Mr & Mrs C S Dhaliwal

Manor House Residential Home

Inspection report

Hall Lane
Old Farnley
Leeds
West Yorkshire
LS12 5HA

Tel: 01132310216

Date of inspection visit:
08 January 2018
09 January 2018
18 January 2018

Date of publication:
25 April 2018

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

Manor House Residential Home is a 'care home'. People in care homes receive accommodation and personal care under a contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

Manor House Residential Home accommodates up to 30 older people and is situated in the Farnley area of Leeds. The home is on two floors with a passenger and chair lift access to the top floor. The lounges, dining area, kitchen and laundry facilities are located on the ground floor. There is a garden area at the rear of the home. At the time of our inspection, 27 people were using the service.

This inspection took place on 8, 9 and 18 January 2018. The inspection was unannounced on the first day; this meant the staff and provider did not know we would be visiting.

A registered manager was in post. 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.

We found improvements were needed to fully ensure records were accurate and fully documented the dates of review and completion. Audits did not always have completion dates, care plans had been reviewed but not all had been updated with the date of review on and we found one risk assessment without a date of completion listed on it. In addition, care worker appraisals did not have a date on the documentation which reflected the date of completion.

Improvements were required to ensure the environmental safety of the home. Carpets were worn and loose and this was a potential tripping hazard which may increase the risk of falls, particularly to those people already at risk. The wall paper was old and falling from the wall. During the dates of inspection the provider had taken some action to address the issues we identified and following the inspection the provider informed us of their plans to change the carpets.

Medicines were managed and recorded safely. 'As required' medicines were administered accordingly and protocols were in place for care workers to follow.

Staffing levels were sufficient to meet people's needs although some people living in the home felt that more staff were needed.

People told us they felt safe and care workers had a clear understanding of the procedures relating to safeguarding and whistleblowing.

Risk assessments were completed and reviewed to support people with specific needs to avoid any harm.

The provider followed The Mental Capacity Act 2005 with capacity assessments documented and best interest meetings recorded, when required. We found consent was obtained from people verbally on a day to day basis and formally at review meetings.

People were supported with their nutritional needs and fluid intake. People were also supported with their health needs.

People living in the home had positive relationships with the care workers, they told us they felt well cared for.

People were encouraged to be independent and make choices regarding their care. Staff respected people's privacy and dignity.

Care plans were detailed and contained relevant information. This included people's preferences, likes and dislikes which made them person centred. There were instructions for care workers to follow although one care file had differing information within the care plans.

Complaints had been responded to with outcomes recorded. Incident and accidents were managed and people using the service told us they felt confident to discuss any concerns with the provider.

The manager provided an action plan from the last inspection to show what improvements had been implemented. Surveys were provided to people living in the home, relatives and care workers to gather their views of the service and the quality of the care provided was monitored through governance systems which highlighted where improvements were needed.

We identified one breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, namely, Good governance. You can see what action we told the provider to take at the end of the full version 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 always safe.

The premises were old and required a refurbishment, with worn carpets creating a tripping hazard and wall paper coming off the walls.

Staffing levels were sufficient to meet people's needs.

People told us they felt safe. Care workers were trained to protect people against potential abuse and knew who to report this to.

Medicines were administered, stored and recorded appropriately and people received their medicines as prescribed.

Is the service effective?

Good

The service was effective

Where people lacked capacity to make decisions, care plans evidenced compliance with the Mental Capacity Act 2005.

Care workers completed an induction programme along with training and regular supervisions.

People were supported to meet their nutritional and health needs, when needed.

Is the service caring?

Good

The service was caring.

People told us they were well cared for. Positive relationships had been built between people using the service and staff.

Care workers treated people with dignity and respect and they were supported to be independent.

Care workers involved people in the running of the home and provided explanations to people they supported.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support. People and their representatives had been involved in the pre-admission assessment of their needs, and involved in devising their own plan of care.

Regular reviews of care plans took place with people and their relatives.

A complaints procedure was in place. People using the service knew who to contact if they wished to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a lack of accurate record keeping. Dates were not being documented to show when actions or reviews had been completed.

The service had a registered manager in place.

