service. Staff had recorded people's allergies. Protocols had been put into place for people who had occasional use medicines. This meant they had met the previous requirement set by CQC.

Care plans were personalised and recognised people's health, social and emotional needs. Care plans gave staff clear guidance about how to support people safely. They were personalised and people had been involved in their development. Plans were in place to involve people and appropriate relatives and friends in care plan reviews. Risk assessments were undertaken for people to ensure their health needs were identified. People were involved in making decisions and planning their own care on a day to day basis. People were being asked daily if they required a bath or shower although many still chose not to have one. They were referred promptly to health care services when required and received on-going healthcare support. People's views and suggestions were taken into account to improve the service.

Staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. Where people lacked capacity, mental capacity assessments had been completed and best interest decisions made in line with the MCA.

There were adequate staffing levels to meet people's needs. People felt there were adequate staff levels but said sometimes staff response times to call bells was slow. The operations manager was taking action to resolve a technical problem with the call bells. They also said they would monitor the response times to call bells to check people's needs were being met in a timely way.

People were supported by staff who had the required recruitment checks. Staff received an induction and were knowledgeable about the signs of abuse and how to report concerns. Staff training had been reviewed by the new manager and training and updates had been put in place to fill gaps in some staffs' training. Staff relationships with people were caring and supportive. They delivered care that was kind and compassionate.
People were supported to eat and drink enough and maintain a balanced diet. People and visitors were very positive about the food at the service.

People said staff treated them with dignity and respect at all times in a caring and compassionate way. A designated activity person and staff supported people to take part in social activities.

The provider had a quality monitoring system at the service. The provider actively sought the views of people, staff and health professionals. There was a complaints procedure in place and the manager and operations manager had responded to concerns appropriately.

The premises and equipment were managed to keep people safe.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's medicines were being safely managed.

Staff knew how to recognise signs of abuse and how to report suspected abuse.

There were sufficient staff on duty to meet people's needs.

Appropriate risks to people were identified and reduced as much as possible.

People were protected by a safe recruitment process which ensured only suitable staff were employed.

Accidents and incidents were monitored and any trends identified.

The premises and equipment were well managed to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was being put into place where the manger had identified gaps.

The manager was undertaking staff supervisions and had a schedule of supervisions and appraisals in place.

Staff asked for people's consent before they carried out any personal care. The Mental Capacity Act (2005) was understood and followed.

Advice and guidance was sought from relevant professionals to meet people's healthcare needs.

People enjoyed a varied and balanced diet.

Is the service caring?

Good

The service was caring.

Staff were caring and kind. They respected people and treated them as individuals and included them in decision making.

Staff recognised the importance of maintaining family contact. Visitors and friends were welcomed.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed. Care plans were developed to meet people's needs.

People had been involved in planning their care. Plans were in place for people to be involved in care plan reviews.

A range of activities were available.

There was an effective complaints procedure in place. People knew how to make a complaint and they had opportunities to offer feedback about the service.

Is the service well-led?

Requires Improvement

The service had not always been well led.

The local authority safeguarding process had identified concerns which had been addressed by the provider. However these concerns had not been identified by the provider and were not embedded at the service.

A new manager had started at the service and was in the process of putting in an application to register with the Care Quality Commission (CQC). Staff were positive about the new manager and improvements at the service.

People's and staff views and suggestions were taken into account to improve the service.

Incidents and accidents had been analysed to see if there were patterns or themes which could be avoided or needed to be addressed.

There were effective methods used to assess the quality and safety of the service people received.

Knappe Cross Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 31 May and 2 June. The first day of the inspection was unannounced. We announced the second day of our visit so we could be sure the operations manager was available. One adult social care inspector completed the inspection.

Knappe Cross Care Centre provides care and accommodation for up to 42 people. On the first day of the inspection there were 30 people staying at the service.

Before the inspection we reviewed information we held about the service such as from notifications. A notification is information about important events which the service is required to send us by law. We had requested a Provider Information Return (PIR) which we asked be completed by the 10 June 2016. The PIR is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make. Therefore we had not received the completed PIR because we had brought forward the inspection.

