Normanton Lodge Limited

Manorfields Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 16 and 17 October 2017 and was unannounced.

We last inspected this service in September 2015 and found the service to be meeting the regulations, although there was no registered manager in post at the time of our inspection.

Manorfields Residential Care Home provides accommodation and care for up to 40 older adults, many of whom are living with dementia. At the time of our inspection there were 28 people using the service.

There was a registered manager 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.

People told us they felt safe with staff and relatives felt their family members were safe. There were enough staff on duty during our inspection visits to meet people's needs. However, staff and some relatives told us there were times when the service was short-staffed and staff were rushed. We asked the registered manager to review how staff were deployed and their response to short-notice staff absence to ensure there were always sufficient staff to meet people's needs.

The risks people were exposed to had been assessed and staff demonstrated they knew how to keep people safe. Some improvements were needed to risk assessments as records did not always reflect people's current needs or changes in risks. Some risk assessments were not personalised to the individual.

Staff were safety recruited to help ensure they were suitable to work in a care setting. They were trained in safeguarding and knew what to do if they had concerns about the well-being of any of the people using the service.

The provider had made improvements to the way in which people's medicines were managed to ensure people were supported to take their medicines safely. People received their medicines when they needed them.

Staff were well-trained and skilled in meeting the needs of people. They were knowledgeable about the people they supported. Staff felt they received good support, and guidance from managers to enable them to provide effective care.

Staff recognised their responsibilities to support people with decision making in line with Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff sought consent from people to their care and respected people's right to decline care. Records did not always support that staff were complying with conditions with DoLS.

The provider was in the process of undertaking an upgrade of the premises to improve the facilities and décor for people.

People were supported to have sufficient to eat and drink in line with their preferences and needs. Staff encouraged people to eat healthily whilst respecting people's right to choose what they ate.

People had their health needs assessed and care plans put in place to meet their needs. People were supported to access a range of health professionals to help them to maintain their wellbeing.

The staff were caring and kind and genuinely enjoyed their work. The atmosphere within the service was welcoming and calm, with staff spending time chatting with people, providing reassurance when needed and being attentive to people's needs.

Staff got to know people by being introduced to them, spending time with them, reading care plans and speaking with relatives. Staff knew people well and used the information they had about people's preferences to tailor their care and support. Some care records were not up to date and did not reflect changes in people's needs. The registered manager was in the process of reviewing and updating care plans and records.

People were supported to take part in one-to-one or group activities. People could choose how they wanted to spend their time and this was reflected in their care plans.

There was a complaints procedure in place and relatives told us they felt comfortable to raise concerns on behalf of their family member and were confident these would be listened to and acted upon.

The registered manager had made improvements in the service to provide safe, personalised care. Staff were clear about their roles and responsibilities and spoke about clear leadership and support which provided them with confidence in managers. The provider undertook a range of audits within the service to ensure people were receiving good care. The outcomes of internal and external audits, together with people's views were used to bring about improvements and develop the service. The registered manager was able to show how they had learnt from incidents in the service and had used the information to improve care. We saw that on-going improvements had been made as a result of this approach. This showed that the service was well-led.

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 and relatives told us they felt safe using the service. Systems to ensure there were enough staff to care for people safely required review. People's risk of harm had been assessed. Records did not always reflect changes in people's needs or measures required to reduce the risk of harm. Staff we spoke with knew how to keep people safe. The provider had implemented processes to ensure people's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had the training they needed to provide effective care. People were supported to make decisions about their care and treatment. People had a choice at mealtimes and were supported to eat healthily. Staff liaised with healthcare professionals to support people to maintain their health and well-being.

Is the service caring?

Good

The service was caring.

Staff had developed positive, caring relationships with people. There was good communication between people and staff. People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs. People's care plans were regularly reviewed; however records were not always amended in a timely manner to reflect people's changing needs. People had access to group and one-to-one activities. There was a clear complaints procedure if people needed to use it.

Is the service well-led?

Good

The service was well-led.

