Farnborough(War Memorial)Housing Society Limited

Knellwood

Inspection report

83 Canterbury Road
Farnborough
Hampshire
GU14 6QN

Tel: 01252542169

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 17 and 18 May 2018 and was unannounced. During our previous inspection on 8 July 2017, we found a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although the service had made some improvements to the provision of appropriate training for staff, further improvements were needed in order for the service to fully meet the requirements of this regulation.

During this inspection, we checked whether the provider had maintained the improvements they had made. We found the provider had made and sustained the required improvements and there was no longer a breach of Regulations.

Knellwood is a care home for up to 52 people who require nursing and personal care. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. At the time of inspection there were 48 people living at the home.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not available for us to speak with on the day of inspection.

There was guidance in place to protect people from risks to their safety and welfare, this included the risks of avoidable harm and abuse. Staffing levels were sufficient to support people safely and where there were any short falls these were covered internally. The provider was in the process of trialling the deployment of extra staff at busy times to see if that further improved the quality of care.

The provider had an effective recruitment process to make sure the staff they employed were suitable to work in a care setting. Risks to people were assessed and action was taken to minimise any avoidable harm to people.

There were systems and processes in place to ensure medicines were managed safely in accordance with current guidance and regulations. Staff were sufficiently trained and regularly assessed for their competency of administering medication.

Staff raised concerns with regard to safety incidents, concerns and near misses, and reported them internally and externally where this was required. The management team analysed incidents and accidents to identify trends and implement measures to prevent a further occurrence.

People were supported by staff who had the required skills and training to meet their needs. Where required, staff completed additional training to meet individual's' needs. People were supported to have a balanced diet that promoted healthy eating and the correct nutrition.

The management team and staff understood their responsibilities in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were involved in making every day decisions and choices about how they wanted to live their lives and were supported by staff in the least restrictive way possible.

People experienced good continuity and consistency of care from staff who were kind and compassionate. The management team had created an inclusive and open culture at the home. People were relaxed and comfortable in the presence of staff who invested time to develop meaningful relationships with them.

People's' independence was promoted by staff who encouraged them to do as much for themselves as possible. Staff treated people with dignity and respect and were sensitive to their needs regarding equality, diversity and their human rights.

Practical arrangements including staff rotas were organised so that staff had time to listen to people, build relationships and trust, answer their questions, provide information, and involve people in decisions.

The service was responsive and involved people in developing their support plans where possible which were detailed and personalised to ensure their individual preferences were known. People were supported to complete stimulating activities of their choice, which had a positive impact on their well-being.

Arrangements were in place to obtain the views of people and their relatives and a complaints procedure was available for people and their relatives to use if they had the need.

The service was well managed and well-led by the management team who provided clear and direct leadership, which inspired staff to provide good quality care. The safety and quality of the support people received was effectively monitored and any identified shortfalls were acted upon to drive continuous improvement of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from risks to their safety and wellbeing, including the risks of abuse and avoidable harm.

The provider employed sufficient staff and carried out recruitment checks to make sure staff were suitable to work in a care setting.

Processes were in place to make sure medicines were administered safely, and to protect people from the risk of infection.

Is the service effective?

Good

The service was effective.

Staff were supported by training and supervision to care for people according to their needs. Care plans were based on thorough assessments, standards and guidance.

Staff were guided by the Mental Capacity Act 2005 where people lacked capacity to make decisions.

People were supported to maintain a healthy diet and had access to other healthcare services when required.

The premises were in the process of being renovated to further meet individual's needs.

Is the service caring?

Good

The service was caring.

People had developed positive relationships with staff.

People were supported to take part in decisions affecting their care and support.

People's independence, privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

Peoples' complaints and concerns were investigated and dealt with thoroughly.

People were supported at the end of their lives and care plans were created to ensure people's wishes and preferences were carried out.

Is the service well-led?

Good

The service was well-led.

The provider had a clear vision for the delivery of people's care and promoted a positive, supportive culture.

Quality assurance processes were thorough and wide ranging and provided input into a system of continuous improvement.

The provider's governance system was effective and promoted quality care and support.

The service worked in partnership with other agencies in the provision of people's care.

Knellwood

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 17 and 18 May 2018 and was unannounced. The inspection team consisted of two inspectors and an expert by experience who had experience of a loved one living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider 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 reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also reviewed information contained within the provider's website.

Throughout the inspection we observed how staff interacted and cared for people during the day, including mealtimes, during activities and when medicines were administered. We spoke with seven people, the recently appointed general manager, the company secretary, two activity co-ordinators, five care staff and one registered nurse.