We met and observed most of the people who lived at the service and received feedback from seven people who were able to tell us about their experiences. We spent time in communal areas observing the staff interactions with people and the care and support delivered to them. We also spoke with three visitors to ask their views about the service.

We spoke and sought feedback from 11 staff, including the manager, a nurse, a senior care worker, care workers, the activity person, the cook and laundry person. We also spoke with the provider's representative referred at the service as the operations manager and a visiting GP.

We reviewed information about people's care and how the service was managed. These included four people's care records and eight people's medicine records, along with other records relating to the

management of the service. This included staff training, support and employment records, quality assurance audits, and minutes of staff meetings. We contacted the local authority safeguarding team, health and social care professionals and commissioners of the service for their views. We received a response from two of them.

Good

Is the service safe?

Our findings

People said they felt the service was safe. Comments included when asked, "Oh yes"; "Oh yes undoubtedly yes. No one is unkind to me"; "Safe as houses" and "Oh definitely…they are on the ball for everything."

At our last inspection, there was one breach of regulation. This related to people's medicines not being safely managed. At this inspection improvements had been made and this regulation was now met.

People received their medicines safely and on time. Medicines were administered by nurses who were trained and had their competence assessed. Where people had medicines prescribed as needed, (known as PRN), protocols were in place about when and how they should be used. There was a system in place to monitor the receipt and disposal of people's medicines. Staff kept a count of medicine in stock to ensure they did not have an excess of people's medicines at the home. The temperature of the medicine fridge and medicine storage area was monitored and recorded daily to ensure it was within the recommended temperature. Medicines at the service were locked away in accordance with the relevant legislation. Medicine administration records were accurately completed. People said they were given their medication and topical creams were applied as necessary and they were happy with their treatment. People said, "The pill merchants come around quite regularly and do what is necessary. They put cream on my feet and legs… they are very good"; "About lunchtime I have them. They say are you in any pain and give me paracetamol if I am" and "They put them in my mouth for me and give me some orange squash."

All appropriate recruitment checks were completed to ensure fit and proper staff were employed. Staff had police and disclosure and barring checks (DBS), appropriate references were obtained and employment gaps were explored. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. A new staff member confirmed they had not been able to start work at the home until they had a DBS and satisfactory references in place.

Our observations and discussions with people and their relatives showed there were sufficient numbers of staff on duty to keep people safe and meet their needs. Staff were seen to be busy but had time to meet people's individual needs. During our visits the majority of call bells were answered in a timely way. People, when asked, had a mixed response regarding the staff response times to their bells. Comments included, "They have been better lately, they used to take a long time"; "They can take up to three quarters of an hour…the night times are worse"; "I don't use it (call bell) very often, I wouldn't know exactly how long it can be… up to half an hour" and "It does depend on the time of day. If they are doing lunches, I might wait some time." We discussed these concerns with the operations manager. They explained that a new call bell system had been installed in July 2015. They were working with the company who installed the system. They had found the pagers which staff carry around to alert them were not charging properly, which meant staff were not receiving the alerts. The operations manager said once they had sorted out their snagging issues they would undertake regular call bell audits.

Staff said they felt there were adequate staff to meet people's needs when a full complement of staff were on duty as scheduled. Comments included, "It depends on the staff on duty and any unforeseen incidents"

and "Six is enough, it depends if an incident happens, we get behind and can be stretched. It also depends who you are working with. Now it is all quite good, better than what we had."

The operations manager said and staff confirmed the scheduled staff on duty. This was a nurse on duty with six care workers each morning. A nurse and five care workers each afternoon and a nurse and two care workers at night. They were supported by an activity person, housekeeping, catering, maintenance, administration and laundry staff who also interacted with people while undertaking their roles. The operations manager said they did not use a formal system to assess the staff levels at the service. They said the manager and staff fed back to them if they had concerns regarding the staff levels and staff levels would be adjusted as necessary.

