Aegis Residential Care Homes Limited

The Knights Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 06 April 2016 and was unannounced.

The service was last inspected 27 September 2013. At that inspection we found the service was meeting the legal requirements in force at the time. We made some recommendations for the provider to consider which included ensuring hand written medicine administration records were double signed to avoid transcription errors. We also recommended the provider to ensure they obtained two references before staff were appointed to work at the home. We checked to see if these recommendations had been taken on board and found the home had followed the recommendations.

The Knights provides accommodation for up to 31 people, who require help with personal care needs. The home is situated close to the centre of St Anne's on Sea and is within easy reach of public transport, the beach and local amenities. Accommodation within the home is situated on three floors.
There is a passenger lift and stair case providing access to the upper floors. Comfortable communal areas, such as lounges and a dining room are available. A limited number of car parking spaces are available to the front of the building on a private forecourt, but on road parking is also permitted.

The registered manager was present throughout our inspection. 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 and associated regulations about how the service is run.

At the time of this inspection there were 18 people who lived at The Knights.
We looked at how the service protected people against bullying, harassment, avoidable harm and abuse. We found that some staff had received training in safeguarding adults and demonstrated a good understanding about what abuse meant.

We found safeguarding incidents had been recorded. The provider had recorded accidents and incidents and documented the support people were getting after experiencing falls. We found evidence staff had sought advice from health professionals.

We found people's medication was being managed safely however plans [protocols] for "as and when medication (PRN) were not robust". Staff had received appropriate medication training.

We found there was a building fire risk assessment on the premises.
People had Personal emergency evacuation plans (PEEPS) which were meant to enable safe evacuation in case of emergency however we found these were not accurately completed and did not give accurate detail on whether people could walk independently, require assistance from staff and where people would be evacuated to.

Staff were suitably recruited and there were enough staff to ensure that people's needs were safely met. There was scope within the staffing levels to keep checks on people's welfare and, when necessary, to provide extra care and support.
We found evidence of staff disciplinary actions being recorded.

The staff showed awareness of Mental Capacity Act, 2005 and how to support people who lacked capacity to make particular decisions. However we found the knowledge was not sufficiently turned into action when planning for care and supporting people on a daily basis. Staff were provided with effective support, induction, supervision, appraisal and training.

We found that people's health care needs were not effectively assessed on admission to the service. Consent was not always sought from people. The home did not consistently involve people in decisions made around the care they received. Care plans did not evidence people's involvement. However the home had a key worker policy in place. The service did not regularly seek people's opinions on the quality of care and service being provided. Evidence on surveys could not be relied on as dates had been altered on surveys before our inspection.

We found evidence of management systems in the home however quality assurance was not effective in order to protect people living at the service from risk. Areas needing improvements were identified by audits however these were not always followed by appropriate action.

People felt they received a good service and spoke highly of their care workers. They told us the staff were kind, caring and respectful. Many people appreciated having their privacy and independence whilst being secure in the knowledge that staff were available when they needed them.

We found the service had effective systems to deal with complaints about care and treatment. However we found people did not feel their suggestions were taken into consideration.
Staff were positive however they reported a negative culture existed among the staff team.

The quality of people's care and the service were continuously monitored to ensure the provider's standards were maintained however management were not prompt in resolving maintenance around the service and audits were not always used to improve the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These included; Regulation 9- person centred care, Regulation 11 – Need for consent, Regulation 12 – Safe care and treatment, Regulation 13 (4) (b) (5) Safeguarding service users from abuse and improper treatment, Regulation 15 – Premises and Equipment, Regulation 17-Good governance, You can see what action we have taken at the end of this report.

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 consistently safe.

People's personal evacuation plans were not accurately completed to facilitate safe evacuation in cases of emergency. People were not appropriately assessed for use of bed rails and risks around premises were not resolved timely.

We found sufficient staffing levels met the needs of people who lived at the service. Robust systems were in place for recruitment of staff. People were safeguard after experiencing falls.

We found some shortfalls in medicines management.
We found infection control measures were not effectively implemented.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not supported in line with the Mental Capacity Act 2005 to ensure that their ability to consent was appropriately assessed prior to decisions being made on their behalf. Consent was not consistently sought before care provision.

