Bupa Care Homes (CFChomes) Limited

Knights' Grove Care Home

Inspection report

Thomas Road
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Southampton
Hampshire
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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

This inspection took place on 4 May 2016 and was unannounced. The home provides accommodation for up to 56 older people with residential or nursing care needs. There were 50 people living at the home when we visited. All areas of the home were accessible via lifts and there were various lounges, dining rooms and accessible outdoor space suitable for the people living at the home. All bedrooms were for used for single occupancy and had en-suite facilities.

The home did not 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 provider had arranged for an experienced temporary manager to act as manager whilst the longer term management arrangements were determined.

Some individual risks had not been identified, assessed and action taken to manage the risk. Other individual and environmental risks were appropriately managed.

Medicines were safely managed however, systems did not ensure people were assessed for pain or other as required medicines at frequent intervals.

People and relatives were positive about the service they received. They praised the staff and the care provided. People received personalised care from staff who understood their needs and they were supported to make choices.

People liked living at the home and felt it was run well. Staff understood their roles, were happy in their work and worked well as a team. There was an open and transparent culture. The provider encouraged staff feedback and visitors were welcomed. Complaints, when received, were investigated and responded to. Quality assurance processes were in place to assess key aspects of the service. Where these had identified a need for improvement action had or was being taken.

Staff treated people with kindness and compassion and formed caring relationships with them and their relatives. Staff protected people's privacy, promoted their independence and involved them in planning the care and support they received. People were also positive about meals and the support they received to ensure they had a nutritious diet.

People felt safe at the home. Care staff knew how to prevent, identify and report abuse. Staff followed legislation designed to protect people's rights and freedom to help make sure decisions were only taken in the best interests of people.

Safe recruitment procedures were in place and staff were suitably trained and appropriately supported in their role and available in sufficient numbers to meet people's needs.

Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs. At the end of their life people received appropriate care to have a comfortable, dignified and pain free death.

People had access to healthcare services and were referred to doctors and specialists when needed. Reviews of care involving people or relatives (where people lacked capacity) were conducted regularly. A range of activities were provided suited to people's individual needs and preferences.

Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some individual risks had not been identified, assessed and action taken to manage the risk. Other individual and environmental risks were appropriately managed.

Medicines were safely managed however systems did not ensure people were assessed for pain or other as required medicines at frequent intervals.

People felt safe. Staff knew how to identify and report abuse and were aware of how to respond in an emergency situation.

There were enough staff to meet people's needs. The process used to recruit staff was robust and helped ensure staff were suitable for their role.

Is the service effective?

Good

The service was effective.

People received the personal care they required and were supported to have their healthcare needs met and action was being taken to improve wound care.

Staff followed relevant legislation to protect people's rights and ensured decisions were made in the best interests of people.

Staff were suitably trained, skilled and knowledgeable about people's needs and received support through supervision and staff meetings.

People were given a choice of nutritious food and drink and received appropriate support to meet their nutritional needs.

Is the service caring?

Good

The service was caring.

People and relatives were positive about the way staff treated them. People were treated with respect. Dignity, choice and

independence were promoted.

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death.

Is the service responsive?

Good

The service was responsive.

People received care that was personalised to meet their individual needs. Care plans were comprehensive and reviewed regularly to help ensure they reflected people's needs.

Staff were responsive to people's needs. People were supported to make choices and retain their independence.

People knew how to make complaints and they were dealt with promptly in accordance with the provider's policy. The registered manager sought and acted on feedback from people.

Is the service well-led?

Good

The service was well led

There was an open and transparent culture within the home. The management team were approachable. People and visitors felt the home was run well. Staff understood their roles, were happy in their work and worked well as a team.

Quality assurance systems were in place using formal audits and regular contact by the interim manager with people, relatives and staff. Policies and procedures had been reviewed and were available for staff.

Knights' Grove Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check 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.

This inspection took place on 4 May 2016 and was unannounced. The inspection was undertaken by two inspectors, a specialist advisor in the care of older people living with dementia and an expert by experience. An expert by experience is a person who has experience of caring for an older person.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. Before the inspection, the registered manager completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with five people living at the home and four visitors. We spoke with the interim manager, the provider's regional support manager, seven nursing or care staff and ancillary staff including the home's administrator, two activities staff, the chef and maintenance staff. We looked at care plans and associated records for nine people, staff duty records, three staff recruitment and training files, records of accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The home was last inspected in April 2014, when we did not identify any concerns.

