

MMCG (2) Limited

Knights Court Nursing Home

Inspection report

105-109 High Street
Edgware
Middlesex
HA8 7DB

Tel: 02083813030

Date of inspection visit:
22 July 2021
28 July 2021

Date of publication:
06 September 2021

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Knights Court Nursing Home provides accommodation and nursing care for up to 80 older people, some of whom may also have dementia. There were 51 people living in the home when we visited.

People's experience of using this service and what we found

During this inspection, we found improvement was required in relation to some aspects of falls management. The provider had a system to record and respond to accidents and incidents. However, there was not enough information about what steps should be taken to reduce the likelihood of the accident/incident occurring again. There were occasions where service users had repeated falls and we were not assured that the provider consistently sought advice from professionals in order to mitigate the risk of repeated falls. We have found a breach of regulation in relation to this.

Medicines were being managed safely at the home. However, we noted that care plans for medicines were not always person centred. We have made a recommendation in respect of this.

Arrangements were in place to protect people from abuse. Staff had received training on how to safeguard people from abuse and were aware of the procedure to follow if they suspected that people were subject to abuse.

The majority of staff we spoke with told us that they did not think there were sufficient staffing levels. They told us that whilst they were able to safely meet people's needs, there were occasions where there were not enough staff. We discussed staffing levels with management, and they informed us that there were sufficient numbers of staff and confirmed that they assessed this using their dependency tool. Staff had been carefully recruited and essential pre-employment checks had been carried out.

The home was well maintained, clean and tidy. The service had taken measures to help prevent and control the spread of COVID -19 and other infections. There was a record of essential maintenance carried out. Fire safety arrangements were in place.

People's care plans included details of the support people needed. However, we found accessing and locating information within people's care records was difficult and time-consuming. Management advised that they were in the process of reviewing these and archiving information so that care plans were user friendly.

Management and senior staff monitored the quality of the services provided via regular checks and audits. The results of the last satisfaction survey indicated that people and their representatives were generally satisfied with the care and services provided.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was good (published 15 August 2018).

Why we inspected

We received concerns in relation to safeguarding people from the risk of abuse and their safety. As a result of this, the Local Authority placed a temporary suspension of new placements whilst the provider made necessary improvements. As a result, we undertook a focused inspection to review the key questions of safe, and well-led. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Knights Court Nursing Home on our website at www.cqc.org.uk.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement

We have identified a breach in relation to safe care and treatment at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Knights Court Nursing Home

Detailed findings

Background to this inspection

The inspection

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

Inspection team

The inspection team consisted of three inspectors, a pharmacist inspector and an Expert by Experience who spoke with people and relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

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

The service had a manager registered with the CQC; however, the registered manager was on leave at the time of the inspection. Instead, the home had an interim manager in post until the registered manager returned.

Notice of inspection

The first day of the inspection was unannounced. We gave the provider one day notice of the medicines management inspection.

What we did before the inspection

We looked at information we held about the service. This information included any statutory notifications

that the provider had sent to the CQC. Statutory notifications include information about important events which the provider is required to send us by law. This information helps support our inspections. We reviewed the last inspection report. We also reviewed information received from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We conducted this inspection over two days. During the inspection, we visited the communal areas and some bedrooms. We spoke with six people who used the service, three relatives and 13 members of staff including the interim manager, quality excellence partner, nurses, care staff and domestic staff. We reviewed a range of care records and records related to the running of the service. These records included ten people's care files, 11 medicine administration records and six staff recruitment records. We also looked at policies and procedures, checks and audits carried out.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training records, incident/accidents records, three people's care records and data in respect of falls within the home. We also received feedback about the service from two care professionals. We also spoke with five care workers.



Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question remains the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Learning lessons when things go wrong