Staff received guidance and support from the managers in the service. People, their families and staff were supported to share their views about the service. The provider had taken action to improve the governance of the service. The provider used audits to check on the quality of the service and made improvements where necessary.

Manorfields Residential 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 16 and 17 October 2017 and was unannounced.

The inspection team consisted of one inspector, a specialist advisor who was a pharmacist and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience for this inspection had an interest in the care of people living with dementia.

We gathered and reviewed information about the service before the inspection, including information from the local authority and previous reports. We spoke with the safeguarding team and commissioners of the service to gather their views of the care provided. We looked at notifications we had received from the provider. This is information the provider is required by law to tell us about. The provider had not been sent a Provider Information Return (PIR). This enables the provider to tell us what the service has done well and improvements planned for the service. We gave the provider and the registered manager the opportunity to share this information with us during our inspection visit.

During our inspection we spoke with seven people and five people's relatives. We also met with the registered manager and the deputy manager and spoke with eight staff, two domestics, a cook and a trainer for staff. We observed care and support being provided in communal areas. We also observed people's lunchtime experience and how they were supported to eat and drink.

We looked at care records and associated risk assessments for five people. We observed medicines being

administered. We looked at four staff recruitment files, training records and documentation related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People and relatives we spoke with told us they felt safe in the service. One person told us, "They [staff] look after me well." A relative told us, "Yes, [Name of family member] is safe here because there's so many staff. I don't have any concerns." Another relative said, "[Name of family member] is definitely safe here. I've never had any issues or anything to worry about. [Name of family member] had an accident once. I felt they [staff] handled it well." This relative told us they thought there was usually enough staff although sometimes they felt their family member had to wait for assistance with personal care, such as using the toilet. A third relative told us, "[Family member] is safe here. I think health and safety are important. They [staff] turn to the senior carer for advice if they are unsure about anything. I think there is enough staff but they don't stop, they are very busy." A fourth relative felt that, at times, there was not enough staff around to support people. They told us, "I think they need more staff, sometimes you have a job to find them [staff], especially if [family member] needs the toilet. I've sometimes had to wait five minutes for help."

Staff who we spoke with told us they felt that there was usually enough staff to meet people's needs but they were sometimes short staffed due to unforeseen staff absence. Staff comments included, "I think there's enough staff, Sometimes, because of [staff] sickness there is no cover and only two of us on duty. That can be difficult but we can ask management for help and they will help," and "Is there enough staff? Yes and no, it fluctuates depending on sickness," and "There is usually enough staff but sometimes we only have two carers on and it is hard, we are rushed. If staff ring in sick we do try and get cover through on-call or staff working extra hours. The seniors do help," and "We are short staffed sometimes in the afternoons. The other afternoon it was just me and another carer. We worked straight through without breaks. We could have done with another staff member as we weren't able to do showers for people in the evening."

We saw staff were busy but had time to speak with people. The atmosphere was calm and people were provided with reassurance and support from either care staff or the activity co-ordinator.

We reviewed staff rotas for the service. These showed rotas were planned in advance and staffing cover was planned in line with the provider's dependency tool. This calculated how many staffing hours were required to meet people's needs. The registered manager told us they reviewed staffing levels on a regular basis to ensure there were sufficient staff to meet people's needs. They told us staff were able to use the on-call system to request emergency assistance in the event of short notice absence that they were not able to cover. They assured us they would review how staff were deployed in the service and meet with staff to clarify the use of the on-call. This would help to ensure sufficient staff were always available to meet people's needs.

Records showed that staff completed safeguarding training when they started working for the provider. This was updated regularly. The provider's safeguarding policies, which included Derby and Derbyshire local authority safeguarding procedures, included procedures for all aspects of safeguarding. This provided staff with the guidance they needed to protect people and work with other authorities with safeguarding responsibilities.