Requires Improvement

Is the service safe?

Our findings

Not all risks to individuals had been assessed and action taken to reduce the risks. We found that a person did not have an up to date risk assessment and care plan relating to dysphagia (difficulty in swallowing). We saw in their daily records '[person's name] choked on their saliva causing breathing difficulty and disruption of O2 levels'. This meant they were at high risk of similar future events. However, their care plan and risk assessments related to breathing and circulation stated there was no history of breathing problems. The risk assessments therefore were not an accurate reflection of all the person's risks. We noted a container of a prescribed drink thickener powder which had not been stored securely and was on a side table in a person's bedroom. Staff immediately moved this and told us the provider's policy was for this to be kept in people's unlocked wardrobes. If people were to eat the drink thickener powder they would be placed at risk.

Where risks were identified action was taken to reduce the risk. A staff member described how one person liked to walk in the garden but was at risk of falling and staff therefore accompanied them outside. Another staff member told us how staff checked the welfare of one person every half an hour as they were at risk of becoming agitated, getting up from the chair and falling. Moving and handling assessments clearly set out the way to move each person and correlated to other information in the person's care plan. Staff had been trained to support people to move safely and we observed equipment, such as hoists and standing aids being used in accordance with best practice guidance. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. Pressure relief mattresses were set appropriately, and people were assisted to change position to reduce the risk of pressure injury. Where people were at risk of choking on their food, they had been referred to specialists for advice and were provided with suitable diets to reduce the risk. Risk assessments, with specific actions to reduce the risk where possible, were relevant to the individual person and had been regularly reviewed.

Environmental risks were assessed and managed appropriately. Records showed essential checks had been completed on the environment such as fire detection, gas, electricity and equipment such as hoists were regularly serviced and safe for use. Emergency procedures were in place. Staff knew what action to take if the fire alarm sounded, completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. Records showed fire detection and fighting equipment was regularly checked. Staff were also aware of how to respond to other emergencies.

The provider used 'as and when necessary' (prn) protocols. However, these were not available for all types of medicines which meant the staff may not have always been aware about how and when these medicines should be administered. Where people were not able to state they were in pain, a recognised pain assessment tool was in use. Pain assessments were carried out once a day which may mean staff would not identify new pain in people or any changes in frequency or severity. For example, one care plan stated that "[person] has pain when moving around the stomach area". We saw this person had strong analgesic patches to help control pain. In their care records it stated "RN to monitor pain every day using [name pain assessment tool]". In the person's care records was a copy of the pain assessment tool used by the provider; however, this had not been completed. Another person had a type of wound which is known to be painful. However, regular pain assessments including before and after wound care had not been completed. The

person had been prescribed a sedative and oral morphine. The staff had selected to use the sedative when the person may have required medicine to reduce the pain they were experiencing. There was no record as to how nursing staff made the decision to administer a sedative and not the pain medicine.

There were appropriate arrangements in place for obtaining, recording, administering and disposing of prescribed medicines. There were also effective processes for the ordering of stock and checking stock into the home to ensure the medicines provided for people were correct. We audited stocks of some medicines and found these were accurate. We spoke with two registered nurses about their knowledge of medicines and found this was up to date and comprehensive. They told us they had received training in medicines management and administration and had competency assessments at least six monthly with the Head of Care. We observed staff administering medicines to people in a patient manner, always asking for variations of consent, which depended on the individual. Staff did not hurry the medicines rounds and we found the Medicines Administration Records (MAR) were up to date and complete.

There was a procedure in place for the covert administration of medicines although no one was receiving covert medicines at the time of the inspection. Covert medicines administration is when essential medicines are hidden in small amounts of food or drink and given to people. In people's care plans there was a medicines consent form which is good practice. There were suitable systems in place to ensure other prescribed medicines such as nutritional supplements and topical creams were provided to people. Care staff told us they were aware of which routine topical creams should be applied for each person.

