Ranc Care Homes Limited

Manton Heights Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Manton Heights Care Centre (Manton Heights) is a residential care home providing accommodation and personal care to up to 91 people. The service comprises of two purpose-built buildings on one site. The main building provides care in three units including one specifically supporting people living with dementia. The second building supports people living with acquired brain injuries.

People's experience of using this service and what we found
Risk assessments were not always sufficiently detailed and, in some instances, had not been completed at all. This, and a lack of incident reporting and analysis put people at risk of harm.

Staff felt overstretched. Not all incidents had been reported, and this may have had a negative impact on how staffing requirements were calculated. We have recommended the provider explores good practice guidance in relation to incident reporting and uses this to support the calculation of staffing numbers required to meet people's needs.

Although pre admission assessments had been completed they lacked essential detail. Staff completing these did not understand how to use the system and consequently completed them incorrectly. It was established during the inspection that the provider had a new, simpler system in place now, but this had not been used by Manton Heights. Care plans and priority risk assessments were not developed in a timely manner following a person's admission to the service. This meant people were put at risk because staff did not have the right information with which to support them well.

Medicines were managed safely, and people were supported to have their health care needs met. They had enough to eat and drink and were supported by staff to make choices about this.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, where decisions had been made in people's best interests, this was not always recorded and the rationale for any restrictions in place had not always been clearly identified.

Staff were checked as suitable before they started work, received an induction and training to support them to carry out their duties well. However, the induction for the new manager had not been completed in line with the provider's policy. They had been left with insufficient support in the first weeks of their role. This, and the lack of a deputy manager meant team leaders and senior staff were under more pressure to carry out more leadership duties. Without time off the care rota for them to do this, the impact on people was team leaders had less time to ensure their needs were being effectively met.

Although the provider had quality monitoring systems in place, they had not been effective in identifying the issues we found at this inspection. However, the provider had recognised the need to make improvements

and was in the process of rolling out a new governance system to all their services.

The service was clean, and staff were trained in infection control and followed robust processes in line with their training to reduce the risk of cross contamination. The provider had a robust and continuously updated strategy for protecting people from the risk of Covid 19 infection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (report published 8 March 2019)

Why we inspected
The inspection was prompted in part by information shared with us about two specific incidents. Following one of these incidents a person died. This incident was subject to a criminal investigation at the time of the inspection. This was discontinued on 12 May 2020. As a result, this inspection did not examine the circumstances of the incident. We looked into the other incident where interactions between two people using the service had put one person at potential risk of serious harm.

The information CQC received about these incidents indicated concerns about the management of admissions, falls and behaviours that may put the person or others at risk of harm. This inspection examined those risks. We undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

The manager and the provider were very responsive to our feedback about the improvements required at the service. On the second day of the inspection we found they had already taken steps to improve support to the service and to start making the necessary improvements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Manton Heights Care Centre on our website at www.cqc.org.uk.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Manton Heights Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three inspectors. The lead inspector carried out the first day of inspection with one inspector and was supported by a different inspector on the second day.

Service and service type
Manton Heights Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a new manager, but they had not registered with the Care Quality Commission yet. This means that the provider alone is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The first day of this inspection was unannounced. The second day of the inspection was announced. We gave very short notice of this visit by telephone on the morning we were due to attend. This was because the visit took place at the beginning of the Corona virus outbreak in the UK and we needed to make sure the service was still able to accept visitors.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We attended a strategy meeting with the local authority and the police about an incident following which one person died. The provider was not asked to complete a provider information return prior to this inspection. This is information we require

providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with two people who used the service and one relative about their experience of the care provided. We spoke with nine members of staff including three members of the provider's senior management team, the manager, team leaders/senior support workers, and care staff.

We reviewed a range of records. This included eight people's care records, medicine administration records, staff files in relation to recruitment and training/induction. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at reports relating to the two incidents that triggered this inspection.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; learning lessons when things go wrong

- Staff did not always record incidents that they perceived as everyday events, particularly in relation to behaviours that may put the person or others at risk.
- This meant that any impact on people was not monitored effectively. Any necessary action was not taken, including referrals to the local authority safeguarding team where necessary.
- This also meant it was not possible to accurately analyse the impact of what took place, or to draw information from it to support improvements to the care provided to people.
- Following the inspection, the provider completed an analysis of the two incidents that prompted this inspection and identified improvements that would be made to the service as a result of these events.

Assessing risk, safety monitoring and management

- Risks had not always been assessed and managed appropriately.
- This included risks that were already known and/or identified on the person's admission to the service.
- For example, one person who lived with epilepsy, and another person who was prescribed blood thinning medicines, did not have any risks associated with these conditions, and a plan for how to support their needs was not developed.
- A third person, who was at potential risk in relation to the known behaviour of a person moving in to the service, had no risk assessment in place in relation to this.
- On the second day of our inspection we found the provider had taken steps to commence a full review of assessment of high-risk care needs such as falls and epilepsy to ensure clear guidance was in place for staff from then on.