There were no staff vacancies at the home, with new staff scheduled to take up their positions. However the operations manager said they would like to have additional bank nurses they could call upon to undertake shifts when gaps arose. There was an on call system at the service. This was so staff could contact the manager, a senior nurse or the operations manager with either clinical or environmental issues. Staff undertook additional duties if required. The provider occasionally used care agencies to cover gaps. The operations manager said they preferred not to because they felt people liked consistency and staff they knew. On the second day of our visit two staff members had called in absent. Changes had been made in the staff group and a nurse was working as a care worker as they had not been able to get an additional care worker. However the staff were happy in their role and people's needs were met. One staff member said, "We have done really well this morning, worked as a team."

The operations manager said they had recognised the difficulties at the service because of its size and layout regarding staff availability. They were looking at reorganising the service. With the possibility of having a residential wing for people without a nursing need and an area for people with a nursing need. They explained that they were also implementing a new senior care worker role at the home. They had two senior care workers who would work three mornings a week supernumerary. Their role would be to undertake checks to ensure staff were monitoring people and completing the required documentation. For example, administering topical creams, repositioning and food and fluid charts. They would also undertake medicine administration for people without a nursing need and work with visiting healthcare professionals. One senior care worker had already started undertaking the medicine administration training with the other scheduled to undertake. This would help ensure people's needs were being met and monitored in a timely way.

Staff were aware of their responsibilities with regard to protecting people from possible abuse or harm. They had received training about safeguarding people and were able to describe the types of abuse people may be exposed to. Staff were able to explain the reporting process for safeguarding concerns. They were confident action would be taken by the operations manager about any concerns raised. They also knew they could report concerns to other organisations outside the service if necessary. The operations manager and manger were aware of their responsibilities. They had been working with the local authority team safeguarding team regarding concerns which had been identified.

People were protected because risks for each person were identified and managed. Care records contained risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments for falls, skin integrity, nutrition and manual handling. Staff were proactive in reducing risks by anticipating people's needs and intervening when they saw any potential risks. People had a full assessment of their skin to check if they had any damage as part of the admission process. This was so staff could ensure they had the correct equipment and measures in place to prevent any further possible deterioration. Equipment included pressure relieving cushions on their chairs and specialist

pressure relieving mattresses on their beds. Care workers checked equipment was safe to use by undertaking monthly sling checks and pressure mattress checks. Documents demonstrated where they had identified a sling was faulty it had been taken out of use and disposed of. Care workers undertook daily skin checks on people to ensure they had not developed any red areas which might break down further. To ensure people's weights were accurately recorded when completing risk assessments the weighing scales at the home were calibrated annually.

One person said they hadn't had a shower since they came to the home. They said, "They offer to take me but I am afraid of falling." They explained that they had an incident in a shower before coming to the home. The incident was recorded in the persons care records. Staff had undertaken a risk assessment to establish as safe way for the person to have a shower. However the person had still decided not to have one.

The environment was safe and secure for people who used the service and staff. Two designated maintenance people over saw the maintenance and garden at the service. Effective checks were in place to ensure the environment and equipment being used was safe. These included weekly tests of the fire alarm, visual checks of the emergency lights, legionella checks with a weekly flush of water outlets in vacant rooms and monitoring the hot and cold water in the baths and showers. Monthly checks were also completed. These included, monitoring of water temperatures and radiator surfaces throughout the house and that window restrictors were in place as necessary. Monthly bedrails were inspected using guidance from the health and safety executive to guide the person completing the checks of what they were looking for. Wheelchair maintenance to check brakes were operating; foot plates in place and tyres were inflated was carried out monthly. The night staff were responsible for the day to day cleaning and checks of wheelchairs.

External contractors undertook regular servicing and testing of moving and handling equipment, fire equipment, electrical and lift maintenance. The fire extinguishers and panel were being serviced on the second day of our visit. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person.

The home was clean throughout. Carpets throughout the service were clean but some were worn and stained. The operations manager said they had a program of replacing carpets and curtains at the service. The bar room, part of the ground floor corridor and dining room had been redecorated with new flooring with new curtains on order. The manager had worked with the housekeepers to put in place a new cleaning schedule. The manager said they had changed the cleaning schedule to give the housekeeping staff realistic cleaning routines. Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. The laundry was compact, soiled laundry was segregated and laundered separately at high temperatures. This was in accordance with the Department of Health guidance. There was a separate room for clean laundry to be ironed and sorted.