Staff understood their responsibilities to safeguard the people using the service. One staff member told us, "We [staff] need to be vigilant and keep an eye out for changes in a person, such as their body language and mood changes. We report any changes and record any unexplained bruises on a body map and report this to managers. I would report concerns to any of the management or the owner and if they didn't take action, I would go to CQC." Another staff member said, "I know the signs of abuse and how to keep people safe. For example, changes in moods or if someone appears withdrawn or if one person abuses another person. I would report any changes and record this. If managers didn't respond to the concerns, I would go above their heads to CQC or safeguarding."

We looked at how risk was managed at the service. We saw that staff were aware of situations where people might be at risk and took proportionate action to keep them safe. For example, when staff supported people to transfer from armchairs, staff prompted people to use aids and chair arms to support themselves to stand and sit. Staff ensured people were sat back in the seat of the chair to prevent them from falling forwards. Another person had a sensor mat in their room so staff were alerted if they got up at night and needed assistance. These were examples of staff managing risk in order to keep people safe.

Where people were at risk, care plans and risk assessments were in place so that staff had the information they needed to help reduce the risk. However, some risk assessments were generic and did not include all the guidance staff needed or reflect the person's current needs. For example, one person's risk assessment identified they were at risk of falls and advised staff to 'monitor at all times whilst mobilising independently.' Records had not been updated to reflect a significant change in the person's needs as they were no longer able to mobilise independently. A reference was made to the use of slide sheets within the risk assessment. However, there were no details or guidance for staff as to how this equipment was to be used to support the person. Another person was assessed as 'unable to weight bear.' However, we observed the person standing and taking small steps. These examples showed that records did not always reflect the current risks people were exposed to and the measures needed to keep people safe.

Staff demonstrated they were familiar with people's needs and knew how to keep people safe. One staff member told us, "There is always someone around in the lounge. If people become agitated, we can diffuse this quickly to prevent harm to them or other people. We have equipment to move people safely, for example standing belts and profile beds and we are trained in how to use this." We saw staff supported people to move around the service safely when they required support or used equipment such as mobility aids.

The registered manager told us they were aware that care records required updating and had already begun the process of reviewing and updating care plans and risk assessments. We looked at a care plan which had been reviewed and updated. Records showed risk assessments reflected the specific risks to the person and included measures staff needed to take to reduce the risk of harm. This demonstrated the registered manager had taken action to ensure records reflected people's current needs and risks to people were assessed and action taken to keep people safe.

The provider was maintaining records of accidents and incidents which occurred in the service. Staff completed incident and accident forms and these were reviewed and analysed by senior staff and the registered manager. Although records detailed immediate action taken as a result of the incident, for example, medical assistance and increased observation, records did not show what action had been taken to reduce the risk of further incidents or accidents. Risk assessments were not reviewed to ensure measures in place to control risks remained appropriate. The registered manager told us they would ensure records showed what action had been taken to reduce the risk of future harm for the person.

There were personal emergency evacuation plans in place in case of emergency, such as fire. The plans reflected people's level of mobility and indicated the support and equipment they would require to move to a place of safety. This information was available for staff to use in an emergency.

Records showed staff were safely recruited. The staff recruitment files we sampled had the documentation in place to demonstrate proof of identify, previous work history and references. Staff had completed a check with the Disclosure and Barring Service (DBS) before starting to work in the service. This meant that checks had been completed to help reduce the risk of unsuitable staff being employed in the service.

Prior to our inspection, we received concerns regarding the management of medicines within the service. The local authority told us there had been a number of medicine errors within the service and they had taken action to ensure the provider brought about the required improvements. We found that improvements had been made to the management of people's medicines, although these had yet to be fully embedded in staff working practices.

At the time of our inspection, the treatment room was under refurbishment and a temporary treatment room was being used to store medicines. This was locked but was not temperature monitored. This is important to ensure the condition of medicines is maintained within the required temperature range. When we informed senior staff of this, they immediately installed a thermometer in the room and told us they would implement daily records to ensure the temperature range was safe.