There were effective systems in place to ensure that people received nutrition and hydration appropriate to their needs.

Staff were receiving training and supervision regularly.

Is the service caring?

Good

This service was caring

There was positive engagement between staff and people who lived at the service. The systems and procedures operated at the home were designed to enable people to live their lives in the way they choose, so that they can be as independent as possible.

People's dignity and respect was promoted. The standard of personal care people received was found to be satisfactory.

People were not consistently involved in their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There were a variety of meaningful day time activities and people's independence was promoted and Social Inclusion was not widely promoted.

Care planning was not consistently person centred and transition between services was not adequately facilitated and Care plans were not amended accurately to show people's changing needs.

People's complaints were dealt with effectively.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a negative staff culture. We found management structure's awareness of people's needs was limited and management did not act promptly to resolve known risks within the service. Audit and monitoring systems in place however these were not being implemented effectively.

The service was sending statutory notifications to CQC however not consistently.

The Knights 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 06 April 2016, and was unannounced.
The inspection team consisted of two adult social care inspectors including the lead inspector for the service. Before the inspection we reviewed information from our own systems, which included notifications from the provider and safeguarding alerts from the local authority.

We gained feedback from external health and social care professionals who visited the home. As part of this we looked at safeguarding alerts we received from Lancashire County Council Safeguarding Enquiries Team and had received regular updates from other associated professionals at the local authority. Comments about this service are included throughout the report.

Before the inspection we had received concerns from other professionals, this had been shared with the local authority safeguarding team for investigation. We used the information from these concerns to focus on some specific areas during this inspection.

We spent time talking with people who lived at the home and where possible their relatives, reviewed records and management systems and also undertook observations of care delivery. We spoke with six relatives, five people who used service, the registered manager, four professionals who had visited the service and five care staff. We looked at four people's care records, staff duty rosters, four recruitment files, accident and incident reports book, handover sheets, records of staff meetings, residents and staff surveys, management audits, service policies, medication records and service maintenance records.

Requires Improvement

Is the service safe?

Our findings

We asked people who lived at the home whether they felt safe. People told us they felt safe living at the home. One person we spoke to told us, "I feel safe and content". One relative told us "She is safe here definitely". Another relative said "He is safe here, safer than the last place he was".

We spoke to professionals who told us they had concerns with how people's skin and pressure areas were managed. They informed us they had raised safeguarding concerns with the local authority due to these concerns on a number of occasions.

Staff knew how to keep people safe and how to recognise safeguarding concerns. They had a clear understanding of the process or procedure to raise any safeguarding concerns for people. This meant people could be assured that staff would raise safeguarding concerns if they noticed someone being ill-treated. We found staff had received training in safeguarding adults from abuse. Five staff spoken with during the inspection demonstrated an understanding of safeguarding procedures and their roles within both provider and national safeguarding procedures. This meant the provider had provided staff with necessary training.

We also found instances where staff had been alleged to have provided unsafe care were dealt with appropriately. The home followed their own organisational policy to ensure staff were investigated and people involved were informed of the outcome.

We looked at how people's risks were managed. We found people's risks were not sufficiently managed to avoid harm. Risk assessments were not robust and did not reflect people's needs. For example we found one person's records showed their risk of falls score had not changed since October 2015, this was despite the fact that this person had experienced further falls from their bed and had been put on falls monitoring equipment. Records of care had not been updated to guide staff on the level of risk associated with this person and what precautions staff had to take.

We looked at another person's file and found they had been in hospital for a month however when they returned to the service, their plan of care was recorded as "no changes". We spoke to the registered managed and they informed us this person was discharged with mobility aids, needed two staff to support with transfers, was discharged with a hospital bed and their mobility had deteriorated and needed hoisting in some instances. We also found staff were using bed rails on this person. This meant that this person's needs had changed since their hospital admission however there was no evidence their needs were reviewed adequately as staff had recorded "no changes in two consecutive months. Therefore people were placed at risk as they could not be assured that they would receive appropriate care when their needs changed.