Emergency systems were in place to protect people. There were individual personal evacuation plans which took account what assistance people required in the event of needing to be evacuated from the home. These were held in the nurse's office near the entrance accessible to the fire services in the event of a fire emergency. There was a fire risk assessment in place. This was being reviewed by the two maintenance people as they were trained fire wardens. Accidents and incidents were reported in accordance with the organisation's policies and procedures. They were reviewed to identify ways to reduce risks as much as possible and relevant health professionals and relatives were informed.

Requires Improvement

Is the service effective?

Our findings

Staff training and updates to ensure staff were competent and effective had not always been updated in a timely way The manager had recognised staff training and updates had slipped at the service. They had put in place a new system to look at staff training and identify gaps. Where they had identified gaps they had issued training workbooks for staff to complete. They were also holding a weekly workshop with staff to complete training workbooks as a group. This was because they had recognised this was how some staff preferred to learn. Twelve staff had completed pressure ulcer prevention training using this technique. Once these training workbooks had been completed they were sent to an external verifier to mark. Not all staff had completed manual handling training. Training had been scheduled with a senior member of staff who was a manual handling trainer. Staff were supported to undertake higher national qualifications in health and social care. One care worker was meeting their external assessor during our visit. They were very positive about the training they received. The manager had also been looking at other training available for staff to complete. They were in discussion with the speech and language team (SALT) and diabetic service regarding training they provided.

The nurses at the service undertook additional training to ensure they had the knowledge and competence to undertake their role. This included, medical emergencies, verification of death training and catheter care. New nurses as part of their induction also completed a competency assessment tool to ensure they had all of the information needed to be in charge of a shift at the home. They had to demonstrate an understanding of what to do in the event of an emergency. For example, if they received a complaint, how to contact professionals and record keeping. Checks were made by the provider to ensure nurses working at the home were registered with the Nursing and Midwifery Council (NMC) and able to practice. The NMC is the regulator for nursing and midwifery professions in the UK. They maintain a register of all nurses eligible to practise within the UK. Nurses were also being supported by the operations manager to maintain their registration through the NMC revalidation process.

Staff had undergone an induction which had given them the skills to carry out their roles and responsibilities effectively. They worked through an induction and orientation document in the first four to six weeks at the home. The document identified a list of tasks to be completed while shadowing on induction. These included understanding tissue viability, continence care, manual handling and the principles of fire safety. They also undertook a period of 'shadowing' experienced staff to help new staff get to know the people using the service. The operations manager said all new staff at the service were experienced care workers with care qualifications. They said any new care workers with no care qualifications would undertake the 'Care Certificate' programme which had been introduced in April 2015 as national training in best practice.

The manager had drawn up a schedule of staff supervisions they were working through. Staff confirmed they had received supervision or were scheduled to meet with the manager. One care worker said they found the supervision really useful "(The manager) asked if I had had any ideas or training needs." Another said, "I was observed moving someone in a hoist (by the manager) and we discussed it afterwards." There was a programme of appraisals scheduled to be undertaken. This meant staff had opportunities to discuss their role, development and future training needs to ensure they were effective in their role.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards and we found the home was meeting these requirements.

People confirmed they were always asked for their consent before care and support was provided. Staff involved people in decisions about the care they received. Staff had considered people's capacity to make particular decisions and knew what they needed to do to ensure decisions were made in people's best interests. Professionals and relatives had been involved in the decision making process where appropriate. However there was not a system to demonstrate that the service had assured themselves of people's relative's rights regarding their power of attorneys and the authorities they had. The management team were aware of the different types of powers of attorneys but were unable to tell us which one nominated people had. The manager said they would ask people to demonstrate which power of attorney they held to ensure it was clear.

Staff had received training about the MCA with others scheduled to complete. They demonstrated an understanding of people's right to make their own decisions. When asked about their understanding of the MCA. Comments included, "Being aware of choices. We can look to help them (people) back up their choices" and "We can't force them to stay. If they want to leave I would go with them they are quite in their rights to leave."