People told us they felt safe. One person said, "it is a nice place with nice people". A visitor told us when they were unable to visit they did not worry because they were confident their relative was safe and they would be contacted if there were any concerns. Without exception all the people and visitors we spoke with were sure they or their relative was safe at Knights' Grove. Staff told us about actions they had taken to make people feel safe.

The provider had appropriate policies in place to protect people from abuse. One of these policies was the "Speak Up" policy which enabled staff to report any concerns they had. We heard that staff had used the policy and that their concerns were taken seriously and addressed. Staff said they would have no hesitation in reporting abuse and were confident the interim manager and provider's representatives would act on their concerns. One staff member told us, "I've had safeguarding training and I know what to do. I would make sure the person was safe and report my concerns to [the manager] if I saw something was wrong". They added that they were confident the interim manager would take the necessary action but knew how to contact the local safeguarding team if required. There were notices around the building about the importance of staff awareness to signs of abuse and the process for reporting safeguarding matters. The interim manager was aware of the action they should take if they had any concerns or concerns were passed to them. The interim manager and provider's representatives followed local safeguarding processes and had responded appropriately to allegations of abuse.

People and visitors felt there were usually enough staff. One visitor told us "Staffing levels are adequate all day". The visitor indicated that staffing was also adequate at weekends when other family members visited. Another visitor said "Sometime there are not enough staff and they have to get agency staff in every now and again. There are less staff at weekends but this does not affect the care [my relative] gets. It does make it harder to get in and out at the weekends if you do not know the door code and need to wait for staff; fortunately I have been given the code number".

Staffing levels took into account the people who were living at the home and the level of support they needed. The interim manager had identified there were certain times of day where people needed more

support and had rostered on an additional "twilight" staff member who worked from early evening until 11pm. The interim manager was clear that when extra staff were needed, the funding was made available and additional staff were on shift. One staff member told us how staff had given feedback to the management that more staff were needed in a specific part of the building and extra staff were now on duty to ensure people's needs were met. Absence and sickness were covered by permanent staff working additional hours or the use of regular agency staff. This meant people were cared for by staff who knew them and understood their needs.

The provider had safe recruitment procedures in place, which included seeking references and completing checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We found these checks had been completed before new staff started working with people.

Good

Is the service effective?

Our findings

People told us they received the personal care they required in a way that met their preferences. One person said "I can choose between a bath or a shower, every day if you want it". Another person said they were able to have a bath or shower whenever they wanted, "they [care staff] are very good at that type of thing". A third person told us "I can get up or go to bed whenever I want". Before providing care, staff sought consent from people using simple questions and gave them time to respond. Care staff told us how they offered choices and sought consent before providing care. One said "We ask them, 'would you like a bath or shower?'. If they said no, we don't do it but try later. We would document and review or try a different staff member." Staff provided people with choices and respected their responses. For example, at lunch time people were offered choices about where they sat for their meal and what they had to eat.

Some people living at Knights' Grove had a cognitive impairment and were not able to give valid consent to certain decisions, including the delivery of personal care, the administration of medicines, the use of bedrails and the use of pressure relieving mattresses. Staff therefore made these decisions on behalf of people in consultation with family members. Staff members explained that if the person did not have the capacity to make a decision about the care and support they were receiving then they would need to do what is in the person's 'best interests'. They added they would complete any relevant risk assessments to determine that the proposed action was the most appropriate and least restrictive option. Staff gave an example of a best interests meeting which was held to decide whether a particular medicine could be given to a person.

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. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. Some mental capacity assessments were not decision specific although the interim manager told us that the Head of Care was working through these to ensure they were all up to date. Staff understood the Mental Capacity Act (2005) and their responsibilities within this. One care staff member told us "MCA is about whether a person can make a decision or not, if they have capacity, you support them, give them advice [to inform them]. If they lack capacity, you have more of a role." They then gave an example of choice, explaining how they would show items of clothing to help the person make a choice.

Care files contained details of relatives who had the legal powers to make decisions on behalf of some people. We found that where appropriate people had information about resuscitation in their records. Most of these had been signed by the person themselves. Others had been signed by relatives showing they had been involved in discussions about end of life care. People can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We found the provider was following the necessary requirements and DoLS applications had been made with the relevant local authority where necessary.