Risks to people from receiving care were managed however we found some shortcomings. We found people's needs were being assessed and staff recorded care being provided. Where risk assessments had been carried out, actions to mitigate the risks were carried out. However we found this was not consistent

throughout the people we looked at.
For example, we observed one person who had been sitting in a wheelchair from the time we arrived in the morning till late afternoon, we spoke to carers and the registered manager regarding this person and the risks associated with this practice, they however informed us this was a specially adopted chair for this person and they were safe to seat for long periods in it. We asked for care plans and assessment to support this however this had not been documented as recommended by an Occupational Therapist.

We also observed staff were using bedrails to support this person, we looked to see if there has been any risk assessment and consent for this piece of equipment however this had not been done. Staff we spoke to informed us that bedrails were widely used within the home and that at least three people had bedrails however when we spoke to the registered manager they informed us they were no bedrails being used. Prior to our inspection we had concerns regarding previous incidents where people had put themselves at risk with bedrails within the home. We found this lack of consistency on use of bedrails meant that people were placed at risk of harm as we were not assured these restrictions had been assessed correctly and were a proportionate response to mitigate any risk of harm to people.

This was a breach of Regulation 13 (4) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we witnessed staff assisting one person to move from a chair in an unsafe manner. This person's mobility risk assessment and care plan stated they required two people to assist them however one member of staff had been assisting resulting in use of unsafe practice. We discussed this with the registered person who confirmed this person's care plan had not been followed. The registered manager informed us they would ensure all staff would receive refresher training on moving people safely. This meant that the home did not have robust measures to assess risks and recognise where people can be placed at risk during provision of care.

We looked at the premises and found there were obstacles around the home which had a potential of causing trips and falls and obstruction in emergency evacuations. We also found structural hazards caused by a collapsed ceiling which had not been repaired in a timely manner. The hazards were affecting one person's bedroom as there was a visible crack inside their bedroom which appeared after the collapse next door. We asked the registered manager to check if the ceiling was stable and they informed us after the inspection that builders had checked and felt it was safe. We found this hazard had existed since December 2015. We also found the provider's own audit of the environment had identified the risks before the inspection however this had not been a acted upon.

This was a breach of Regulation 15 (1) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people's medicines were managed and found medication administration was safe however medicine management systems as a whole were not robust. For example, we found care plans for "as and when medication" (PRN) were not completed accurately to provide staff with adequate guidance on when to offer people medication. For example, two people's PRN plans [protocols] did not say what the medication was for. We also found in some PRN plans [protocols] information was inaccurate with instances where male residents were referred to as "she".

In another example we found PRN medication was not signed at all. We could not tell whether people had been offered this medication and refused or not offered medication at all. This meant that people's PRN medication was not adequately managed and people could not be assured they would receive their

medication safely when they needed it.

This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people were supported when moving between services. People's care plans did not contain important information they needed if they were being transferred to hospital or other services. Regulations state that people's details such as their health and social care needs, allergies and medication are recorded and ready for when they need to be shared with other professionals. We spoke to the registered managed regarding this and they showed us some details they had kept however this was not equivalent to detail required on hospital passports and did not provide enough detail. Lack of these important details had a potential of adverse impact on people. This meant these people were at risk of not being effectively supported if they were to be transferred to another service or hospital.

We looked at how people would be supported in the event of emergencies. We found people had personal evacuation plans (PEEPS) in place for staff to follow should there be an emergency however these plans were inaccurate and we found them not fit for purpose. We found these were not accurately completed and did not give accurate detail on whether people could walk independently, require assistance from staff and where people would be evacuated to. For example one person's PEEP which had been recently completed stated they were able to walk unaided. It also stated this person could get out of bed and chair unaided. However when we looked at this person's mobility care plan and observed them being supported by staff, we found they needed assistance from two carers to transfer from chairs and bed and could needed to transfer with a hoist in some instances. This person used a wheel chair to move about.

In another person's care record we found their mobility care plans stated they were no longer able to walk, their risk assessment stated they could walk with a zimmer frame and their PEEP stated they were able to walk unassisted.
The PEEPS we saw did not inform staff where the evacuation point was and how to support people who may not understand the need to move out of the building in case of emergency. This meant that the services had not put sufficient measures in place to establish what assistance each individual required and people could not be assured they could be evacuated in a safe and timely manner during an emergency.