People had access to healthcare services for ongoing healthcare support. They were seen regularly by their local GP, and had regular health appointments as required. For example with the dentist, hospice team, physiotherapist and chiropodist. People's medical history and health needs were recorded. The care records contained the contact details of GPs and other health care professionals for staff to contact if there were concerns about a person's health. An example where staff had contacted a health professional included; staff had referred a person to the GP because they had pain in their knee. The action the GP had requested had been undertaken. Another person difficulty swallowing had visits from the speech and language team (SALT). Health care professionals said they received referrals promptly and in a timely way.

People without a nursing need at the home had their nursing needs met by the local community nurse team. Staff worked with health professionals such as the community nurses, occupational therapists and physiotherapists. The community nurse team said staff sought advice promptly when required. A visitor said they felt staff recognised changes in their relative quickly. They said, "Health professionals are called in promptly. I am kept informed."

People were supported to eat and drink enough and maintain a balanced diet. The service had a four week rotating menu. Staff completed a nutrition profile when a new person came into the home. This included information about their likes, dislikes and meal requirements. For example staff had identified a person with a milk allergy. We saw lactose free yogurts in the fridge for this person. This information was shared with the catering staff. There was also a white board in the kitchen where staff recorded people's special dietary requirements. These included people who required additional snacks because staff had assessed them as at risk of losing weight. People were asked the previous day for their meal choices. Staff used a document populated with people's dietary needs to record people's choices. For example, diabetes, puree diet. This was given to the catering staff so they had clear instruction about people's choices and requirements.

People were positive about the food at the service. Comments included, "Not too bad a choice"; "Too big a portions, they say eat what you can leave what you can't. It is very nice though"; "Very good, I get a choice": "The food is very good" and "I can't fault the food, plenty of it they are not mean. I only have to say I don't want it, they don't make a song and dance about it." Staff had put in place monitoring charts for people assessed as being at risk of losing weight or drinking poor amounts of fluid. These were regularly completed and reflected what people had received. The nurses and senior care workers had an oversight of these monitoring charts to ensure people received an adequate diet and fluid intake. Staff recognised where people had difficulties using mugs or cups and gave them more specialist beakers with handles to help maintain their independence.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff who treated them with warmth and compassion. Staff were kind, friendly and caring towards people. People were seen positively interacting with staff, chatting, laughing and singing. People said they were happy at the home. Comments included, "Oh yes oh yes in many ways I am quite fortunate to have landed up in here"; "All of the staff are lovely. They are very good to me I don't get refused anything. I don't ask for anything outside the realms of reasonable in a care home" and "I can't fault them". A visitor commented, "The care is quite good, seems to be alright. (Person) has health ups and downs."

Letter of thanks to the staff included, "Excellent kindness and care"; "I admire your professional dedication loving care and endless hard work" and "The warmth towards (person) the sympathy and many kindnesses shown meant a great deal."

Staff said they felt people received good care and support at the service. Comments included, "Staff have a positive attitude, they do their best, the people make it nice…we do the job the way it should be done"; "The care given here is being focused on residents"; "Staff are lovely all very caring. They are here to ensure needs are met… all friendly" and "The atmosphere in the house is positive and the residents get good care".

Staff treated people with dignity and respect when helping them with daily living tasks. Staff said they maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on bedroom doors before entering and gained consent before providing care. One person said, "The carers knock on the door…they are very caring."

Staff treated people with kindness and compassion in everything they did. Staff were working well as a team; they were smiling and respectful in their manner. They greeted people with affection and by their preferred name and people responded positively. Staff were bantering with one person about their choice of morning refreshments. They knew the person's preferred drink and when they asked the person about their supper choice they could predict their response.

Staff involved people in their care and supported them to make daily choices. For example, people chose what time they wanted to get up and the clothes they wore. One person said, "I get up at seven. As soon as I wake up, I get up. I like to go to bed about seven thirty." People were asked daily whether they wanted to have a shower. Staff were recording when people had been offered a shower although many declined the offer. One person said, "I don't like to have a shower, I do have a wash and need someone to help me." Another person said "I am about to have a shower, I can have one at any time." A care worker said, "We ask them if they want a shower, not all of them say yes, only about half."

People were being supported to complete their postal electoral ballet papers regarding Europe. The member of staff supporting them to complete these gave them the information they required to make an informed choice. They remained impartial and did not try to sway the views of the people they supported.