Each person had a medicines plan which explained how they preferred their medicines to be given to them. Medicine records included a photograph of the person and details of any allergies or specific instructions to support the person to take their medicines. Where people were prescribed medicines as and when required, such as pain relief, protocols were in place to provide staff with the information they needed as to when and how these medicines should be administered. This helped to ensure people were given their prescribed medicines safely, when they required them.

We observed as a member of staff administered medicines to people. The staff member demonstrated they involved each person as much as possible in the process, giving them time to take their medicines and supporting them in line with their preferences. Where people declined their medicines, the staff member respected this and returned a short time later to try again in line with the person's medicines plan. One person required their medicines to be administered covertly, disguised in food or drink. Records showed this had been authorised by the GP and was in accordance with best interest decision making for the person.

Staff who were responsible for administering medicines told us they had recently completed additional training in the management and administration of medicines and this was confirmed in the records we saw. This provided staff with the knowledge and skills they needed to support people to take their medicines safely. However, we saw some practice that was potentially unsafe. For example, the staff member dispensed medicines from blister packs or containers to a small medicine pot and took this to each person. If a person declined their medicines, this pot was returned to the medicines trolley for the staff member to try again a while later. The pots contained loose medicines and were not labelled. The staff member told us they recognised the tablets and knew which tablets belonged to which person. However, this practice increased the risk of error in administering medicines to people. The registered manager told us they would ensure this was not common practice and would advise and monitor to ensure staff followed the correct procedures.

We observed that the morning medicines round was time-consuming and took senior staff away from care for some time. This was because rather than take the dispensing trolley to people, medicines were

dispensed from the treatment room and staff returned to the treatment room after supporting each person around the service. The registered manager told us this was because staff found they were distracted by people during the medicines round and felt this process reduced the risk of error. We recommended the registered manager review this once staff were confident with new systems and procedures to identify if this was the most effective way of administering medicines.

The registered manager had reviewed and revised systems and processes for managing medicines as a result of recent concerns. This included the re-ordering and supplying of medicines to ensure people were provided with medicines in a timely way. Staff who administered medicines undertook daily audits of medicines and records and reported any low stocks to senior staff to re-order in good time. A senior staff member had the responsibility of liaising with health professionals and the pharmacist to ensure that medicines were received in time and people did not miss medicines due to a lack of availability.

Good

Is the service effective?

Our findings

People and relatives we spoke with thought staff were well trained and able to provide effective care. One relative told us, "I think they [staff] are good at what they do. They treat [name of person] as they were family. I don't think they could have been looked after better elsewhere." Another relative said, "I think the majority [of staff] have the skill and knowledge they need to look after [name of family member]."

Throughout the inspection we observed staff supported people effectively. We saw they were confident and skilful in their interactions with people and used equipment effectively. They talked with people as they supported them to put them at ease.

Staff were positive about the training they received. One staff member told us, "We have lots of training. I've done most of it, dementia awareness, tissue viability, challenging behaviour, etc. If you don't feel confident in an area you are supported to get more training. New staff always shadow experienced staff to learn the ropes." The staff member went on to tell us about further development training they were about to undertake to support them in their role. Two staff described their induction as positive and gave them the skills they needed to do their role. They told us they undertook regular training to keep their skills and knowledge updated and were keen to attend any training to enable them to develop in their roles. Another staff member told us they had asked for further training as they were not confident in using some of the equipment in the service. They told us managers had responded by ensuring they did not use the equipment and were arranging further training to give them the confidence they needed.

We spoke with a visitor who was responsible for providing some of the training to staff in areas such as managing behaviours that can challenge and administering medicines. They told us training sessions were face to face and provided staff with an opportunity to discuss 'real-life' scenarios to help them apply the training in practice. This demonstrated staff were supported to gain the skills and knowledge they needed to provide effective care.

The provider maintained records of staff training and these showed staff had completed a wide range of courses. Some were general, for example health and safety, and other specific to the service, for example dementia awareness. Training was planned in advance and provided on a regular basis to enable staff to attend sessions throughout the year. The registered manager described staff induction which included face to face training and time spent working alongside experienced staff to get to know people and their routines and preferences. Senior staff undertook competency assessments on all staff to ensure they were competent in their role and supported staff to identify any development needs and staff were provided with regular feedback about their work.