The provider had community links which promoted research opportunities to improve people's care.

The service actively involved people, care workers and relatives in the service. They sought their opinion in order to improve the service provision.

Manor House Residential 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 comprehensive inspection took place 8, 9 and 18 January 2018. It was unannounced on the first day and was carried out by one inspector and an expert by experience who had experience of older people's care. 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 our inspection, we reviewed all the information we held about the service, including previous inspection reports and statutory notifications sent to us by the provider. Statutory notifications contain information about changes, events or incidents that the provider is legally required to send us. We also contacted the local authority, other stakeholders, West Yorkshire Fire Service and Healthwatch to gather their feedback and views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Before the inspection, the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection, we spoke with six people who used the service, two relatives, three care workers, the deputy manager, the registered manager and the nominated individual (provider's representative).

We spent time looking at documents and records relating to people's care and the management of the service. We looked in detail at three people's care plans, medicine records and a variety of policies and

procedures developed and implemented by the provider.

Requires Improvement

Is the service safe?

Our findings

We found the home's decoration was worn and some carpets were old and needed to be replaced to prevent potential hazardous conditions. Carpets were worn and loose which was a potential hazard to people living in the home who may be at risk of falls. We found marks on the walls and the wall paper was starting to fall off in various parts of the home. On the second day of our inspection we found the provider had taken action to update the wall paper and this had been removed in some areas of the home. We informed the provider of our concerns as the carpets could be hazardous and people may be at risk of falls. We discussed this with the nominated individual and recommended that they take action to address this potential hazard. We were informed following our inspection that an action plan had been started and that the carpet we saw was due to be replaced.

The registered manager told us there had not been any evacuation drills to show two care workers during the night could evacuate all the people living in the home safely. Personal Emergency Evacuation Plans (PEEP's) were in place and we found two people living in the home at the time of our inspection required two care workers to assist when evacuating. We asked the West Yorkshire fire service to attend the home to ensure there were adequate staffing levels at night to carry out an evacuate. The West Yorkshire fire service confirmed there were sufficient staffing levels to safely evacuate people from the home.

We were informed by the West Yorkshire fire service that their last visit took place in 2016 and the provider told us that they had achieved broad compliance at this time. In November 2017, the provider had put one stair gate in the middle of each stairway. This did not follow the provider's policy which stated 'ensure that all escape routes and exits are free from obstruction.' The provider removed the stair gates following a visit from the West Yorkshire fire service after our inspection.

Safety checks within the home were completed. This included fire safety certificate, gas and electrical, water, alarms and legionnaire checks. We saw the fire risk assessment had been completed in September 2017 and were informed by the registered manager that the provider last completed a simulated evacuation of the building in July 2017 with all care workers and this took place during the day time.

At the last inspection, the provider failed to ensure sufficient staffing levels were in place. At this inspection we found staffing levels were sufficient. The registered manager told us they had now employed a care worker to work till 10pm every night. They were employed to complete medicines and support people living in the home to bed. Although this was an improvement to the previous staffing levels, people living in the home, their relatives and the staff provided us with mixed views on staffing levels.

People living in the home told us, "I do think there's enough staff on, sometimes they are hard to find", "They usually don't have time to chat to me, but they are around if I need it" and "There's always staff when you want it." One relative said, "On the whole, there are enough staff. They're not always visible, they may be with someone else, but there's always somebody in the office and the kitchen."

People living at Manor House told us they felt safe with comments including, "Very safe here – safe as

houses" and "You are safe here." One relative said, "I feel she's safe. She lived by herself before, and she kept falling over, but she has people with her now so she is safe."

A safeguarding and whistleblowing policy was available to care workers with a process in place to report suspected abuse or harm. From January 2017 we found nine safeguarding referrals had been made to the local authority. The provider had a matrix to record relevant details of the incident. This included the date, who had reported it, log reference number, notification to the CQC and when this was closed. Care workers had a clear understanding of the safeguarding and whistleblowing process. One care worker told us, "It's to safeguard vulnerable adults and children if they are being abused. If ever I am unsure I contact the safeguarding team and we've got to inform the CQC."