People received the personal care and health care they required. One person said "they [the staff] look after you well. The staff are very good, attentive and help you a lot". Another person said "the care has always been good and consistent". A visitor told us they were happy with the way their relative's personal care needs were met. They said "[relative's name] always looks well presented, like they would be if they could do it for himself". The relative also confirmed that health professionals were contacted when required.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. Where people had specific health needs such as diabetes this was managed safely. Nursing and care staff described how they supported people which reflected the information in people's care plans and risk assessments. Care staff in the residential area of the home told us they completed a form which asked a number of questions if they thought people were becoming unwell. This was given to the nurse on duty to consider. Staff also said they could call the doctor out themselves if this was more urgent. Staff were aware of action they could take to help identify if a person was unwell. For example, they said that if a person became confused, they would test their urine for infection. People were supported to access other healthcare services when needed. People were seen regularly by doctors, dentists, opticians and chiropodists as required.
The head of care and interim manager told us they had identified that wounds were not always being managed appropriately. As a consequence nursing staff had received wound management training in April 2016 from a local tissue viability nurse. The head of care said they would be monitoring wound care closely until they were satisfied that nursing staff were managing these effectively.

People's nutrition and hydration needs were met by staff who had time to support them to eat, when necessary. One person told us "The food is good". Another person said "food is good here; I get a choice for lunch". A visitor said, "we have been told that [resident's name] has been eating better. I can see that they are putting on (a little) weight". Most people appeared to receive the appropriate amount of support and encouragement to eat and drink. Staff, including kitchen staff, were aware of the specific needs of individual people. For example, a staff member correctly told us a person required their meals in a softer texture and their drinks thickened to a specific consistency. Meals, including those which had been pureed were pleasantly presented. Staff were attentive to people and whilst promoting independence noted when people required support. For example, we observed one person finding it difficult to eat with a fork and staff offered them a spoon which they accepted. Where people required more support this was provided patiently, giving people time to finish their mouthful before they were offered more.

Drinks were available throughout the day and staff prompted people to drink. A staff member said "Every time we go into a room, we offer fluids". We noted one person who the GP had recently reviewed and recorded 'encourage fluids' however, their records said that they had not been offered a drink between 8.30 and 11.10 am. The nurse said they did not think this was a recording error and would speak with the care staff about this. Staff monitored the weight of people each month or more frequently if required due to concerns about low weight or unplanned weight loss and nutritional risk assessments were in place.

People were cared for by staff who had received appropriate training. New staff completed an induction which covered a range of training. Training was provided either in house or through external training providers and staff were positive about the quality of the training. One staff member told us "There is a new trainer. The recent moving and handling training was really good, more in depth, she showed us some tips on how to use the slide sheet. I was moved on the slide sheet and she showed us a way which felt more comfortable." The staff member also told us about the Dementia training they had completed and said it had been "Amazing, I didn't know there were so many types of dementia." The staff member added that the training had enabled them to "understand [dementia] more, understand behaviour and the type of dementia [people] have." Staff confirmed they had refresher training and could access additional training to

what was provided in house. One said "You get letters which say what you are due, or it is on the noticeboard. [Management] offer National Vocational Qualifications. Every year we have a list of college courses we can access."

Staff were supported in their work through the use of one to one supervision and annual appraisal. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. One staff member said about supervision "You can ask for training, [management] are really hot on supervision, once a month and annual appraisal. It always takes place, if you have any concerns about people, staff, you can speak to [the supervisor], or she will tell you what improvements you need to make." Another staff member said "if there any areas for improvement, they can advise you, or give you reassurance that you are doing ok. You can say any training or development you want to".

The environment was appropriate for the care of people living there. All areas of the home had been decorated and accessorised to provide a positive and suitable environment for people living with dementia. This followed the best practice guidance on providing environments which were both safe but also provided opportunities for people to explore and encouraged memories. The home was also suitable to meet the physical care needs of people with corridors, doorways and bedrooms large enough for the use of any specialist equipment required. All bedrooms were for single occupancy and had ensuite facilities of at least a toilet and wash hand basin. Individual bedrooms had been personalised to meet the preferences of the person living there. People were able to bring in items of their own including furniture to make their rooms feel homely and familiar. One person said, "I am proud of my room – it has pictures hanging up, my memories". A visitor told us that their relative's room was "decorated to her taste and is homely". This would help people with dementia to settle in and feel at home. People had access to an enclosed garden which we were told was popular in the warmer months.