When people arrived at the home they were asked to formally consent to having care at Knappe Cross. This included permission for photographs to be taken, care record agreements and designated access to care records.

People's relatives and friends were able to visit without being unnecessarily restricted. People said their visitors were made to feel welcome when they visited the home. One person said, "I have visitors coming today…yes they look after her." The majority of people's rooms were personalised with their personal possessions, ornaments and photographs. A newly redecorated bar area was available for people and their visitors to make themselves refreshments when they visited. Although the operations manager said it was not being used as often as they had hoped it would.

Good

Is the service responsive?

Our findings

At our last inspection, there was one breach of regulation. People were not always receiving personalised care that was responsive to their needs and preferences. At this inspection improvements had been made and this regulation was now met.

The service was responsive to people's needs because people's care and support was planned and delivered in a way the person wished. Wherever possible a pre admission assessment of needs was completed prior to the person coming to the service. When people arrived at the home an admission checklist was completed. This included ensuring people received the welcome pack, had an explanation of the management of the home, were informed about fire systems, medicine administration and meal timings. People and their families were included in the admission process to the home and were asked their views and how they wanted to be supported. People's needs were assessed using the 'barthel scale' to assess people's needs. Depending on the score staff decided whether a care plan was required. This information was used to develop comprehensive care plans.

Care plans set out people's care needs. For example a person was assessed as at high risk of skin damage due to their immobility, weight, continence need and age. Their care plan set out the outcome to be achieved. For example, to maintain skin integrity. Then the actions needed to achieve the outcome. For example, daily pressure care, use of a pressure mattress, guidance for staff to report concerns to the nurse, administering topical cream and regular skin assessments. People's care plans included, care for elimination, communication and anxiety, personal care, disability, diabetes, catheter care (record of leg bag changes done weekly) anxiety, emotional wellbeing, pain management and end of life care.

Care files included personal information and identified the relevant people involved in people's care, such as their GP, optician and chiropodist. Care plans gave information about people's health and social care needs and showed that staff had involved other health and social care professionals when necessary. When necessary, referrals were made to the Speech and Language Therapy (SALT). Where recommendations had been made to reduce the risks to people, these had been incorporated within the care plans. A speech and language therapist said they had timely referrals and were happy staff acted upon their advice. In the kitchen staff had information about people's identified special diets, whether diabetic or fortified and the required consistency of food, for example whether fork mashable or pureed.

Risk assessments included an assessment of nutritional needs, mobility, falls and skin integrity. These assessments were completed and up to date. Care plans had been reviewed and reflected risks identified in a timely way. However it was not always clear that people had been involved in reviewing their care plans. The manager said they had recognised this and had put in place a system of designated staff members to undertake the reviews. They said they would be inviting people and appropriate relatives to be involved with their care reviews.

People and their relatives knew how to share their experiences and raise a concern or complaint. People were happy they could raise a concern if they needed to and were confident the nurses and management

would listen and take action if required. One person commented, "I am well looked after that is the point." The person made us aware they had raised concerns in the past about a care worker which had been dealt with. Another person was not sure who they would complain to. They said, I don't know who everyone is, there are so many of them…I honestly don't know. They must all be in charge of their own separate divisions. If I had a complaint I would tell one of the girls and ask for the manager. It hasn't come to that they have been very good." Another person said, "Good question, I would speak to matron (manger) I don't think I have any complaints to be honest."

Complaints were being managed appropriately. There was a complaints procedure in each person's care folders held in their rooms. The procedure included information about the external agencies people could contact if they were not satisfied with the response from the service. There were two complaints being managed at the time of our visit. The manager was having an ongoing dialogue with one person's family through regular emails. There were also plans being put into place to have regular face to face meetings to resolve issues before they became a concern. Another concern regarding a person's curtains and carpet was being dealt with in line with the provider's policy.

People were supported to take part in social activities. There was a designated activity person employed at the service for 18 hours a week. People and staff spoke positively about the activity person. Comments included, "(Activity person) is very nice I am very fond of her, she takes me out into the garden" and "(Activity person) is really nice with residents." A social evaluation and social profile activity questionnaire was completed when people came to the home. People were asked about their interests, hobbies and asked what activities they would like to partake in. They also asked how often people would like to meet with them.