Staff told us they felt supported in their roles. One staff member told us, "I am well supported. [Name of deputy manager] is stern but not rude about it. She sits us down and tells us what we are doing well and anything we are not doing or need help with." Another staff member told us, "I have regular supervisions and feel well supported. They [deputy manager] helps me out if I am struggling with anything. I feel they are there for me." Staff told us about working together as a team and supporting each other. New staff spoke

about feeling welcomed into the team and supported by experienced staff to develop their skills and knowledge of people's needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any 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. The registered manager told us there were nine people with DoLS authorisations in place and applications had been made for a number of other people. This was in relation to people who required constant supervision and people who were restricted by a locked door for their safety. We saw that where conditions were in place for authorisations, these were mostly being met. However, we found that staff were not maintaining accurate records for one person where this was a condition on their authorisation. This was important to support best interest assessors to review if the authorisation was still required in the person's best interests. The registered manager told us they would ensure this information was recorded immediately.

The registered manager kept a record of all DoLS authorisations, including the date they were granted, the date they were due to expiry and the date applications were made. This meant authorisations were kept under review to ensure people were not being unlawfully deprived of their freedom.

Staff had had training in the MCA and DoLS and understood the importance of people consenting to their care and their responsibilities to comply with this legislation. We observed this applied in practice, with staff respecting people's right to decline care and treatment and an awareness of who had DoLS authorisations in place. People's care plans detailed decisions and choices people were able to make and what, if any, support was required. Where people were unable to make decisions about their care, for example the use of specific aids or equipment or consent to medicines, decisions were made on their behalf using best interests procedures. If people had a Lasting Power of Attorney (LPA) in place for relatives to legally make decisions about care in their best interests, care plans included a copy of the relevant documentation. People's mental capacity was reviewed so staff could monitor people's choice making abilities.

People and relatives said the meals were good. We saw people were supported to have drinks and snacks throughout the day. One person told us it was the first time they had tasted a smoothie which the cook had made as an alternative choice to hot drinks and juice. They showed interest in this and asked the cook what was in it. They told us they had enjoyed it for a change. One relative told us, "[Name of person] eats well and gets drinks whenever he wants them and extras like yoghurts." Another relative told us, "It's lovely food. His drinks are thickened (in line with dietary guidance) and he gets enough to eat and drink. He gets a choice of food." A third relative told us how staff had supported their family member where they were at nutritional risk. They told us, "[Name of person] wasn't eating very well so they [staff] tried little things to encourage her, like putting little things on a plate or giving her supplements (following advice from nutritionist). I know staff are monitoring her weight because they told me she had put on weight. They support her to eat and sometimes they feed her. She has choices of food which is on the board."

People were provided with a choice of meals and these were presented in pictorial and word form to support people to make choices. The cook told us they were provided with information about people's dietary requirements and this was updated regularly. Although menus were set by head office, the cook told us they knew what people did and didn't like and therefore offered meals in line with people's preferences. The cook told us they catered for people with cultural needs, such as Halal, by ordering Halal foods and ensuring separate storage and preparation areas. They gave examples where they had consulted with people and amended menus and choices as a result of people's feedback.

We observed the lunchtime meal. We saw that people were offered choice of where to eat and where to sit. Tables were laid with tablecloths and flowers to support a pleasant dining experience. The food looked appetising and nutritious and was adapted in terms of portion sizes and choices of sauces to suit each individual person. Where people needed support to eat their meal, this was provided in a sensitive way. We saw some occasions where staff did not interact with people and simply placed meals in front of the person. This practice did not support a positive eating experience. People appeared to enjoy their meals and were able to eat at their own pace.