Good

Is the service caring?

Our findings

People were consistently positive about the way staff treated them saying that all the staff were kind and caring. One person said "they [staff] are very nice". When asked if they thought the staff were caring another person said "yes". Relatives also felt staff were caring. One said "They [the staff] are always very friendly". We observed staff on the three floors supporting people with their meals in ways that were kind and patient. Staff did not rush people and they spoke with them about the food and how it was prepared. This ensured, where people were being supported to eat even in their own bedrooms, they enjoyed a social occasion rather than a task being completed. We observed a staff member assisting a person with a drink. The staff member and the person were having a laugh about the drink and held other conversations that were amusing. Other people in the room were enjoying the banter.

We observed staff over the whole course of our inspection and found staff were caring and kind. Staff spoke to people in a respectful but friendly manner and people responded the same. Staff had a good awareness of people's needs and there was a great deal of warmth between staff and people. Staff responded to people in a caring way that also protected their dignity. For example, a person had a continence need. The care staff member provided prompt assistance without drawing attention to the need. A person who was asleep was gently woken by a care staff member holding her shoulder and saying, "[person's name] you gonna start eating your lunch". The person started to eat their lunch. When staff were clearing plates at the end of the meal we saw that if there was food on the plate they asked the person if they had finished before the plate was removed.

Care staff were observant and provided support to people without restricting their independence. We observed a care staff member tell a person which way they needed to go from the dining room to find their bedroom. This allowed the person to find her own room independently. On another occasion we heard a person say to a care staff member that everything was blurry. The care staff member asked the person if they would like them to go and find their glasses, the person agreed. They were able to eat more successfully when their glasses arrived and this also demonstrated that staff knew the person usually wore glasses.

Care was individual and centred on each person. People received care and support from staff who knew and understood their history, likes, preferences and needs. Staff said "We know everyone well, their lifestyle. Their care plans have 'My Story' which tells us about their jobs, preferences, family tree." They also described how they encouraged families to help with the memory boxes outside bedroom doors. We saw these contained various items relevant to the person and their life story. Another staff member told us "We've all got a really nice friendships with the residents downstairs." They described how they formed caring relationships with people and said "the way you speak to them, sitting down with them, trying to take people out for walks." Another staff member said "We chat to people, talk to them about their family". We observed a care staff member discussing relatives with a person, demonstrating that the care staff member knew about people who were important to the person.

Where people had specific religious or cultural preferences these were known and met. We were told that two people's bedrooms had been specially allocated for them to enable their beds to face in a particular

direction to meet a religious need. In addition religious items had been placed on the wall opposite the bed to further facilitate their religion. A person was being visited by a minister who was praying with them and reading from the bible. A nurse told us the minister visited people who had requested a visit, or whose families had requested he visit. People could visit church or sing hymns on Sundays.

People's dignity was protected during the provision of care. From conversations with staff and observations of the interactions between them and people it was clear that staff understood the importance of promoting people's dignity. Care staff told us "One lady doesn't like male care staff, this is in her care plan and we make sure male staff are told." Care plans identified if people had a preference for the gender of staff providing personal care. Staff described how they promoted dignity and privacy, such as ensuring doors were closed and people were covered as far as possible during personal care. One care staff member said "We knock on their door, wait for an answer. We make sure people are covered; promote independence for them to do as much as they can. We have signs to put on the door (to let anyone else know not to come in)". Another staff member described how they supported people showing they provided individualised care. They told us "one person gets very cold; we cover her up with warm clothes and reassure her. Another person is extremely private; we do personal care as discreetly as possible." We saw a notice hanging on a bedroom door handle, it read, 'Please wait, receiving personal care'. This would help prevent anyone from accidentally entering the room maintaining the person's dignity. Dignity was also protected as confidential information, such as care records, was kept securely and only accessed by staff authorised to view them.