This was a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people were protected by the prevention and control of infections. We found the service did not have effective infection control measures in place. For example we found in the bathroom the yellow clinical waste bin was placed at the top of the bath tab. Which meant staff and people who use the service could not access this bin when they needed it. In the bathroom cabinet we found used clinical gloves that had been disposed. We also found cleaning chemicals in an unlocked cupboard and some medication which has been prescribed in 2011.

We found soiled continence pads outside one person's bedroom door and these had not been placed in a protective plastic bag. In one person's bedroom we found the bedroom had been soiled with faeces and staff had not cleaned the room until mid-morning. This meant that this person was able to go in and out of their bedroom and potentially spread contamination.

This was a breach of Regulation 12 (2) (h), Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people were protected when accidents and falls happened. We found the provider had effective processes for reporting or recording accidents or incidents and had monitored, responded to issues to reduce the risk of reoccurrence. Accidents and incidents were recorded and staff sought advice from health professionals to ensure people had appropriate after care. For example one person who lived at the home suffered a fall; staff contacted 111 services and sought some advised to determine whether hospital admission or a visit by paramedics was required. Records we saw showed observations had been carried out after the falls.

We found attempts to analyse the accidents and incidents had been made however, the recording was not identifying how to reduce the re-occurrence of the accidents. For example one record we saw had recorded details about the accidents in the section where staff were supposed to put details on what they had done to reduce the accidents. This meant that the system of learning from accidents and risk minimisation was not sufficiently implemented.

We looked at whether the service had sufficient staff to meet people's needs. On the day of inspection we found there were sufficient numbers of staff. We asked people about staffing levels and we got mixed reactions. Some people told us there was sufficient staff to meet their needs. One relative said, "They are always prompt." However one relative told us "I think they are pushed staff wise". Another person who lives at the home told us "Staff are stretched because we have no domestics" and "We are supposed to have keyworkers speaking to us but I do not see them". This was supported by another relative who told us, staff seem to be stretched due to doing other domestic chores. We asked staff if they felt the home was staffed sufficiently enough to meet the needs of people they cared for. Some staff told us the service was well staffed and if additional staff was needed the registered manager organised staff to support.

We asked professional regarding staffing levels and we had some mixed reactions. Some professionals said, "You can never find staff when you go in there" and "They are either outside or back of the dining room". Another professional told us, "I don't have issues with staffing levels when I go in there". During the inspection we discussed staffing with the registered manager who informed us they have vacancies for domestics that they are in the process of recruiting for.

We found the home had a formal system to assess when people's needs had deteriorated and when more staff were needed. We spoke with the registered manager regarding the system they used to determine staffing levels. They were able to demonstrate to us how they formally determined staffing needs. We found the service was using regular staff and if they have shortages they preferred to use staff from their other care homes instead of agency. The registered manager informed us this has helped the service to maintain consistency.

We looked at whether the home followed safe recruitment practices. We found the service followed safe recruitment practices. We checked staff files and we found they were well organised, which made information easy to find. All the files we looked at contained evidence that application forms had been completed by people and interviews had taken place before an offer of employment. At least two forms of identification, one of which was photographic, had also been retained on people's files. Staff members we spoke with confirmed they had been checked as being fit to work with vulnerable people through the Disclosure and Barring Service (DBS). This meant the provider followed safe recruitment procedures that helped to protect vulnerable adults.

Requires Improvement

Is the service effective?

Our findings

We asked people who lived at the service and their relatives if they felt staff were competent and suitably trained to meet their needs. One relative told us, "They have been prompt to seek assistance" and "They keep me informed of what is happening." Another relative gave us a different view on this and said, "I ask questions and never get answers" and 'they are never in their own clothes'. However the majority of people we spoke to felt that the home was effective.

We asked a visiting professional for feedback. They told us, "The home seems to be trying hard to promote independence and wellbeing." Another professional told us, "They cannot sustain changes we suggest; we find we have to repeat ourselves constantly". They also added "We can never find care records, they go missing".