Staffing and recruitment

- Although the manager told us the numbers of staff on the rota exceeded those assessed as required to meet people's needs, staff reported feeling overstretched at times. Not all incidents had been reported, and this may have had an impact on how the number of staff required was calculated. In one unit during lunchtime, we observed one staff member was trying to help three people to eat their food. They left a person they were supporting to eat three times to help two others. This meant the person had to wait longer for their next spoonful of food.

We recommend that the provider follows current good practice in relation to monitoring incidents and uses this information to effectively inform the staffing levels required to meet people's needs safely.

● The service did not have a deputy manager at the time of the inspection. This meant that, when the manager was not on duty, the most senior staff in the building were unit team leaders or senior support workers. This put additional pressure on them on top of their usual duties. The provider's representative confirmed that recruitment to the deputy post was underway.
● The provider had a safe recruitment process to help make sure staff employed by the service were suitable. This included checks such as references and disclosure and barring checks that were carried out before employees started work. This kept people safe because it helped the manager make sure that only suitable staff were employed.

Using medicines safely
● Medicines were managed safely.
● The provider had systems in place to order, store, administer and dispose of medicines effectively.
● Medicines were only administered by staff who were trained and assessed as competent to do so.
● Where any errors took place, these were recorded and acted on appropriately, and staff involved in the error received further training before being able to administer medicines again.
● Where people were prescribed 'as required' medicines, protocols were in place to ensure they were administered in lines with the direction received from the prescriber.

Preventing and controlling infection
● People were protected from the risk of infection.
● The service was clean and well maintained. There were no lingering odours.
● Staff understood good practice in relation to infection prevention and control and had a good supply of personal protective equipment such as disposable gloves and aprons.
● The provider had developed a robust plan to manage the risk of infection by Covid-19 virus and was updating this daily in line with public health guidance.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Before this inspection we asked the manager to send us further information about the pre admission assessment process for one person who had recently came to live at the service. This was because an incident had taken place following their admission which had put another person at risk of harm.
- The person admitted to the home was known to the service as they had previously been a visitor and had been involved in incidents which placed the same person at risk. This had resulted in the police being in attendance at the service on more than one occasion.
- We found the pre-admission assessment carried out for this person lacked detail about their needs. It had also had not referenced the known risk, the rationale for the admission in the light of it or steps to be taken to reduce it.
- During the inspection, we looked at the admission process for the five people most recently admitted to the service, including pre assessment and the development of care plans and risk assessments.
- We found shortfalls in these processes for all five people. This included incomplete information on assessments, incorrectly followed assessment processes, and a failure to recognise priority care needs and associated risks, resulting in care plans not being put in place in a timely manner.
- Following the first day of the inspection, the manager was taking action to review these assessments and to reinstate a system to ensure an initial care plan and risk assessments were put in place within 24 hours of a person being admitted to the home.

Staff support: induction, training, skills and experience

- The provider had an induction process for all levels of staff when they were newly appointed. However, we found this process had not been followed for the new manager when they took up post.
- There was no written record of an induction taking place for the new manager and the induction workbook was not completed or signed off by the manager's line manager.
- A representative for the provider told us that the manager's induction had been carried out by the previous manager before they left the service. However, this was not in line with the provider's policy and no written record was made.
- There was no record of the new manager having received any formal supervision from their line manager. We were told by a representative for the provider that supervision of the manager would have formed part of the monthly quality monitoring visit. This would not be usual practice and supervision would normally be a separate process.
- During the inspection we identified that changes to the provider's systems and processes were not relayed to the new manager during their initial weeks of work. This meant that the service continued to work with

systems that were out of date.
● Staff received training to equip them with the skills they required to carry out their duties.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any 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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● We found that restrictions had been put in place for two people in relation to their contact with each other. Due to a risk of harm to one or both people concerned a decision had been made to only allow them to meet under staff supervision.
● This may have been appropriate and the least restrictive way of managing the risk. However, there were no capacity assessments completed for either person in relation to this decision and no record that, if they had capacity to do so, they had been asked for their consent.
● There was also no record of a best interest decision being followed or who had been involved in deciding that this was the best course of action.
● One of the people concerned had a DoLS in place but this restriction was not identified within the authorisation. The other person did not have a DoLS in place. The manager told us that they were uncertain whether the person required one as their capacity fluctuated. They confirmed they would be seeking advice from the local authority DoLS lead in relation to this.
● We saw that DoLS for other people using the service had been applied for appropriately and where conditions were in place these were recorded and addressed in the person's care plan.
● Staff asked people for their consent before providing care and worked within the principles of the MCA.