We reviewed six people's care records, which contained comprehensive assessments, care plans and risk assessments. We looked at six staff recruitment files, training logs and supervision files. We examined the provider's records, which demonstrated how people's care reviews, staff supervisions, appraisals and required training were arranged. We also looked at the provider's policies, procedures and other records relating to the management of the service, such as staff rotas, health and safety audits, medicine management audits, infection control audits, emergency contingency plans and minutes of staff meetings. We considered how people, relatives' and staff members' comments were used to drive improvements in the service.

Good

Is the service safe?

Our findings

People and staff consistently told us they felt the service was safe. People had developed positive and trusting relationships with staff that helped to keep people safe. One person told us "Yes, the home is clean and they look after me. Of course I feel safe." One staff member told us, "We have more staff in the mornings now, when we need them. That's made a big difference."

The provider had procedures to protect people from the risk of avoidable harm and abuse. The staff members we spoke with had undertaken adult safeguarding training within the last year. They understood the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the Local Authority Safeguarding Team should be made, in line with the provider's policy and procedure. Staff were aware of the whistle blowing procedure and understood how to report any concerns. One staff member said, "I would whistleblow to the CQC if I had to but I know the manager would do something".

We looked at recent safeguarding concerns with the general manager. These had all been followed up with the local safeguarding authority and notified to us as required by the regulations. Suitable policies and procedures were in place for staff to refer to. All staff that we spoke with were aware of the whistleblowing policy, and the importance of raising any concerns about people's safety and wellbeing.

We noted that in people's care plans there was information regarding the risk of accidents or incidents, including falls. It was identified where, when and how accidents had occurred. Therefore, it was possible to identify any trends which enabled the provider to put measures in place to prevent similar occurrences happening. For example, one person had been provided with a sensor mat in their room to alert staff should they put themselves at risk by walking alone. We observed staff consistently deliver care in accordance with people's risk assessments, which kept them safe and met their individual needs.

The provider kept records of routine maintenance of equipment used to support people, and there were regular checks on fire detection and prevention equipment. Legal checks were in place for electrical equipment.

The provider carried out the necessary checks before staff started work. Staff files contained evidence of proof of identity, a criminal record check, employment history, and good conduct in previous employment. There was no recent use of agency staff. If required staff worked extra hours or shifts to cover any sickness or holidays.

The provider had recently been trialling increasing staff members at busy times to find at what times this was most helpful.

Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with people. Staff told us there were enough staff to respond in a timely manner when people required support, which we

observed in practice.

The provider had systems and processes in place to ensure medicines were managed safely in accordance with current guidance and regulations. Staff were sufficiently trained and regularly assessed for their competency of administering medication. Where it was identified that staff needed to attend refresher training before this was due, the provider arranged this. We observed that one new staff member required further training regarding medicine management. The provider immediately made arrangements for the staff member to attend this training have their competency assessed and to be supervised by the clinical nurse manager.

We looked at the Medicines Administration Records (MAR) for all people living at the home. We noted there were no gaps in these records. These contained relevant information, such as people's allergies or their ways of taking medicines. Medicines were safely stored in locked cupboards and those that required refrigeration were stored in a lockable fridge. Room and refrigerator temperatures were monitored daily.

The provider had arrangements in place to make sure the premises were kept clean and hygienic. and to reduce the risk of infection. Staff were aware of their responsibilities with respect to infection control, and there were regular spot checks, audits and supervisions of housekeeping staff. The provider ensured personal protective equipment (PPE), such as gowns and gloves were available to staff. There were also individual infection control risk assessments, where appropriate, in people's care plans.

The provider had arrangements in place to learn and make improvements if things went wrong. Staff reported and recorded accidents and incidents so that they could be analysed for any trends and patterns. Where there were lessons to learn, the provider used staff meetings and daily meetings of heads of departments and supervisions to communicate them.

Good

Is the service effective?

Our findings

At our previous inspection on 8 July 2017 we found a continuous breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff had not always been provided with training necessary to enable them to carry out the duties they were employed to perform. At this inspection we found improvements had been made in this area to meet the requirements of this regulation.

People and staff told us that people received care and support that met their needs and that they were given choices about the care they received. One person told us, "The care is good, they ask me what I prefer to have for lunch or to do." One staff member told us, "We work [from] peoples' care plans which clearly state their preferences and wishes; there are individual boards with people's likes and dislikes that help us to know them better."

People received comprehensive assessments which identified their needs. People and their relatives formed part of this process and care plans were reviewed regularly. People's' care plans included a section called, "who am I" which included details of people's eating and drinking preferences, routines, important people, life history and their interests and hobbies. Assessments, risk assessments and care plans were person centred and written in line with national guidelines, such as those provided by National Institute for Health and Care Excellence.

New staff undertook an induction programme which was mapped to the Care Certificate standards. The Care Certificate is the industry standard which staff working in adult social care need to meet before they can safely work unsupervised. Staff competence was assessed by the general manager, matron and clinical nurse lead regularly. Competence was also assessed and discussed in regular supervisions. The general manager has recently introduced a new training package using e-learning. This included a wide range of training such as infection control, palliative care, falls, health and safety and medication management.