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 make 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was not working in line with the key principles of MCA. This included the inability to complete mental capacity assessments. For example, there were people with fluctuating mental capacity to make decisions around their care were not free to leave the home and could not come and go as they wish. We found the home operated a locked door which was operated by a key pad. Some people were unable to operate this key pad and did not have the code, which meant they were unable to leave the service freely if they wished to do so. Where these people were deemed to be unable to go out safely due to a lack of mental capacity, suitable authorisations had not been sought from the Local Authority in line with Mental Capacity Act. These people were also subjected to continuous supervision and control. Where people are restricted in this way the law requires the provider to apply for authorisation from the Local Authority to ensure the restrictions are lawful.

In another example we found one person's mental capacity had not been considered. This person's care included some aspects which could have been restrictive, such as the use of bedrails. However, there was no capacity assessment or consent in place and no evidence that best interest decisions had been made through specific meetings and discussions between all those involved in this person's care.
This was a breach of regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

Records showed that arrangements to obtain consent from people who lived at the home were inconsistent. Staff did not always obtain valid consent from people who lived at the home. The plan of care for one

person showed that consent for medication management and taking photographs had not been signed. There was no evidence of the person's relatives being involved. Another person's care involved the use of a pressure mat to monitor their movements and alert staff if they were out of bed. Although this was a positive way of managing risk, the person involved or their family had not signed to say they consented with this practice which could be seen as restrictive and constant monitoring. We found no mental capacity assessments for any decisions for this person.

We looked at training records and found staff and the Registered Manager had completed training to help them understand the principles of the Mental Capacity Act, 2005. Staff showed a good awareness of people's rights however this was not sufficiently demonstrated through practice and record keeping. Some staff we spoke to informed us they did not feel it was their role to consider mental capacity. We spoke to the registered manager who informed us they will consider arranging further training for all staff and will ensure all staff understand the importance of formally recording people's consent.

We found the registered person had not ensured people's rights were always protected, because consent had not been obtained through best interest decision making processes before the provision of specific areas of care. For example we found in people's care records the registered manager had recorded restrictive practice forms for locked doors and use of monitoring devices and stated that this was in people's best interest. However we could not find evidence to show that people lacked mental capacity or any evidence of best interest meetings. For one person the information was contradictory as we had found records showing the person had capacity however decisions were being made for them.
This was a breach of regulation 11(1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014- Need for consent.

Staff had received supervision and appraisal regularly and in line with the organisation's policy. We found staff meetings were undertaken regularly and staff told us they found these helpful in understanding where the service was going.

We found training had been undertaken for key areas of the service, for example moving and handling training, safeguarding, mental capacity, managing nutrition and first aid training. Staff we spoke to showed awareness of people's needs and how to respond.

We found the provider had suitable arrangements for ensuring people who used the service were protected against the risks of inadequate nutrition and hydration. We found snacks and drinks were readily available throughout the home and people were helping themselves. Nutritional care records we looked at showed some people who had been assessed as at risk of malnutrition had been referred to specialist services such as dietetics, however this practice was not consistent throughout the care plans we looked at. We spoke to a professional who informed us they had concerns regarding the management of hydration in the home. They informed us they had raised safeguarding concerns and made suggestions to staff and things had improved.

We observed people eating during lunch time. We saw people were offered choice and encouraged to eat. The atmosphere was relaxed and people seemed to enjoy their meals. People's views on meals were positive. One person told us "They are good but not the best however they always offer alternatives". A relative told us, "I require special meals and they get them for me". The menu was displayed in the home and people could choose what they wanted to eat. We found evidence surveys were completed for people to have a say about the food and menu.

We looked at how people were supported to maintain good health, access health care services and received on going health care support. We found the service had measures in place to ensure people were referred to

specialist professionals. We saw evidence of referrals to mental health services, dieticians, district nurse's and people's doctors. We found this was done in a timely manner to ensure people received suitable care in a timely manner. However we found evidence where staff where had been advised by a relative to alter care guidance provided by a professional. We spoke to registered manager and they informed us staff were aware that they should refer back to professionals and not to follow relatives guidance.