- We could not be assured that the provider consistently took appropriate action to reduce reoccurring falls.
- The interim manager told us that a falls record was completed on a monthly basis. The record completed between January 2021 and 31 July 2021 showed that there had been a total of 49 falls in the home. We looked at the monthly data and noted that in January there were five falls. By July, this had increased to nine which was proportionately higher as the home was not at full capacity and was providing care to 51 people.
- The provider had a system in place to record and respond to accidents and incidents which included falls. We observed that these contained a description of injuries sustained, details of any investigation carried out as well as follow up action. However, we noted that there was a lack of information about what steps should be taken to keep people safe and reduce the likelihood of the accident/incident occurring again.
- There were occasions where people had repeated falls. We noted that two people had fallen out of bed a few times. In such instances, we were not assured that the provider consistently sought advice from professionals such as occupational therapists or the falls prevention service in order to mitigate the risk of repeated falls and prevent people from being seriously harmed. We also found that the provider was unable to demonstrate that they had looked into other ways to prevent falls.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was an in-house post falls protocol in place which provided detailed guidance to staff on what action to take in the event a service user falls. Staff we spoke with were aware of the procedures to follow where a service user sustained a fall. We however noted that staff had not all completed falls prevention training. The interim manager explained that the clinical team had completed this and that all other staff were scheduled to complete this on 17 and 19 August 2021.
- Falls and other incidents were recorded on a 'hub'. This was electronic and live so that the provider quality assurance team and senior management had oversight of the information.
- Management staff told us of the improvements they have made recently. This included monitoring charts and ensuring these were completed properly by staff. We found that fluid charts, nutrition, personal care, comfort checks, bowel charts, daily mattress checks were completed well with very few gaps.

Using medicines safely

- Medicines were being managed safely at the home.

- Medicines were stored securely at appropriate temperatures.
- There was adequate stock of prescribed medicines.
- Medicine Administration Records (MAR) we reviewed provided evidence people were given their medicines as prescribed.
- Some people were prescribed medicines to be taken on when required (PRN) basis. Guidance in the form of PRN protocols were in place to help staff give these medicines consistently.
- Care plans for medicines were not always person centred. For one person the care plan did not have information about medicine to be given at specific time for Parkinson's disease. For two people living at the home their care plans did not have information relating to food and the time of administration of a medicine to be given weekly on a particular day of the week. This meant the staff may not always be able to support medical and health needs for people living at the home appropriately.

We recommend that the provider should review the medicines care plans for people to make them person centred.

- There was a medicine policy in place.
- Staff members were competency assessed and received training to handle medicines safely.
- There was a process to report and investigate errors and incidents.
- There was a process in place to receive and act on medicine alerts.

Staffing and recruitment

- There were sufficient numbers of staff deployed to safely meet people's needs. However, there was mixed feedback about staffing levels in the home. One person told us, "I think that often there are only two carers on duty. I think there should be more, they can't do everything if they are helping one person". Another person said, "The carers are all very nice, they are not usually rushed in what they do for me but they never have too much time to stay with me".
- On the day of the inspection, we noted that there were sufficient numbers of staff and staff did not appear to be rushed.
- The majority of staff we spoke with told us there were occasions when there were not enough staff on duty. They told us that there were occasions where staff did not arrive at work and were not replaced and at other times, they were busy due to people's high needs. They also advised that a significant number of staff had left their posts.
- We discussed staffing levels in the home with the interim manager. Staffing levels were assessed according to people's needs and occupancy levels. The provider used their own dependency tool which monitored the dependency of people in the home and calculated the appropriate numbers of staff to safely meet people's needs. Management reviewed staffing numbers and people's dependency monthly to ensure there were sufficient staff.
- The provider followed safer recruitment practices and had ensured appropriate pre-employment checks were completed satisfactorily before care workers were employed.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse. The service had policies and procedures in place to safeguard people from abuse. Staff we spoke with were aware of action to take if they suspected people were being abused.
- The home had a safeguarding log which enabled management to monitor and keep track of current safeguarding investigations.
- One person's relative told us that they felt that their mother was safe in the home and had no worries about her safety.