People were supported to express their views and were involved in making decisions about their care, treatment and support. Staff described how they involved people in choices. One said "We ask them, we help with make-up and clothes, we pick some bits from their wardrobe and show them, or say, 'skirt or trousers?'". Another staff member said "We use their toiletries and perfumes. We show them their clothes; they can smile or give facial expressions that gives you a clue. We ask if they want to get up or not."

Systems, such as pictures of meal options, were available to assist care staff in seeking people's preferences. The menu was displayed in several places around the home and showed a range of choices. As well as the usual mealtime menus, there was a "Night Bite Menu" which showed people that there was a range of snacks, some cooked, which could be provided outside of the kitchen opening hours. High quality pictures of the food available showed options included fruit, toast, cornflakes, orange juice, cakes, biscuits, beans on toast, sandwiches, tea, yoghurt, spaghetti on toast and soup. Records showed people were provided with food when they wanted it, for example, one person was awake and hungry in the middle of the night and they were given a sandwich. Staff also told us that they got food for people in the night if the person required this. Some people required specialised cutlery and crockery to enable them to remain independent with eating and this was provided. Kitchen staff who were serving meals were aware of who preferred a smaller portion as a large portion would have a negative impact on their desire to eat their meal. Similarly, they also knew who had a good appetite and liked a bigger meal.

People and when appropriate relatives were involved in care planning and reviews of care. One person told us "I have a care plan and have been involved with it". A relative said "Staff involved us with care plans". Care plans contained information about people's backgrounds and family history. Family members told us they were always kept up to date with any changes to the health of their relatives. Contact with family members was recorded in care records. One relative said "they [staff] tell us of any changes, for example, the nurse rings us if [person's name] is on antibiotics". Another visitor said of the staff "all have been very good and keep us informed".

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death. We observed two care staff members sat in a room with a person who was very frail. This demonstrated that

care staff spent quality time with all residents. Information about people's preferences for their end of life care were included within care files. Nurses were aware of how to obtain emergency medicines should these be required for end of life care and had completed end of life care training.

Good

Is the service responsive?

Our findings

People told us they felt staff were caring. One person said "The care is good here, they really look after you". Another person said they were happy with the care and "[staff] are good to me". A visitor said, "the care is very good here. [Name relative] kept falling [at home] following a urine infection. Since coming here they have put on weight. I read the care plan and when I feed him I add that information to the care plan". This demonstrated that the visitor felt involved with their relative's care. A second visitor told us how they were aware of issues affecting their relatives care. They said, "I keep in touch with [resident's name] care plan. They have a special mattress and are repositioned every two hours." Another visitor told us how staff had taken prompt action when their relative had become unwell. They told us "[resident's name] was ill, they [care home staff] called a doctor and the nearest relative. It proved to be a urine infection". People looked cared for, in that they were wearing clean appropriate clothing with hair styled and those in bed looked comfortable.

Care staff said they were able to be responsive to people's needs. For example, a care staff member said "People like care differently, I ask them if they want a bath or shower, or to get dressed. One person likes to sit and chat before they get dressed." Another care staff member told us care was "Very person centred, everyone is treated as an individual, not just a resident, we care for them according to their preferences and needs, to give them the best quality of life possible." Knights' Grove had both residential and nursing care units. The residential unit provided care for people who did not usually require nursing care, although nurses would support care staff if required. The other two units were staff by both nurses and care staff and provided care for people with nursing care needs. The interim manager said people could "start in residential and then move upstairs. They can start and end, sadly, their dementia journey here." This meant as people's needs increased they could continue to receive care at Knights' Grove and would not need to move to a different nursing home.

Staff responded promptly to call bells. At a busy time of the morning we saw call bells were answered promptly. An audit was undertaken daily and any call bell which had taken longer than three minutes to answer was recorded and followed up. The time of the call was also noted so any patterns could be identified. The records showed the majority of call bells were answered within three minutes meaning people received prompt support when they required it.

Knights' Grove was well resourced to meet and respond to the needs of people living with dementia. There were various memory areas that were specific to the ages of people living at the home. There were, for example, tactile and visual experiences in most corridors where people could experience the products evident in their youth and adulthood. We were told people would often take items with them and staff would return these when found. This supported people living with dementia to explore and reminisce. Dementia was covered briefly on induction and when staff had been working at the home for a few months they attended a course entitled "Person First Dementia Second." The interim manager said everybody living at the home was living with dementia so all staff working at the home attended the dementia training. This was confirmed by ancillary staff we spoke with including the chef and maintenance staff.