Good

Is the service caring?

Our findings

We asked people if the staff team were caring. People told us, "They are absolutely brilliant". Another person said, "They get the basics right" and "Yes I think they are all very nice". Another person told us that although they found the care staff to be kind and helpful, they were often unable to provide answers to relatives promptly.

During the inspection, we observed staff interacting with people in a kind and compassionate way. We heard meaningful conversations taking place between people. People appeared to be very comfortable with staff and staff knew people well. We saw members of staff working, providing consistent care and support to people.

We observed some positive interaction between care staff and people who used the service. We noted that care workers approached people in a kind and respectful manner and responded to their requests for assistance. People were referred to by their preferred names.

We spoke to professionals who visit the home and they informed us they felt staff were caring and they witness a warm relationship between carers and people when they visit. One professional who visits the home regularly told us, "The residents do appear to be very happy there and well cared for. It is clean and tidy when we are present and the staff are always well presented".

We looked at how the service support people to express their views and how they are actively involved in decisions about their care treatment and support. We saw evidence people were asked about their views regarding meals. The provider had carried out surveys regularly to ask people for their suggestions around meals. We however did not find evidence people had been actively involved and consulted about their care and treatment. We spoke to three people and asked if they had been involved in their care planning and review and they told us they had not been involved. We also spoke to relatives and asked them if they had been involved. Some informed us they had not been actively involved however they felt they were free to approach staff if they had suggestions.
One person told us, "I would like to sit down with my key worker now and again".

We looked at how people's privacy and dignity respected and prompted. People we spoke with told us they could get up and go to bed when they wished and they said their privacy and dignity was respected by the staff team. We observed this and found this to be true. Plans of care we saw outlined the importance of respecting people's privacy and dignity and promoting their independence. A staff member we spoke to told us how they would respect people's dignity. They told us, "Our residents are our family" and "We treat people like how we want to be treated". We spoke to relatives and they told us, "Staff are respectful and people's dignity is always respected". Another person said, "They speak to them gently and very nice".

We were able to see people's rooms and the rooms we saw were personalised with their own possessions.

Requires Improvement

Is the service responsive?

Our findings

We asked people who lived at the service if they felt their needs and wishes were responded to. One person told us, "They are improved" and, "They are receptive and I feel confident with them".
One relative told us, "Stimulation is great" They keep people occupied with activities every day. Another person told us, "They know my conditions I'm confident with them".

We spoke to a professional who visited the home and their views were mixed. One professional told us, "They are reluctant to take guidance and change" and "They either listen to you briefly then go back to their ways or they get defensive". Another professional however said the team seemed very committed.

We looked at how the service provided person centred care. We observed evidence of person centred care by the way staff were interacting with people during our inspection. Staff treated people as individuals when they interacted with them. We however found personal preferences were not always taken into consideration. For example we looked at some care files and found staff were able to describe people's needs however they could not evidence what would work for different people. There were no instructions for staff to follow as preventative measures. We looked at care plan reviews and found them to be generic and not recorded in a person centred manner. For some people reviews stated "as above" for months even when people had been discharged from hospital and their needs had changed.

We looked at the plans of care to see if they were written in a person centred way. However we found the care records were not consistently person centred. For example one person's file recorded that this person presented some behaviours that could be seen as challenging by others however there was no mentioning on what staff could do to ensure this person can be supported. We found care records focused on this person's behaviour without mentioning how they can be best supported.

We found another person's file mentioned their needs had remained the same when they had returned from hospital with significant changes to their physical health needs. Information recorded in their file was inconsistent and could not clearly guide staff what this person could do.

We also found one person had been put on behavioural monitoring charts which are meant to monitor a person's behaviour to inform what support they needed for their mental health needs. We however found although this person was on behaviour charts, there was no assessment of their mental health nor was there a mental health care plan and risk assessment.

We also looked at how the service assessed people before they were admitted into the home. We found pre-admission assessments had been completed however not consistently. For example some people had pre-admissions which were fully detailed and reflected the support they needed before admission. However some people did not have pre-admission assessments but had pre-admission care plans. We could not ascertain where information to complete the care plan was obtained without a pre-admission assessment. The registered manager could not explain to us how they completed a pre-admission care plan without an assessment.