Supporting people to eat and drink enough to maintain a balanced diet
● People had enough to eat, although food and fluid charts were not always completed fully.
● This may have been partly due to some staff completing records at the end of their shift rather than at the time of supporting people to eat and drink. Team leaders were aware of this issue and told us they were addressing this with staff to improve practice.
● The food provided at lunchtime appeared to be of good quality and people said they enjoyed it and were offered options to choose from.
● Plenty of drinks were available throughout the day which protected people from the risk of becoming dehydrated.
● People's specific dietary needs, such as a soft diet to reduce the risk of choking, or a diet suitable for people living with diabetes, were known and provided for.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Staff knew people's needs well and ensured that any changes in a person's condition was noted and discussed with the management team.
● They shared information with each other as necessary to ensure effective care could be consistently provided from shift to shift.
● We saw from records that staff made referrals to professionals such as GPs, Community Nurses, Opticians and Chiropodists as necessary.

Adapting service, design, decoration to meet people's needs
● Manton Heights is a purpose-built premise on two floors with a detached annex containing the unit for people living with acquired brain injury.
● In addition to the buildings, there were level access garden areas. The buildings were fully accessible and equipped to meet people's physical needs.
● The premises were decorated to a high standard and people were encouraged to bring belongings to furnish their bedroom and support them to feel at home.
● There were several areas of the home with signage to help people find their way around the building. Some people had their photograph and a memory box outside their bedroom doors to help them find which room was theirs. Memory boxes are small wall mounted boxes containing pictures or familiar items which may help people recognise that room as their own.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the time of this inspection the manager had not submitted or had approved their application to register with CQC.
- We identified shortfalls in quality performance that had not been identified by the provider's own monitoring systems. We found not all incidents had been recorded and monitored. Additionally, the lack of adequate and timely risk assessment and care planning had also not been identified by the provider's auditing systems. It had also not been picked up that pre admission assessments were ineffective; that staff were not only using an out of date assessment form but did not understand how to use it and had completed it wrongly.
- The new manager was an experienced manager, but had not received a robust induction to the service from the provider when they took up post. This meant that they were still familiarising themselves with the provider's systems and processes.
- On the manager's first day in post the team leader for the Acquired Brain Injury left their position, and within a short period of time, the deputy manager also left. This meant that the new manager had very little support when taking on their new role and staff did not have support from managers who were familiar with the service. Although the provider was recruiting to the deputy position and the team leader position was now filled, they did not take adequate steps to ensure the service was supported adequately in other ways at this time.
- When the manager was not on shift, the most senior staff were team leaders or senior support workers who were responsible for running the shift and managing any issues that arose in the service. Staff at this level we spoke with felt overstretched and ill equipped to take on this responsibility.
- The provider had not taken sufficient steps to ensure staff were aware of, and confident to make use of, emergency support systems. Although an on-call system was in place to support staff in an emergency, this was not utilised on one occasion when a serious incident took place when a person fell and sustained a serious injury. Staff managed this critical situation for several hours in the absence of the manager without contacting senior managers for support.
- Quality monitoring systems have now been created by the provider as part of their further development and commitment to quality, improvement and good governance.
- The provider was also in the process of reviewing assessments of needs using a new process, as well as risk assessments and care plans for all people using the service. The provider was ensuring that senior management support to the service was strengthened and recruitment of a deputy manager was made a

priority.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We found that the views of people and visitors had not always been treated with equality, particularly if the individual raising concerns was thought to lack capacity or to have mental health issues.

● There were ways for people and their relatives to make their views known, including satisfaction surveys, a suggestions box and regular meetings. People's views from these sources were considered when making improvements to the service.

●Staff gave mixed feedback about whether their views were taken seriously and used to make improvements to the service and some described morale as low. Some staff told us they felt the manager was inconsistent; sometimes responding in a positive way and other times being less approachable. Other staff, however, said that their relationship with the new manager was improving as they got to know each other and understood each other's expectations.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider promoted a person-centred culture within their policies and stated values and staff understood and shared these. However, staff reported feeling stretched and unable to provide the quality of care they wished to.

●Team leaders and senior staff did not have off rota hours to enable them to carry out their leadership role, which over time had an impact on the quality of care and the outcomes for people. This was further affected by there being no deputy manager in post.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager told us they promoted transparency within the team. They communicated with people, family members and health and social care professionals in an open way.

Continuous learning and improving care; Working in partnership with others

● The service worked in partnership with health and social care professionals who were involved in people's care.

● Following the incidents that had triggered this focussed inspection the provider carried out a thorough analysis of each incident and produced a report of actions taken as a result of what had happened.

● The provider and manager were responsive to constructive feedback from CQC and other partners and acted swiftly to address any issues identified.