At the time of the inspection the provider had recently implemented a new computer based care planning system. The general manager told us this had prompted staff to think about peoples' care more and would alert when a review was due. The implementation of the new system showed the provider considered areas where technology could be used to improve peoples' care and support. Changes to a person's needs were communicated to the staff team at their daily meetings so all staff members were aware. Multi agencies would be involved both inside and outside the home and records showed people were supported to access healthcare services and attend hospital visits where needed.

The staff we spoke with were knowledgeable about people's differing dietary requirements. They were aware of the importance of healthy eating, special diets and of maintaining a balanced diet. They were also aware of the balance to be struck between the need for this and peoples' right to decide for themselves. The care plans contained up to date and relevant information about people's dietary needs. These included choking risk assessments, the use of food and fluid charts and, where necessary, referrals for specialist advice from professionals.

The provider had developed a good working relationship with local healthcare providers. Records showed people had access to healthcare services when needed. There were records of visits from GPs and other specialists, such as a dietitian and speech and language therapist. Health and social care professionals told us the standard of care was good and that peoples' care was the priority in the home.

The provider had built a good relationship with a local GP and pharmacy who worked together to ensure peoples' healthcare needs were assessed and where appropriate they were referred to other specialist healthcare services. The general manager stated that support was given to people to take them to healthcare appointments if they were unable to attend independently.

There were some adaptations and improvements being made to the home at the time of inspection. The provider was conscious of the disruption this could cause and did all they could to minimise this by keeping building works to small areas at any one time. Some improvements already made were; upgrades fire doors to electronically close, bathrooms that had different style baths to cater for different peoples' needs and a respite room. Peoples' rooms were personalised to their taste and had some 'homely' belongings in them. There were two dining areas for people to choose from. One smaller room provided less busy dining environment.

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 people 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 are called the Deprivation of Liberty Safeguards. We checked to confirm the service was working within the principles of the MCA, and was meeting all conditions on authorisations to deprive a person of their liberty. We found that legal requirements were being met and people's human rights were recognised and protected.

Good

Is the service caring?

Our findings

People gave us positive feedback about the quality of care they received. People were supported by staff who demonstrated kindness, compassion and a genuine interest in the people they supported. Feedback from people was positive. One person said, "They are very kind, it is excellent care and they look after us really well."

People and staff reported that people were treated with respect and compassion. We observed caring interactions between people and staff who consistently took care to ask permission before intervening or assisting. One person told us, "We are cared for wonderfully, I've no complaints at all." One member of staff told us "We do get time to spend with the residents and get to know them. We all do so we get to know them well."

There was a high level of engagement between people and staff. Staff were responsive to people's needs and addressed them promptly and in a warm and caring manner. It was evident all staff knew people well; for example, staff knew people's food preferences without referring to documentation. Those at risk were monitored closely but discreetly where necessary; for example, those who were at risk of choking.

We looked at people's care plans in order assess how staff involved people and their families with their care as much as possible. Care plans and risk assessments were discussed and agreed with people and their relatives or representatives where appropriate. Records of contact with family members were kept. People were asked about their hobbies and interests, what they wanted, and what they liked and did not like. People's care plans took into account peoples wishes, needs and preferences.

People told us they felt their privacy and dignity was respected. We observed staff closing people's bedroom doors when they were going to assist them or give personal care. Staff showed an awareness of the need to protect people's dignity; we saw one member of staff adjusting a person's clothes as they were supported to move into another room. Staff consistently described how they would cover people appropriately when delivering personal care. One member of staff told us "People need their privacy and to be respected, I will always knock before entering and ensure their dignity is respected as much as possible when carrying out personal care."

Good

Is the service responsive?

Our findings

People and staff told us consistently that the service was responsive to people's needs. One person told us "I like to come here in the afternoon, I knit and natter - it's lovely, the best part of the day."

Staff assessed peoples' individual needs and gave them choices to enable them to receive care and support that met their needs and respected their preferences. People had boards in their rooms that had a photograph of them and held information on a person's history, family life, likes and dislikes. This was referred to by staff and activity co-ordinators to ensure they were knowledgeable about peoples' wishes which enabled them to meet them.

We spoke with the home's two recently appointed activity co-ordinators about their role. We were shown evidence of a variety of present and future plans regarding the provision of meaningful activities including; arts and crafts, gardening and sports, such as croquet and knit and natter. There were also external entertainers and interest groups regularly visiting the home. We were told, "None of this would be happening without the manager. We have no limit on our budget and have been told to try and make the residents' dreams come true. I don't feel like this is work and it's making such a difference to peoples' lives." We were told of one example about a person that after a long period of time of not leaving the home, they now engage in activities and have been on a trip away from the home which they thoroughly enjoyed. Another example was that one person who in the past enjoyed baking had joined the 'baking group' and baked a relative a cake.