People were registered with a local GP. The registered manager told us that the GP was very supportive and undertook weekly 'ward visits' to the service to check on the health and well-being of people. The registered manager told us the GP was available to assess any changes or concerns regarding a person's needs and completed regular medication reviews. This professional relationship supported staff to identify and respond to any concerns about people's health and well-being promptly and ensure people had access to the healthcare they needed. Records showed that people saw a range of healthcare professionals routinely for health checks and as necessary if there were concerns about their health.

The premises had been adapted to meet the needs of people living with dementia. The provider was in the process of re-decorating and upgrading areas and rooms to improve the environment for people. Some communal areas had already been re-decorated and visitors spoke positively of the improvements. One relative told us, "It's a wonderful environment for people with dementia. They've [provider] done marvels with the decor. It was a bit dingy before. Some of the residents come and touch the books (on the wallpaper)." The premises were clean and comfortable, although there were areas where improvements could be made. Some communal areas were cluttered. Staff told us this was temporary whilst upgrading work was being carried out. There was a malodour in the lounge area on both days of our inspection. We spoke with domestic staff who told us they were aware of this and used specific cleaning products to address this. However, they told us this was surface cleaning and deep cleaning of fabrics and upholstery was less frequent and had to be planned in advance. We asked the provider to review materials in communal areas, including flooring, to ensure fabrics and materials were able to support the needs of people using these areas.

Good

Is the service caring?

Our findings

Relatives told us the staff were caring and kind. One relative we spoke with said, "I think they [staff] form close bonds. They have some wonderful carers here. They [staff] are very amenable so you know she's getting genuine affection when the family aren't here. Even the domestics - they show a genuine interest in the residents." Other comments included, "The quality of staff is caring, they can't do enough," and "I'd put my trust in them. They [staff] are kind and caring," and "Staff always greet you at the door. It's like a family and I think that's good," and "It feels like home, it's like one big family here. The staff are so friendly and always make you feel welcome."

Staff who we spoke with told us they enjoyed working in the service. Comments included, "I think we develop bonds with the residents. I love it here," and "I like working with the residents, it's the same as a family. It's a nice feeling to make them happy, it gives me job satisfaction," and "I like working here. I am attached to people and it's a great staff team."

We saw good communication between people and staff throughout our inspection. Staff took time to listen to people and check if they needed any help or support. People looked relaxed in staff company. There was 'banter' and shared humour between staff and people which ensured that all the people were involved and included in the everyday interaction. One person's main language was not English and we observed them respond positively to a staff member who was able to converse with them in their first language. A relative told us, "Staff can communicate with [name of person]. It's difficult because [name of person] speech is limited but they [staff] know him. They know his moods, they can tune in. They report back to me to tell me if it's a good day or bad day."

Staff were discreet when offering to provide personal care to people. Staff gave examples of how they promoted privacy and dignity, such as knocking on doors, covering people, adjusting clothing and putting screens around people if they were receiving medical assistance. Staff spoke in a respectful way to people and addressed them in the way their care plan said they preferred. Staff explained to people what they were doing. When supporting people to cover their clothing with protective aprons during meal times, staff checked with people if they were happy to wear them and explained what they were for. This was an example of staff respecting the people they were supporting.

Relatives told us they had been involved in developing their family member's care plan with the person wherever possible. One relative told us, "I am fully involved in [name of family member] care. Staff have always involved me and keep me informed of what's happening. They also provided information about the stages of dementia and what I could expect which has been really helpful as [name] dementia progresses." Two relatives told us they had been signposted to the service by health and social professionals and were able to make a decision before using the service through visiting, speaking with staff and information given to them in the service user guide.

Good

Is the service responsive?

Our findings

Relatives said they thought the service provided responsive care that was personal to their family member. They provided examples where staff had responded to changes in people's needs and kept relatives informed of these. One relative told us, "They [staff] keep me informed and involved in the care (of family member). For instance, some of [Name of family member] medicines were stopped and staff think it's affected [name] behaviour negatively. Staff and myself are meeting with the GP to review medicines and discuss this." Another relative told us how staff responded to their family member's moods and adjusted their approach to "good and bad days."