We looked at how people are assured they would receive consistent co-ordinated, person centred care when they use, or move between different services. We found no evidence of information that had been completed to facilitate information sharing when people move between services. For example when people move into hospital or into a home.
The above evidence amounted to a breach of regulation 9(1) (c) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We found some evidence of involving people who lived at the service in decisions made about the general running of the home. However this had not been done consistently. We found people's views had been sought in 2014. Surveys that we were shown to have been done in 2016 had dates altered from 2014 to 2016. We could not rely on this as evidence that the service had consistently sought people's views. We spoke to the Registered Manager about this and they told us they had analysed the surveys unaware the dates had been changed. We spoke to people and some people told us they had seen some surveys for food however not about the general running of the home. This meant the provider could not demonstrate that people's voices were always heard and their opinions used to shape how their care was delivered.

We asked the manager if residents' meetings were held and they explained meetings were taking place. People we spoke to told us meetings had not taken place for a while. We asked for minutes of meetings however we could not find evidence of this.

We looked at how people were supported to maintain local connections and take part in social activities. We observed that people were provided with stimulating activities to promote their wellbeing or to prevent social isolation. For example, one relative told us, "There are always activities different times of the day and they provide people with a lot of stimulation". Another relative told us "Mum never used to join in however since she came here she gets involved, they encourage her". The activities co-ordinator engaged with people in a positive and inclusive manner. Activities we observed were well suited to people and allowed all people to participate regardless of their abilities. One visitor told us, "The activities coordinator is very caring and works hard to involve the residents in appropriate activities".

We spoke to people who told us they could do with going out in the community a lot more. We spoke to staff who also shared the same views. They informed us they wish they could have time to take people for walks around the beach. Registered manager informed us this was being resolved with recruitment of domestic staff.

We looked whether people were encouraged and supported to develop and maintain relationships with people that mattered to them and avoid social isolation. We found people were supported to continue maintaining contact with their loved ones. Local churches maintained contact with the home and visited at key religious events. Two people told us they were visited by their family and friends frequently. Another person told us, "I go out with my daughters." Relatives of people who lived at The Knights told us they could visit anytime of the day or week and there were no restrictions and they felt welcomed. This meant that people were able to continue maintaining important relationships in their lives without restriction.

We reviewed how the service responded to complaints and found that the manager had kept records to show how complaints were responded to. We found the service encouraged people to make suggestions and raise concerns directly to the manager. There was a complaints policy and procedure which people were aware of. However people informed us that, although management encouraged them to make suggestions, they did not feel that their suggestions were responded to in a timely manner. We spoke to some relatives, staff and two people who lived at the home who shared the same sentiment. One professional also shared the same view and said, "They are reluctant to take suggestions and guidance on

board and can be defensive".

People told us they had attended some meetings, completed surveys and made suggestions however they did not feel their suggestions were acted on effectively. For example we saw staff surveys that had been completed and suggestions had been made by some staff which the registered manager was not aware of when we spoke to them. This meant that systems to listen to people and learn from their experiences had not been sufficiently implemented and people did not always feel their suggestions mattered.

Requires Improvement

Is the service well-led?

Our findings

We asked people who lived at the home and their relatives if they thought the home was well led. One relative told us, "We find the manager approachable" and "She is helpful". We asked people who lived at the service if they would be able to speak with the manager about any concerns. People told us, "Yes, I can approach her however I don't always get answers". Another person told us, "When she is here we can talk to her however we don't see her regularly" and "She is not here often".

We spoke to staff regarding leadership at the home and there were mixed responses, some staff told us they were free to approach the manager and raise any concerns they had. However some staff told us they did not feel free to approach the manager as they felt it was too much to ask and that the registered manager was busy. Staff added that they felt management would listen to complaints however they did not feel they listened to suggestions or action them, one example we were given was a request for equipment.

Professionals who we spoke to also gave us mixed responses, one professional said, "The manager is well informed and proactive". However two other professionals informed us "management are not visible and do not always act quickly to suggestions".