The activity person produces a monthly newsletter to make people aware of what was happening at the service. The newsletter also advised people they could have alternatives to the menu and contained puzzles for people to complete. The newsletter for May 2016 made people aware of the upcoming summer fete, people's birthdays, activities scheduled which included bingo and a film club. People had the opportunity to join in group activities. On the first day of our visit people were enjoying hand bell ringing with an atmosphere of laughter and chatting.

There were also external entertainers who visited the home to entertain people. A notice board in the entrance advised people and relatives of entertainers that were coming to the service. These included in May 2016 a piano player; nail therapist and arts and crafts sessions. On the second of day of our visit we were shown decorated jars with wool. An external entertainer had been at the home the day before supporting people doing crafts. People and staff said everyone that had taken part had enjoyed the craft session and further sessions had been scheduled. The activity person said they liked to celebrate special days at the home. These included, saints days (for example, St Georges and St Patricks), valentine's day, Halloween. They were looking to have an event to celebrate the American independence day on the fourth of July. There was a system to ensure all people had the opportunity to partake in regular meaningful activities each.

The majority of people at the home chose on most days to stay in their rooms. People that did come downstairs chose to sit in the main lounge area. They chose not to use the newly decorated dining room at meal times. Although staff were heard encouraging people to use it for lunch. The activity person was planning a celebration tea to celebrate the queen's birthday and it was hoped people would use it then. The operations manager said they would really like people to use the communal areas more.

Requires Improvement

Is the service well-led?

Our findings

The service was the subject of a whole home multiagency safeguarding process at the time of our inspection. There were areas for improvements identified during this process. These included better communication between the staff, families and health professionals; staff to receive training in catheter care and pressure ulcer prevention; some people's care plans needed updating and more accurate completion of people's monitoring charts. The operations manager and manager had been very proactive in taking action to resolve the concerns highlighted. However they had not identified the concerns as part of their quality monitoring of the service. The changes put in place need to be embedded to ensure the improved practices continued.

The registered manager had changed their registration with The Care Quality Commission (CQC) to manage another service belonging to the provider. A new manager had been appointed and they were in the process of completing their application with CQC to become the registered manager at the service. The manager had been at the service for five months at the time of our visit. Staff described the manager as someone they had confidence in and could contact if they had any concerns. Comments included, "She is lovely, it is better now but still a lot to do here"; "I feel appreciated and listened to"; "Very approachable… good with staff, more understanding of our needs" and "lovely, very approachable. Brilliant, definitely lifted the mood of it here, if any problems go to her." A visiting GP said they had noticed improvements and signs of a better team forming at the home.

The operations manager usually visited the service monthly. However following recent concerns raised by the local safeguarding team they had been at the service supporting the manager for two weeks. The operations manager said there had been a change of management style at the service. They said they had undertaken a three month review with the manager which had been positive. The manager had said they liked the opportunities the home gave and was very motivated. The manager said they were enjoying their new role and the challenges they faced. They were positive about the support they received, their comments included, "This is a very supportive environment to work in." The manager was also supported by the nurses at the home and registered manager's at the provider's other services in the local area.

The manager had introduced 'Employee of the week' to build up staff morale. The manger and administrator would consider feedback from staff each week and nominate a staff member. The staff member would receive chocolates, wine or flowers as a prize. The successful nominated employee was also recorded on the homes private social media page. The administrator said staff were really positive about the new scheme. They said staff wrote positive comments on the social media pages congratulating their colleagues. The manager had also introduced a new assessment tool which assessed people's needs. This helped to improve the staffs understanding of what care plans people required.

The operations manager completed a monthly quality assurance audit when they visited the service. They used three different audits which they rotated. The first was an in-depth health and safety audit, the second a governance check audit. The third was a new recently introduced audit which focused on two people using the service and the care they received. The new audit included observing care being delivered and

staff working practices. The operations manager would then have a discussion with the people and the staff about their observations. They would then look at the people's care records, medicine records to see if they were accurate and completed correctly. The operations manager would also look at the staff they had observed employments records to see what support and training they had received. An action plan was then generated and given to the manager to complete and would be followed up at the operations managers next visit.