There was a member of staff employed to support people with their hobbies and interests, known as the activity co-ordinator. On the day of our inspection we saw people playing indoor bowls. There was laughter and cheers when anyone knocked down the pins. The activity co-ordinator supported each person to hold and throw the ball in turn. People were also supported with individual activities, such as jigsaws and colouring. The activity co-ordinator told us that she provided manicures to people and hand massages which they enjoyed.

Relatives who we spoke with shared mixed views about the activities provided. Comments included, "There is not enough activities to keep [name of family member] stimulated. He likes music, they [staff] used to have music and old songs but they don't do that now. He has to be encouraged to do anything. They [staff] put puzzles on the table but without encouragement he can't do it," and "They [people] need more entertainment. [Name of family member] says 'I am sitting here doing nothing.' I don't see staff give him one-to-one attention." The registered manager told us they were in the process of developing the environment and activities to provide stimulation for people who needed this.

People's care plans contained information about their health, social and personal care and recreational needs. Care plans included a one page care summary which provided staff with a quick reference to the person's profile and needs. These included information about what a good and bad day looked like for the person. For example, for one person a good day was sleeping well and having visits from their family. A bad day was a day without any family visits and being exposed to excessive noise. This guided staff to recognise and provide additional support on the person's 'bad' days. Care plans included details of the person's wishes and preferences, for example bedtime routines and how they liked to spend their time.

People and their relatives had contributed to a document titled 'This is me'. This enabled people and their relatives to detail personal history, including life and work, any significant events, hobbies and interests and people who were important to them. For example, one person had a preference for a particular object that provided comfort to them. Care records showed this person had been provided with this object and they had responded positively to this. This gave staff insight into people's life history and how they wanted their care to be provided. It helped staff provide personalised care.

Care plans and risk assessments provided staff with key information about the people they supported and included explanations of what might cause behaviour that challenges us, how to prevent it, and how to

respond in a positive way when it occurred. This meant staff had the information they needed to diffuse potentially challenging situations.

We found that although care plans were regularly reviewed, some care plans were not reflective of people's current needs. For example, care plans had not always been updated to reflect changes in people's mobility or health conditions. However, staff demonstrated they understood people's current needs and knew how to meet these. The registered manager was aware of this and showed us they were in the process of updating all care plans and records. We looked at one person's care plan that had been reviewed and updated by the care manager and found this reflected the person's current needs and provided detailed information and guidance to support staff to provide responsive care.

In order to monitor people's well-being, staff recorded each person's activities, their behaviour and communication, food and fluid intake (where appropriate) and interaction on handover records. This included any changes, outcome of appointments, details of care provided and a summary of the person's state of mind and well-being. We heard staff, in the privacy of the office, discussing changes in people's condition and considering the best course of action to take. This demonstrated that staff shared information appropriately and were responsive to people's needs.

The provider was committed to providing care that was responsive to the needs of people living with dementia. The registered manager was a trainer in 'Jewels in Dementia.' This approach categorizes stages of dementia into different gemstones, each with a unique set of characteristics to highlight what helps—or doesn't help—when caring for someone at that stage. Each person's care plan included an assessment through the dementia jewels and identified which gemstone, or stage, the person was. This helped staff to understand each person's stage of dementia and the approach they needed to take in response.

The provider had a policy and procedure in place for complaints and records showed if these were received there was a set process to follow. This meant complaints were investigated and responded to within a set time period. If people were unhappy with the outcome of their complaint, they were provided with contact details of external agencies to which they could escalate their concerns. Relatives who we spoke with were confident to raise concerns with staff and felt staff usually took immediate action to address their concerns.

Good

Is the service well-led?

Our findings

People who we spoke with told us they were happy living at Manorfields. Relatives who we spoke with were mostly positive about the leadership of the service. Comments included, "This care home impressed me when I was looking for somewhere. You can have a five star home but you need the right staff (which they have here)," and "They [staff] manage [name of family member] needs well. I wouldn't consider a change of care home," and "I think it's well led, the leader of the care team - such dedication!" One relative felt that staff would benefit from more management support on each shift to provide them with supervision.