Nursing and care staff were able to describe the care and support required by individual people. For example, they were able to describe the help a person required with fluids and what consistency these should be. They were also able to describe the support people required to meet nutritional needs. Staff were kept up to date about people's needs through a formal handover meeting at the start of each shift. Care plans provided comprehensive information about how people wished to receive care and support. Care plans were well organised and the guidance and information for staff within them was individualised and detailed. Care plans also included specific information to ensure medical needs were responded to in a timely way. For example, a care plan contained detailed guidance as to how often a person should be repositioned. The care people received corresponded to information in care plans. The care planning system included a section for evaluating and reviewing the care people had received. However, not all staff appeared to have a good understanding of how to use this effectively. Staff in the residential unit were completing the forms correctly and this provided clear examples of evaluation of the care people had received.

Staff responded appropriately in an emergency. They identified a person who appeared to be choking. Emergency suction to clear secretions was provided along with emergency medicine to reduce secretions. Medical observations were recorded and staff called the Out of Hours doctor who advised to "keep an eye on her". During our inspection we noted the person had loud chest sounds and wheeziness. We spoke to the nurse in charge who told us the GP had been contacted the previous day.

Activities staff explained how they provided activities within Knights' Grove. They said "we have a 'sort of weekly plan' of activities". They explained that the plan was flexible and amended according to how people were feeling on that day. For example, if the weather was good, as on the day of our inspection they would plan an outside activity. We saw some people were taken outside for tea and biscuits. A mixture of formal and informal activities were provided with afternoon activities being more structured and involving the care staff in group activities. During the afternoon we observed the 'knit and chat' activity which was a positive social experience. Activities were organised to meet people's needs. For example, activities staff told us "on the upper floors people require more sensory activities and they do not bring everyone to activities. The exception is that everyone enjoys singing. Each floor has its own dining areas which we have themed differently, for example the ground floor has a holiday theme and the top floor has an American diner theme. We take people from the 2nd and 3rd floor and occasionally give them lunch on a different floor; this is like taking them out, giving them a different experience". External entertainers such as musicians and singers were also contracted to visit the home. Advice about activities had been sourced from a Dementia specialist nurse (Admiral Nurse) who had advised "not to over-think things and just try them, if they did not work, change them". One person said "The activities are okay". Another person told us, "There is a lot to do; I can't keep up so I don't join in all the time. It is nice to be free – out of my room". They added, "people on the ground floor choose where they want to be. A visitor said, "[resident's name] goes to the ground floor for some entertainment". Another visitor on an upstairs unit told us staff got their relative up every Monday to listen to music in the ground floor lounge. In the afternoon we saw a person from one of the upstairs units was taken into the garden by staff. This demonstrated that the staff did take people, from the 1st floor, to activities and the garden on the ground floor.

People, their relatives and friends were encouraged to provide feedback and were supported to raise complaints if they were dissatisfied with the service they received. People and visitors said they would make any complaints to the manager or the nurse. No one we spoke with had ever had cause to formally complain. One visitor told us they had raised a problem and said that it was rectified immediately. Staff said people could complain and added, "at resident's meetings, we remind them who they can speak to." There were arrangements in place to deal with complaints which included detailed information on the action people could take if they were not satisfied with the service being provided. The complaints file showed that

where complaints had been received these had been investigated and the result of that investigation fed back to the person concerned.

People told us residents meetings were held every two months. The minutes of these showed people were kept informed about any changes in the service and asked their views about aspects of the service such as meals and activities. We saw a survey of relative's views had been undertaken. There was a notice board detailing the action that had been taken as a result of the survey. Staff told us there was an annual staff survey and following this they were informed about the outcome. Staff told us about the provider's "2020 vision". They explained this was what the provider hoped to achieve by 2020.

Good

Is the service well-led?

Our findings

The service did not 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 provider had appointed a manager with a view to their registering with CQC. Shortly before the inspection the provider had arranged for an experienced temporary manager to take over running the home whilst the longer term management arrangements were determined.