Risk assessments were completed when required or if needs changed for example, we saw risk assessments for people requiring hoists, moving and handling, falls and wheelchair use. One risk assessment effectively managed the risk of falls and prevented further incidents. The person using the service had been having regular falls, care workers used a monitoring sheet to record falls and actions were taken when these increased. The monitoring falls record stated, 'There is a pattern of falls between 7am and 8am – staff to assist [Name] to the toilet.' Following the actions to support the person to the toilet during this time, we found falls had reduced.

Although we found the majority of risks were being managed we found one care file which made reference about a person's catheter care. We found care workers using a 'hygiene sheet' to support the person's care needs. This was dated 2010 and had been written by a 'nursing student'. We asked if the district nurses had advised to use this but were informed by a care worker that they had not seen this. We could not be sure that this documentation was best practice and included the relevant information required to ensure the person's personal hygiene related to their catheter was adequate. The provider planned to review this documentation immediately.

There was a robust process in place for when accidents and incidents occurred and this was followed by care workers. Actions were taken to reduce risks for example, following a fall, the provider contacted the falls team to arrange an assessment for any additional support the person may require and body maps were used to document any injuries sustained. Monthly audits showed if there had been any themes or trends, and falls were recorded on monitoring forms within people's care files to identify if further actions were required should these increase.

We looked at staff recruitment records which showed which checks were undertaken before staff began work. Checks included application forms, interview notes, confirmation of identity, two references and a Disclosure and Barring Service (DBS) check. These checks identify if prospective staff have a criminal record or are barred from working with vulnerable children or adults. We looked at four care worker files and found they had the relevant information. We did find one file only contained one reference rather than two, however, since this time the policy had changed and the care worker had been in post for over 10 years.

At the last inspection we found the provider had failed to ensure the safe administration of medicines. At this inspection we found the provider managed medicines safely and people told us they received their medicines on time.

Medicines were mainly kept within 'bio dose boxes' which provided four weeks of medicines. Bio dose boxes contain designated sealed compartments, or spaces for medicines, to be taken at particular times of the day. The boxes had a picture of the person living in the home and all relevant information needed for care workers to identify a person prior to administration. Signatures and dates were added to individual boxed

medicines so care workers could identify when these had been opened to ensure safe administration. 'As Required' medicines were used when people needed these. We saw protocols in place which provided explanations of when these may be required and the dose to administer. Topical Medicines Administration Record Sheets (MAR's) were used for those people who required creams and a body map was in place to show care workers where these should be applied.

Medicines were stored securely in a lockable cupboard with fridge temperatures recorded daily, stock checks completed weekly and controlled drugs (CD's) were kept in a secured cupboard. CD's were administered and signed by two care workers and we found the log book documented this along with the stock of medicines stored.

Monthly medicine audits were carried out to identify any errors and actions taken to ensure this was not repeated. For example, we found one care worker had used an incorrect code on the MAR; this was picked up on the audit and care worker spoken to.

At the last inspection two care workers at night were not trained to administer medicines and therefore medicines could not be administered by these care workers. The registered manager told us, all but one night staff had now been trained to administer and there was always at least one care worker on shift to ensure people received medicines when required.

Good

Is the service effective?

Our findings

Care workers had sufficient skills and knowledge to care for people. One person living in the home said, "The support here is what I need." One care worker told us, "I did my moving and handling training recently, it was good and I learnt a lot from it, there's more than enough training."

New care workers completed an induction programme including shadowing of established care workers, competency tests and supervisions. Care workers without experience completed the Care Certificate which is a set of standards that social care and health workers follow as recommended by Skills for Care, a national provider of accreditation in training. The registered manager told us they were involved in the skills for care forum, with other managers, which provided opportunities to look at the learning and development of care workers.

A matrix was in place which showed care workers had completed the required training. This included, Mental Capacity Act (MCA), moving and handling, health and safety, food hygiene, infection control, fire, safeguarding and Deprivation of Liberty Safeguards (DoLS).

We found all care workers were supported with regular supervisions that followed the provider's policy. We saw appraisals had been completed, however, there were no dates recorded to say when these had happened. We discussed this with the registered manager who said they would put the dates on. Care workers told us they felt supported, one care worker said, "Yes, if you have a problem you can go and speak to [The manager] and ask."