Assessing risk, safety monitoring and management

- People's care records included risk assessments for example on falls, moving and handling, skin integrity, eating and drinking and catheter care. Malnutrition Universal Screening Tool (MUST) risk assessments were in place where necessary. These are used to assess people with a history of weight loss or poor appetite. Risk assessments included information for staff about actions to be taken to keep people safe. Care plans and risk assessments were kept under review and updated when necessary.
- People who had pressure wounds or who were at risk of developing them had appropriate risk assessments in place. Staff recorded the actions taken to show they were following the risk assessments. We saw documented evidence that wounds were reassessed and dressed regularly. There was photographic evidence showing pictures and measurements of ulcers. There were also records of repositioning charts. Wound assessment body maps were in place and we saw that the tissue viability nurse had been involved with people's care. We also saw that necessary pressure relieving equipment was available.
- One person's relative told us that they were very happy with the care their relative had received. They said that the ulcers on [the relative's] legs had improved a lot and that staff had managed [the relative's] pain well. This relative told us, "Staff are fantastic. Nothing that you ask for that they don't do. It is fabulous."
- People had been assessed as to whether they can or can't use a call bell. Action, such as hourly checks were carried out when people could not use a call bell.
- People had individual emergency evacuation plans which highlighted the level of support they required to evacuate safely.
- Health and safety checks including fire safety, lifts, mobility equipment, water temperature checks and electrical and gas safety checks were carried out to ensure the environment and equipment was safe for use.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date and this included risk assessment procedures for any clients or staff from black and minority ethnic communities who faced potentially higher risks from COVID-19 infections.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Audits were conducted by management and the provider. These covered various aspects of the service including infection control, medicines, care plans, complaints, staffing arrangements, maintenance, health and safety and business continuity. However, we found some improvement was needed in relation to falls management and care plans.
- The provider recorded details of when a fall occurred, the type of fall and the injury sustained. The purpose of this was to identify trends and themes and give the home an overall picture of falls. However, we did not see that the home then took personalised steps for each service user to reduce the risk of them reoccurring. We have addressed this under 'Safe'.
- People's care plans clearly detailed the support people needed to achieve good outcomes. However, we found accessing and locating information within people's care records was difficult and time-consuming. For example, we noted that one person had two very similar 'Managing pressure relief and skin integrity care plans' in place. This created confusion as to which was the up to date version to be relied upon. Due to the format of the current care plans, staff, particularly newly employed members of staff or agency staff could experience difficulties accessing important information quickly. We raised this with management, and they acknowledged our concerns and explained that care files were being reviewed and information was being archived so that care plans were simplified and contained relevant information. They also explained that their aim was to move towards an electronic system within the next year.
- The manager spoke positively about the support they had received from the provider during the pandemic. The provider had created a specific COVID-19 'task force' team, led by a chief nurse, that kept them up to date with all information relating to COVID-19 as well as guidance.
- Management carried out a monthly clinical analysis which included various aspects of the running of the home including accidents, skin integrity, deaths and infections. The purpose of this was to provide management with an overview so that they were able to monitor trends and patterns.
- Management carried out weekly clinical governance meetings which provided staff with an opportunity to discuss individual service user's progress and share important information and updates.
- The provider held a monthly national conference catch up meeting where managers could share information, best practice and lessons learnt. The interim manager told us this was particularly important at the start of the pandemic.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people;

- People's relatives told us they were kept well informed about people's progress and of any issues to do with their care.
- Monthly staff meetings had been held where staff could express their views and received updates regarding the care of people. This ensured that staff were fully aware of how to meet the needs of people.
- The provider had followed current government guidance to support people's relatives to visit them during the COVID-19 pandemic.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The home had a registered manager in post. The registered manager was on leave at the time of the inspection. Whilst on leave, the home was being managed by an interim manager with the support of the deputy manager and regional manager.
- Management staff understood their responsibility under the duty of candour and were open, honest and took responsibility when things went wrong. They notified the CQC of any significant events at the service.
- Care documentation contained information related to concerns and complaints and action taken by the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- Records showed feedback from people and relatives was sought through meetings. Meetings were held via video call and areas such as COVID-19 updates, vaccinations, visits, activities and visits from healthcare professionals were discussed.
- Staff meetings were held to discuss the management and running of the home. Minutes of these meetings showed aspects of people's care were discussed and staff had the opportunity to share good practice and any concerns they had.
- Staff spoke positively about the registered manager and said that they felt supported. When speaking about the registered manager, one member of staff said, "[The registered manager] is a great manager. She is very fair. She is very composed and professional." Another member of staff told us, "[The registered manager] is very, very nice. She is really engaging and looks after staff. She has good human and leadership qualities." Staff also explained that when the registered manager had initially gone on leave, there had been a period of uncertainty due to the involvement of different managers. However, there was now an interim manager in post and things had settled.
- Staff we spoke with knew the importance of understanding and respecting people's differences. Care staff spoke about how they ensured people's cultural and religious needs were met.
- The provider carried out a formal satisfaction survey in December 2020 in order to obtain feedback from people and relatives. The feedback obtained was generally positive. The provider also carried out meal and activities survey in order to gain people's views and took positive steps to make improvements where needed.

Working in partnership with others

- The service worked in partnership with organisations including local authorities that commissioned the service and other health and social care professionals.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks to people's safety in relation to falls was not being managed effectively to minimise the number of falls occurring at the service.