The provider had an annual audit program which they required manager's to complete to monitor the quality of the service provided. This included infection control, staff and residents meetings, medicines audits, complaints log and a visual check of premises. These audits and meetings had taken place in line with the provider's programme. For example, a medicine audit had identified small concerns. A memo had been sent to the nurses of the action required and was the checked to ensure completion. The visual premises audit was completed by the maintenance team four times a year. Once completed the manager had to check and sign they had seen and ensure any actions identified were carried out. The operations manager said they insisted that any audit delegated by the managers had to be checked by the manager to ensure they had completed any actions identified. The infection control audit had identified the seal on a wet room floor had lifted this had been actioned and resealed. A new diabetic audit was being trialled to assess people with diabetic needs and how they were being supported. The operations manager said they would be looking at the effectiveness of the audit and whether it would be beneficial to continue. However there was no system to undertake formal audits of the call bells to ensure call bells were responded to in a timely way. The operations manager said they would be undertaking call bell audits when they had resolved the technical difficulties with the call bell system.

The manager completed a monthly return for the operations manager where they stated the audits were completed in line with the provider program. The report also included information about people with damage to their skin, staff training and recruitment. The operations manager said the provider was kept informed about the service and saw all of the reports. This helped them have an overview of how well the service was being run.

People were asked to share their views about the service. They could complete comments cards, attend twice yearly residents meetings, catering and activity reviews. The manager and operations manager also walked around speaking with people to ask their views. The comments cards had been in use at the service since January 2016. In January there had been four comments. One was about the cleanliness at the home which had resulted in a change to the cleaning schedule. At the last resident meeting held in April 2016 a request had been made for a waste bin in the bar area which had been actioned. People also mentioned the response times to call bells. The operations manager had been working with the call bell installation company to resolve this concern. Following the twice yearly catering reviews staff looked at people's menu choices and suggestions and assessed what had been successful and what had not. The last activity review had found people wanted to undertake more craft activities. This had resulted in an external crafts activity entertainer coming to the service. This showed people's views were being listened to and actions taken to improve the service.

In June 2015 staff, relatives and health professionals were asked to complete a questionnaire about the service provided at Knappe Cross. This randomly selected survey was completed by a designated staff member at the providers head office overseen by the operations manager. The information had been collated. The operations manager said if a concern was identified it would be looked into and action taken straight away. However there was no formal system to let people and their friends and relatives know the outcome of these surveys. The operations manager said they would look at ways to inform people of the outcome of the surveys and actions taken in response.

Staff meetings showed a variety of topics were discussed and staff were able to share suggestions and voice their views. The manager had met with the nurses the week before our visit. They had discussed findings from visiting health professionals at the home. The nurses were reminded about the Nursing and Midwifery Council (NMC) guidance and their responsibilities when on duty. The manager had also met with staff to keep them informed about the safeguarding process at the home. Staff were positive about the meetings and being involved in improving the service. Comments included, "When (manager) came, she talked with us, if we had something to say she listened. She also gave us a lot of information"; "We have had a couple of meetings with the new manager…very informative, she did an agenda if anyone had anything to say or what we felt" and "We had a meeting where they (manager) introduced themselves and said it would be a regular thing."

The staff monitored and acted appropriately regarding untoward incidents. The manager completed a monthly falls grid over view and looked at trends and patterns in accidents to ensure appropriate actions were taken to reduce risks. For example where one person had fallen behind a door action had been taken to minimise it happening again. This included, the door closure being repositioned and the person had being offered to move to another room.

Staff had a staff handover meeting at the changeover of each shift where key information about each person's care was shared. This meant staff were kept up to date about people's changing needs and risks. One care worker said "Handover is quite good, very thorough." A new handover shift document was being used to enable better communication between the nurses and care workers. Care workers could record any changes to people or concerns they identified. After each shift the document was given to the nurse who would record the details and actions taken in people's records.

The provider had displayed the previous Care Quality Commission (CQC) inspection rating in the main entrance of the home and on the provider's website. The provider was meeting their legal obligations. They notified the CQC as required and provided additional information promptly when requested and were working in line with their registration.