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where 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 processes for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider was working within the principles of the MCA and met the conditions on authorisations to deprive a person of their liberty. Capacity assessments had been completed when a person lacked capacity and we saw 15 DoLS applications had been made. Best interest meetings were documented and available in people's care files. We saw people's relatives had been involved in decision making where appropriate and a record of confirmation dates for when DoLS had been applied for and when authorised was kept. Care workers were knowledgeable about the MCA for example, one care worker told us, "If someone doesn't have capacity you have to make decisions in their best interests. Some people have advocates who support people with this."

Consent was obtained from people that had the capacity to give their consent. Care workers told us they would always verbally explain what they were doing and ask people for their consent. We also saw this

documented in people's care plans for example, 'Explain to [Name] what will be done before carrying out personal care.' Regular reviews with people living in the home and their relatives also meant people's consent regarding their care was obtained at these meetings.

People living in the home were provided with regular meals, snacks and fluids. People were weighed regularly to monitor for any gain or loss. For those people that needed them, fluid and food charts were in place and the reasons why a person needed this was fully documented. People who were nutritionally at risk were weighed on a weekly basis to make sure they retained a healthy weight.

People living in the home provided mixed reviews about the food, comments included, "The food is edible. There's not a choice that I know of", "Food is good. I like most of it. You get a choice – you get a list with it on" and "Food sometimes is good, sometimes not. Nothing I particularly enjoy. Whatever we need, we get it."

We observed the lunch time experience and found care workers provided a choice of meals and drinks and offered support to people who needed it. For example, a care worker supported a person to eat as they were unable to do this themselves.

We saw health professionals attended the home as required, or if people's health needs changed and they required input into their care. These included, district nurses, GP's and chiropodists. One care file clearly identified how a person was supported to manage their diabetes. It stated, 'District nurse to administer insulin morning and tea time, monitor blood glucose levels'. It also made reference to what specialist care the person had in place for support. There were instructions for staff on how to monitor symptoms of when the person's blood sugars were high or low and the contact details of the relevant health professionals should an emergency occur.

Good

Is the service caring?

Our findings

People living in the home, and their relatives, were positive about the care workers at the home and told us they were kind and caring. One person said, "One lady will come around and ask you if there's anything you are worried about." Another person said, "At night, I have a wandering leg, and it will slip out of the bed. When the ladies come, they will tuck my leg back into bed. I don't notice it's out!"

A relative told us of their experience when their loved one was in hospital following a broken hip and the care worker came to see them. The relative said, "[Care worker] was one of the main people that cared for [Name] – when she came, [Name] knew her straightaway, they remembered her, which doesn't happen very often now with the dementia. The carers know her really well, they can gauge when she's getting agitated, they know all her little quirks and signs. They've got a really good rapport with her."

The Registered Manager held regular 'resident meetings' which people who used the service attended. One person living in the home told us about their involvement in the meetings and said, "We have a residents' meeting every two months. I suggested it might be nice if we went for a meal out, because I'd been out with family to this place. It was arranged, and we went out after that. Some won't go as they have to pay. But three or four taxis of people went. We're going to go out again, somewhere different next time."

We observed care workers providing explanations to people when supporting them. Care workers held the chair for most people while they sat down at lunch, and pushed the chair under the table when the person was ready, asking "Are you sat down? Shall I push you in now?" There was a great deal of social interaction between care workers and people, with each person being called by their preferred name.

Care workers supported people to remain independent. One care file documented a person's challenge with mobility and the actions taken to support the person to remain independent. It stated, 'The challenges I have -Trying to walk and move parts of my body are the biggest challenge. How you can support me to make the best of my home - I've seen a physio who has provided me with exercises for me to do in my room and staff help me with my knee.'

The registered manager told us some care workers were dementia and dignity champions who promoted these areas of interest and developed their learning of these topics.

Care workers treated people with dignity and respect and showed due regard for people's privacy. This was documented in people's care files for example, one plan stated, 'I like my privacy when I go to the toilet. If I need anything I will press the nurse call button.' One care worker told us, "I would close the door when assisting someone with personal care. I would always cover people up if I'm doing personal care; you put yourself in that situation or your family and treat them as you would your own."