Staff told us they enjoyed working at the service and many staff spoke about positive changes and improvements following recent changes in the management of the service. Comments included, "I feel well supported and [name of deputy manager] bends over backwards to help us out. It's much better than when I first started due to the management changes," and "It is well-managed, we have good and bad days," and "[Name of deputy manager] is brilliant. If we are struggling or need support we go to her and she sorts it out. She 'mucks in,' it is much better than when I started. There was a large staff turnover because they were unhappy about the management. Since [name of registered manager] has come in they make sure we know what we are doing," and "Things are done straight away. The manager changes have been good. I like working here, communication is so much better."

Staff confirmed they were consulted and supported to share their views through staff meetings, questionnaires and through one-to-one meetings with managers. We looked at minutes of staff meetings for July 2017 and found staff were provided with opportunities to share their views and review working practices to identify where improvements could be made. For example, managers had discussed recent concerns around the areas of managing medicines in the service with staff and identified where and how improvements needed to be made. These had been implemented which meant people received their medicines safely. Meetings were used to refresh staff knowledge of key policies and procedures, such as procedures for supporting people in the event of their death, which helped to ensure staff responded consistently and had the knowledge they needed in their role.

There was a registered manager in post who was supported by a deputy manager. The deputy manager oversaw the day-to-day management of the service and worked closely with the registered manager who visited the service at least three times a week or as and when needed and was in regular contact with the deputy. The registered manager told us they were supporting the deputy to gain the knowledge and skills they needed to take on the role of the registered manager. This involved training and mentoring which the deputy manager told us enabled them to gain the confidence and skills required in the role. The registered manager had recently appointed a staff member as 'head of care' who was responsible for liaising with the pharmacist and health care professionals to ensure people were provided with safe care. This management structure provided clear leadership and effective communication within the management team.

We saw that the registered manager and deputy manager were available to speak with staff, people and relatives throughout the day. Both the registered manager and the deputy manager had a visible presence in the service and we saw people and staff approaching them comfortably. Relatives meetings were held

throughout the year and were used to discuss changes, forthcoming events and issues in the service. A small number of relatives attended these meetings but other relatives were supported to share their views through annual satisfaction surveys. We saw these had been completed and comments were largely positive such as, "Staff are excellent and do their job over and above what it is required," and "We always have a warm welcome. Staff are very busy - friendly and chatty." The registered manager had collected comments and suggestions and put the results up on notice boards in the service to share feedback with people and visitors and advise them on what action was being taken. Where relatives had raised individual concerns, for example one relative has asked for better communication about their family member's care, records confirmed improvements had been made as a result. This showed people and relatives were able to share their views of the service and influence how it was run.

The provider had a system in place for assessing the quality of the service. They visited the service regularly to obtain feedback from people and staff. The registered manager carried out a series of audits. These were both scheduled and random, for example audits of records and observations of staff working practices. These covered all aspects of the service including care, medicines, staffing, food and premises and health and safety. The area manager reviewed audits and responded with support and guidance to the registered manager to ensure improvements were made. This helped to ensure the provider and registered manager had an overview of how well the service was running.

Records showed these audits had identified where some developments were needed to the service and timescales for these to be actioned. For example, audits undertaken in August 2017 identified improvements were required in care plans and records to ensure they were up to date and personalised. The registered manager had begun to take action to address this. The registered manager had introduced new systems and procedures, including staff training, to support the safe management and administration of medicines. The provider was in the process of upgrading the premises which included a new treatment room to support the safe storage of medicines and a ground floor wet room for people. These were examples of on-going improvements within the service.

The local authority told us they felt the service had made improvements to the quality of care people received. They told us the provider was working through an action plan to ensure improvements were sustainable and embedded into working practices. This was being monitored through the local authority quality processes.

The registered manager was aware of their legal responsibilities and statutory notifications had been submitted about significant events and incidents within the service. The provider had ensured that the current ratings for the service were displayed in the service and on the website.