The provider had arranged for a celebration for the Royal wedding. People, relatives, friends and staff would be celebrating this together and making it a day's event. The provider had recently been arranging to celebrate cultural and special days, for example; celebrating one culture with a themed day and food that would be available in the country whose culture they were celebrating.

We noted the complaints procedure was available for all to view in communal areas. It contained information about how and to whom people and representatives should make a formal complaint. There were also contact details for external agencies, such as the Local Government Ombudsman should people wish to speak with them.

The general manager told us it was very important that people were listened to and concerns dealt with. Complaints and concerns were followed up and used by the service to develop practice and improve the care and support people received. We saw evidence that the provider responded to concerns or complaints in a proactive manner, and that staff training or support had been implemented where this was appropriate.

People told us that if they were unhappy they would speak to a member of staff or the registered or general manager and were very confident any issue would be dealt with. One person told us, "If I had any problems I would speak to matron and it would be sorted out." The staff we spoke with were clear about their responsibilities in the management of complaints and felt confident that any concerns would be acted on appropriately and in a timely manner.

The management team kept a record of the many compliments that they had received about the service provided to people. These were in the form of cards, emails and letters from relatives of people, which were placed in a folder for people to be able to access. One person's relative said, "Thank you so much for the way you dealt with [loved ones] fall last night, please give our thanks to all the staff who were involved." Another relative said "The kindness and friendliness of the staff helped my [loved one] settle in quickly, they really treated him as an individual and responded to his changing needs."

The provider took care to ensure people in the final stages of life received care and support which met their needs, respected their wishes, and kept them free of pain. When people's care plans indicated end of life care was needed a dedicated end of life care plan was created. This included peoples' wishes and preferences for their care and treatment when they were in their final stages of life. The registered nurses were all trained in end of life care and worked closely with external agencies including hospice nurses to provide care to people. Nurses from the hospice visited regularly to look at people's care plans and to assess whether any changes were needed.

Good

Is the service well-led?

Our findings

People and staff we spoke with were all very positive about the management of the service. They described the general manager who had been in post less than six months as being extremely supportive and approachable. One person told us, "I think the new boss is very good, [they] will always talk to you." Another person said, "Oh yes I think the home is very well run, I would recommend it." One staff member told us when we asked if they felt the home was well led "I really do, especially since the new manager came. [They're] an inspirational person."

There was a clear vision to provide a high standard of care and support based on the provider's aims to provide a 'secure, relaxed, homely, comfortable home that is appropriate to meet individuals needs and rights'. We observed staff members following these aims within their day-to-day work.

The general manager walked round the home daily which enabled [them] to make sure the aims were embedded in the daily practice of staff. There was a morning meeting held each day where the heads of departments would discuss any updates or incidents from the night before to feedback to their teams. There was a positive, encouraging, strong open and inclusive culture within the service. One staff member told us "I think the general manager has made a huge difference. He is able to see potential in staff even if they can't see it themselves."

There was an effective governance framework in place, and individual responsibilities were clear and understood.
The general manager and registered manager were supported by a leadership team which included a company secretary, clinical nurse lead, housekeeper, administrator, head chef, activities coordinators, and maintenance staff. The general manager and registered manager supervised heads of departments with other supervisions delegated to heads of department, senior staff and registered nurses.

There was an effective system of quality assurance in place; this included weekly, monthly, six monthly and yearly audits. Topics covered were infection control, medicines management, health and safety, cleaning, support plans, and observations on staff to assess continued competency. The registered manager also completed reports to consolidate this information, which fed into a business improvement plan to capture and monitor improvements and the progress. There was also a business management plan in place. The management team were in the process of starting to update their policies and procedures.

Resident and family meetings were held monthly. This enabled people and their families to express their views as to any changes that could be made to the service. The provider was open to making changes from these meetings. There was a newsletter with information on what the home was offering and any updates or events included for people and their families to be kept updated. Feedback forms were also offered to people to gain feedback to feed in to changes being made in the home.

Staff meetings and supervisions allowed staff members to raise ideas. This meant they could express their views on the service and to be informed of updates.

Measures were in place to monitor incidents people experienced and to ensure appropriate actions had been taken for people. The management team analysed any incidents that occurred, identified the cause and made a person-centred plan to avoid re-occurrence. Records showed that following incidents relevant measures had been taken for people such as the provision of equipment or a change in the number of care staff required for a person.

The home worked in partnership with multiple agencies. These included local authority, GP's, hospice nurses and community nurses. There was evidence in people's support plans outlining professionals involved and the roles they held in a person's care.