The home catered to people's diverse nutritional needs, for example, one care worker told us they supported a person who did not eat pork due to their religion. This was documented in their care plan and kitchen staff were aware of this.

The registered manager told us four people living in the home were supported by an advocate and we saw details of this within people's care files. Advocates help to ensure that people's views and preferences are heard. The provider had links with a local advocacy service and the registered manager said they would make referrals for those people requiring end of life care or people who may lack capacity for extra support.

We saw people's records were held securely. Information held in the office on computers, was password protected and documentation was stored in lockable facilities to maintain confidentiality and abide by data protection legislation.

Good

Is the service responsive?

Our findings

At the last inspection we issued a warning notice in respect of Regulation 9 because care plans were inconsistent and some had not been updated to mitigate risk when incidents had occurred. The registered manager had completed an action plan following the last inspection to update each care plan to reflect people's needs. These were audited on a weekly basis by the registered manager or senior care workers.

We found improvements had been made with most care plans having been updated regularly and reviewed however; we did find one care file which were inconsistent. We found a person using the service had two falls documented in February 2017. Following this, the person's care plan was updated in March 2017 to include staff assistance due to the increased falls at this time. Although this was reflected in the person's falls care plan, we found another care plan which stated, 'Person is independent when using the toilet'. This was not consistent with the updated falls care plan and we informed the nominated individual of this who said they would change this immediately.

Other care plans we looked at had been reviewed more recently. For example, we found a care plan had been updated in February 2017 to reflect as person's diabetic needs that had changed. The care plan outlined instructions for the staff, including what signs and symptoms to look for and what action to take during an emergency.

Reviews had taken place with people using the service on a six monthly basis, or when needs changed. People living in the home told us, "I think someone did the care plan with me – I'm not sure. I did have opportunity to say what I think" and "I don't see the care plan. It's kept in the office. They do read it out to you and if there's anything you're not happy, you can say."

Care plans were person centred and identified people's preferences, likes and dislikes. For example, one care plan documented details of how a person wished to take their medicines. It said, 'I like to have them all put on my tray so I can see what I am taking. I take them one by one with a drink of water.' We saw 'This is me' documents in all care files which allowed care workers to have a better understanding of the person and supported them to build relationships. These documents outlined people's histories, what they were most proud of in life, things that make them happy and things that make them sad. For example, 'I'm proud that I passed my driving test the first time. My family make me happy and I have five grandchildren, I enjoy being able to spend time with my family. The death of my brother makes me sad, he used to look after me before he passed.'

At the last inspection we found a lack of activities being provided. At this inspection we found improvements had been made however, people had mixed views about the activities. For example, one person said, "I don't think there is anything going on here. During the day, we sit and chat to each other." Whilst another person told us, "They've been very good when I get fed up of sitting here and doing nowt (nothing) – I feel so useless sometimes. So they let me bake some buns. I sometimes chair the residents' meetings, and I have been involved in interviewing new staff."

We saw residents meetings took place in March, June, October and December 2017. These meetings included what people living in the home would like to do for activities. One person said they loved to dance and enjoyed ballet. The registered manager told us the Royal Ballet attended the home and that they had received positive feedback from this. The registered manager said they ask people in meetings, and on surveys, about activities but stated that not all people express their wishes or want to join in the activities which is their choice.

Relatives told us people were encouraged to go to the pantomime and told us ministers come in to sing hymns with people. One person living in the home had expressed their religious beliefs and we saw the provider had arranged for the priest to come and visit.

We saw there had been two complaints made over a 12 month period. The provider had taken the appropriate steps to manage these complaints which included a written letter of apology, detailed accounts of the concerns raised and assurances provided.

The provider also received compliments from people using the service, their relatives and other people that visited the home. One compliment stated, 'A note to say that one of your carers was absolutely wonderful when I came. [Carers name's] attitude to all the ladies was really nice. If my mum had been one of your residents she would have been delighted.' A relative commented, 'Many thanks for the wonderful care you gave to my dad during his long residency with you.'