We looked at how the service demonstrated good management and leadership. We were told that people had a lot of faith in the manager. One relative told us, "We are free to speak to management, they are brilliant". Another relative told us, "They listen however the responses are not quick".

We found there were staff meetings which were held regularly. Areas of improvement were discussed between staff and management. We did not find evidence of residents meetings. We spoke to people and some people told us they used to have meetings however they had not had one recently.

We found systems that ensured the delivery of high quality care were in place however they were not adequately implemented. For example audits were being carried out on the environment, care plans, health and safety, medication and accident and incidents. These audits were identifying areas of improvement however action plans were not implemented timely to ensure issues could be resolved in a timely manner. For example we found a ceiling had collapsed in one bedroom and a leak had been discovered in December 2015; however at the time of our inspection these issues had not been resolved. We also found previous audits had found risks around obstacles within the home however during the inspection we found the obstacles in corridors and around the home had not been removed.

During the inspection we also identified some failings in a number of areas. These included person centred care, inaccurately completed PEEPS, lack of consent, mental capacity assessment and risk assessments for bedrails. These issues had not been sufficiently identified or managed by the provider before our visit which showed that there was a lack of robust quality assurance systems in place.

We looked to see if the registered manager understood their responsibilities. We found the registered manager had some understanding of their responsibilities and the regulations. However we found there was

inadequate management oversight and leadership within the home. For example we found a number of areas that the manager had failed to identify before the inspection. For example, they were unaware staff were using bedrails for a number of people, risks around the building had not been acted on promptly and one person was exposed to risks caused by the collapsed ceiling. People's care was not accurately recorded. People's evacuation plans did not provide sufficient detail on how to evacuate people and where to evacuate them.

We also found the registered manager had analysed resident surveys that had been altered by staff and informed us they were not aware of this when they processed the questionnaires. In another example we spoke to the registered manager about staff surveys and the feedback from the surveys staff had expressed negative feelings around the staff team. This had been analysed however when we spoke to the registered manager they were unaware of the contents of the survey. This meant that management oversight was not robust.

This was a breach of Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the culture within the home and observed some staff were positive however some did not feel positive. We saw evidence in the staff surveys that some staff had felt there were negative feelings which they felt had an impact on the day to day provision of care. Some staff we spoke to also felt negative and did not appear to share the same ethos on why they were being asked to carry out certain tasks in the home. For example some staff did not see the value of keeping robust records and expressed that they did not feel carrying out mental capacity was their role. We shared these views with the registered manager and they informed us they felt staff understood the importance of competing documentation correctly.

We checked to see if the provider was meeting Care Quality Commission (CQC) registration requirements, including the submission of notifications and any other legal obligations. We found the registered provider had fulfilled their regulatory responsibilities and submitted some notifications to CQC however some notifications had not been sent, for example incidents that had a potential of disruption the delivery of services in a safe manner. Regulation requires that providers should notify CQC of any physical damage to premises owned or used by the service provider for the purposes of carrying on the regulated activity which has, or is likely to have, a detrimental effect on the treatment or care provided to service users.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not provide person centre care because people's care was not adequately and accurately assessed or planned for to ensure their needs and preferences were met. Regulation 9 (1) (c) (3) Person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have suitable arrangements in place to ensure that the treatment of service users was provided with the consent of the relevant person in accordance with the Mental Capacity Act 2005. Regulation 11(1) (2) (3) - Need for consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not being well managed. Regulation 12 (1)(2)(g) The registered person had not assessed risks to health and safety of people and taken appropriate steps to mitigate such risks exposing people to a risk of significant harm. Regulation 12(1)(a)(b)

Areas of the environment were dirty and unhygienic and therefore infection control was not being promoted.
Regulation 12(1)(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not safeguard people from abuse and avoidable harm. Regulation 13 (4) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were posing a risk to people using the service and repairs to structural damage had not been made promptly to maintain people's safety. Regulation 15(1)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have sufficient systems in place to identify or address issues that affected the quality of the service people received or the risks they were exposed to. Regulation 17(1)(2)(a)(b)(c)