The interim manager had identified various aspects of the service which required improving and showed us their action plan. We saw that this included dates for actions to be completed and was being kept under regular review. For example, they had identified that recruitment processes and inductions had not been managed according to the provider's policy. They had therefore re-interviewed all staff recruited since November 2015 and ensured all aspects of the induction process had been followed. The interim manager was supported at least one day per week by a regional support manager. Both the interim manager and regional support manager were present throughout the inspection. Discussions with them showed they had a good understanding of the service, staff and people living at Knights' Grove. Staff told us they felt supported by the interim manager and that they felt optimistic about the future. The interim manager was supported by a head of care who was a qualified nurse. We observed the head of care interacting with nurses and care staff and found the relationship between them was supportive. Senior staff and the registered nurses attended a brief review meeting each morning so that they had a good understanding of the key events and issues in the home that day.

People felt the home was well run. A person said "There is nothing bad about this home". Another person was asked what they would change. They replied, "I like things the way they are". A relative was able to identify who was managing the service and said they would feel confident to approach them if they had a need to do so. Staff described the management team, including head of care and interim manager as "Approachable"; they said they felt comfortable to speak up; felt "respected and not penalised or treated differently". Staff said they felt the management team wanted the best for their staff, "If we have issues, they're happy for us to voice them". Staff told us there were regular staff meetings to discuss issues and for "us to be heard." There was a whistle blowing policy in place, which staff were aware of. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations.

There was an open and transparent culture within the home. A relative said that periodic meetings were held with the families. Visitors were welcomed, there were good working relationships with external professionals and the provider notified CQC of significant events. Following a safeguarding concern the management team had notified people and relatives about the issue under their duty of candour policy. Staff told us "It is a nice, friendly place, clean, person centred, dementia specialised. We can speak to [head of care], or we could go to [interim manager]." Staff added that the management were open, honest, and the door was always open. They said they felt they could take ideas to staff meetings or directly to the

management. For example, staff had identified that improvements were required in the way activities were organised and had produced an action plan. This included, for example, monitoring people's access to fresh air and for new staff to spend time with activities staff as part of their induction.

The interim manager was developing links with the local community. People were supported to use facilities in the local community. The Activities Coordinator said, "We have joined the local library, we take some residents to the Library where we get audio books and music, so there is something different everyday". There were also links with the local church with some people attending Sunday services and visits to the home from the Vicar. The local Admiral nurse (dementia specialist nurses) had been invited to the home to provide advice and guidance about the environment and activities.

Auditing of all aspects of the service, including care planning, medicines, infection control and staff training was conducted regularly and was effective. The provider had a quality assurance and clinical governance system which directed managers as to the areas they should audit throughout the year. Other quality indicators, such as infections, accidents or incidents, could be directly viewed by the provider's senior management team via an information technology system. Systems in place meant that any accident or incident reports were seen by the manager. They described how they would discuss these further with nursing or care staff if necessary and ensure risk assessments and care plans were amended. We saw how the March 2016 quality matrix included the identification of a medicines error. Action was taken to reassess the competency of the staff member involved and the person's family and local safeguarding team were informed. We identified that some staff were not completing the incident forms for all occasions where this was required meaning that the interim manager was not aware of all incidents. This meant it was not possible to accurately monitor incidents and to ensure learning took place around these. The interim manager told us they monitored the quality of service daily by "walking the floors". This gave them the opportunity to talk to people, visitors and staff as well as observing interactions and care in communal areas.

The interim manager and area support manager were aware of key strengths and areas for improvement for the service. They had already taken action in respect of some of these such as arranging wound care training for nursing staff. We identified areas which could improve the service; the management team acknowledged these and suggested appropriate action which they planned to take to address these areas. For example, we identified a person who was regularly having their hand redressed at around 5am. There was no information either within care records or from the interim manager or head of care as to why the dressing was being undertaken at this time. The interim manager stated they would take action to investigate this and ensure wound care was undertaken at a more reasonable time.

The provider had an extensive range of policies and procedures which had been adapted to the home and service provided. We saw these were available for staff in the nurse's offices. We were told any new policies were reviewed internally by the manager before being put in place to ensure they reflected the way the home was working. This ensured that staff had access to appropriate and up to date information about how the service should be run.