The registered manager told us they supported people living in the home with end of life care with relevant care plans in place which identified the wishes of the person and instructions for staff on how to support the person. For example, one person had requested to remain at Manor House at the end of their life and had contact numbers for both the family members and solicitor.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection the quality assurance systems did not include robust processes that were operated effectively enough to ensure people's safety and the quality of the service. At this inspection we found some improvements had been made to the auditing process, however, we still found shortfalls in record keeping and therefore the provider remains in breach of Regulation 17.

Audits were carried out at various times. Areas covered included, medicines, care plans, mattresses, kitchen, laundry and fire safety and maintenance. These areas were audited monthly and infection control was audited every quarter. Six monthly health and safety checks were carried out and we saw a matrix to confirm this. We found audits were completed and actions had been identified however, not all actions had completion dates. We found this to be a recording issue as the registered manager was able to show invoices for the work that had been completed to address these actions. The registered manager said they would now attach the invoices to the audits to show that work had been completed. We did see some completed actions for example, a fire audit identified the need for the fire extinguishers to be checked, and this was then completed in August 2017.

Care plans did not always have an up to date record for example, we found care plans dated 2014 and saw a risk assessment that had no date so we could not be certain if this had been reviewed and when it was completed.

Appraisals with care workers had been completed with dates and the year recorded on the provider's matrix but we saw no record of the dates on the appraisal documentation in staff files to show that records were current and accurate.

The provider failed to keep accurate, complete and contemporaneous records in respect of each person and their care.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 entitled Good governance.

We spoke with the nominated individual who was at the home during the inspection. The nominated individual told us how proud they were of being the owner and that they were excited to be planning a party this year to celebrate the home being open for 30 years.

There was a registered manager who had worked at the home for a number of years. Some people living in the home, and their relatives, knew who the manager was. One relative said, "There is good communication there, and I do feel [The manager] is honest with me." One person living in the home told us, "The manager is [Managers name]. I would be comfortable talking to her if I had a problem."

The registered manager had positive community links and told us about a research project they had been involved in which looked to promote people's independence and prevent falls. The provider worked in

collaboration with Leeds University and Bradford University hospitals to promote work on mobility with physiotherapists supporting people in the home with movements, positioning of the body shape and the benefits of activity. This was completed in December 2017 and the registered manager told us they have recently involved themselves in more training in this area.

Resident, relative, care worker and health professional surveys were completed on an annual basis. These focused on the Care Quality Commission inspection model domains of safe, effective, caring, responsive and well-led. At the time of our inspection the registered manager was still collecting feedback from surveys sent out in November 2017 and there had been no analysis of this information collated. From looking at the six completed forms received, we found overall that people were satisfied with the care they received. However, one person commented on the lack of activities provided, another said they did not know about their care plan and one person said their family member using the service was not encouraged to provide feedback. These individual matters were looked into by the manager and resolved.

From the survey in November 2016 we saw mainly positive outcomes with most answers being above average to very good. Some people using the service had identified areas which were poor, these included the lack of activities, comfortability in the home, promptness to the call bell, temperature of drinks served, satisfaction with washed clothes, privacy not being respected and overall choice. We saw the results posted on the communal wall in the entrance hallway with actions taken to address the concerns raised. For example, 'What we can do to make things better. We now have two laundry assistants that will make sure your clothing is brought back to your room clean and ironed to your standard. All staff will be reminded at the next meeting, to knock on people's door before entering their room. Also will be documented in the communication book as a reminder.' The three residents who stated they did not feel they had overall control of their life or their choices had a discussion with the registered manager to find the source of this and a solution.

We saw regular meetings took place with people living in the home and care workers to gather views and to identify areas of improvement.

People living in the home, their relatives and care workers provided positive views on the home which included, "Staff morale is good and everyone gets on. Staff do care, you can see that." One relative said, "They are very special people, [Care workers] at Manor House. They make me feel reassured that [Name] is getting the best possible care. It's not everyone that can do that kind of job. Hats off to them completely." One care worker said, "I love it here, I've been here for 24 years." Care workers also told us that the management of the home were approachable and they felt able to communicate any issues.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to keep accurate, complete and contemporaneous records.