Hyde Lea Nursing Homes Limited

# The Manor House Nursing Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
The Manor House Nursing Home is a residential care home providing personal and nursing care to 70 people aged 65 and over at the time of the inspection. The Manor House Nursing Home can support up to 125 people in three adapted buildings. One building accommodates people with general nursing needs. The second building accommodates people living with dementia and mental health needs across three separate floors, each of which has adapted facilities. The third building accommodates people who have recently been discharged from hospital and require assessment of their longer-term needs over two separate floors.

People's experience of using this service and what we found
People were not protected from the risk of abuse. Incidents were not reported to the safeguarding team. People were exposed to risks from COVID-19 as staff were not following the government guidance. Risks to people's safety were not assessed and mitigated which exposed them to the risk of harm. Medicines were not given as prescribed and the guidance for staff was not effective leaving people at risk of their health deteriorating. Where people had accidents or incidents occurred there were no actions taken to prevent reoccurrence and people were left at risk of harm

We found significant concerns about the management of the home. The systems were either not in place or not effective to assess, monitor and improve the quality and safety of the service. The system had failed to ensure risks were assessed and mitigated. When things went wrong the provider had failed to analyse incidents and take action to prevent reoccurrence. The systems had failed to ensure people were safeguarded from abuse.

The systems to check on the quality of the care people received had failed to identify the concerns we found which are summarised above.

People were supported by enough staff. However, agency staff were in use which meant people were experiencing inconsistent care. There were improvements needed to how people, relatives and staff could feedback about the service. The provider needed to improve how they engaged with other professionals.

Rating at last inspection
The last rating for this service was requires improvement (published 21 February 2020).

Why we inspected
The inspection was prompted in part due to concerns received about whether people were receiving safe and effective care including a number of allegations raised about people being neglected. We received concerns about the management of risks to people and clinical oversight. As a result, we undertook a focused inspection to review the key questions of safe 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.
We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Manor House Nursing Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding people from abuse, managing risks to people's safety and governance and oversight of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work with the 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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-led findings below.

# The Manor House Nursing Home

**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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of four inspectors.

Service and service type
The Manor House Nursing Home 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 manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection so we could clarify the service's Covid-19 Personal Protective Equipment (PPE) practice for visiting professionals and identify persons who were shielding or Covid-19 positive so we could respond accordingly.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, clinical commissioning group (CCG), continuing health care (CHC), Police, coroners service and professionals who work with the service. We used all of this information to plan the inspection.

The provider did not complete the required Provider Information Return (PIR). This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account, however in line with our suspension of the PIR process due to the ongoing Covid-19 pandemic this did not inform our judgements in this report.

During the inspection
We spoke with two people who used the service and 2 relatives about their experience of the care provided. The registered manager was not available during the inspection; however, we spoke with 18 members of staff, including the nominated individual, deputy manager, quality assurance lead, clinical nurse manager, unit managers, nurses and healthcare assistants. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included 11 people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. 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 establish how identified risks were being managed and mitigated. We looked at the providers action plan. We spoke with partner organisations and professionals for information on how risks identified at the service were being managed and mitigated.

Inadequate

# 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 Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- The provider had failed to ensure people were safeguarded from abuse. People and relatives gave mixed feedback on whether they or their relatives were safe. One relative told us the service was not safe. This was following their relative experiencing a fall after the service had not shared information to an ambulance crew that their relative was unable to weight bear.
- Where staff had reported incidents of abuse the provider had failed to follow their policy and report these to the local safeguarding team or conduct any internal investigation.
- We found three incidents of unexplained injuries had been documented in people's care notes, however these had not been reported to the local authority safeguarding team nor investigated further by the provider, leaving people at risk of harm.
- In another example, we found failures for a person receiving treatment for a deteriorating condition causing neglect. This had not been reported to the safeguarding authority for investigation.
- Staff had not consistently received training in how to safeguard people from abuse. Some staff were unsure if incidents were followed up. One staff member told us, "If one person hits another, I pass this on to the nurse, I think it should be investigated but I don't think this happens." Staff we spoke with knew how to whistle-blow and said they would follow the whistle-blowing policy if required. However, there was no evidence this concern had been raised as a whistle-blowing incident.
- This meant the provider had failed to follow procedures which ensured impartial investigation of potential abuse and people were left at risk of harm.

People were at risk of harm as systems and processes had not been operated effectively to investigate any allegation or evidence of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Using medicines safely; Preventing and controlling infection

- The provider had failed to ensure care plans were followed and concerns were escalated to relevant health professionals. One person experienced a deteriorating skin condition. The condition got worse and despite this being identified by care staff and reported to a nurse, no immediate action was taken which caused harm and discomfort for the person.
- The provider had failed to ensure government guidance was followed to protect people from the spread of Covid-19. We found two people had been admitted to the home and should have been in isolation, records showed both were taken into communal areas during the isolation period. This placed other people at the home at risk of contracting Covid-19.
- The provider had not ensured staff were using PPE effectively and safely. During the inspection we saw

staff not wearing masks correctly, including when supporting people in isolation. This exposed people and staff to increased risk of contracting COVID-19.

● The provider had failed to ensure staff had guidance to manage risks to people's safety. There was insufficient guidance for staff to support people when they displayed distressed behaviours and in the use of restraint. For example, one person's care notes described two separate incidents where staff had used restraint. There was no description of what form of restraint methods could be used safely by staff. The incidents had not been reviewed by the management team to identify these risks or what alternative measures could have been taken to avoid the use of restraint. This meant people were exposed to the risk of harm and inappropriate use of restraint.

● Where people were living with diabetes there was no guidance for staff on effective management of the risks. For example, one person required assistance to monitor their blood sugars and administer their insulin. The person's care plan did not include their normal blood sugar range, or the frequency their blood sugar levels should have been taken, which increased the risk of significant harm.

●Epilepsy risk assessments and care plans lacked information required to keep people safe. Staff were not consistently able to describe how they supported people to manage these risks, which meant people were at risk of significant harm. For example, one person experienced seizures and required specific support to aid their recovery. On three occasions, potential seizures were recorded only as falls and the person's care plan was not followed by staff. Neither a review of the incidents was completed, nor updating of care plans and risk assessments.

● Where people were at risk of malnutrition and required regular monitoring of their weight, this had been completed. However, when people had experienced weight loss there had been no action taken to review the care plan or seek medical advice. For example, one person's care plan documented they required their weight to be monitored monthly and any concerns were to be referred to a dietitian or speech and language therapist. We found the person had lost 5.5kg of weight over a six-month period. This was not identified by the management team and no referrals were made to health professionals for advice or support.

● The provider had failed to ensure systems for do not attempt cardiopulmonary resuscitation (DNACPR) in line with the Mental Capacity Act 2005 were understood by staff to ensure people received care in line with their wishes.

● There was no consistent system in place across the home to ensure staff understood people's wishes and staff relied on nurses to inform them which meant there could be a delay in people receiving treatment.

● One person had a DNACPR in place but staff had documented they had expressed a wish to be resuscitated. No action had been taken to review the DNACPR and assess the persons capacity to make an informed decision and the decision remained in place. This meant they were at risk of not having their wishes followed.

● The provider had failed to take appropriate and timely action in response to accidents and incidents to mitigate future risks leaving people at risk of further harm.

● Incidents had occurred with people using bedrails and sustaining injuries. We found no action had been taken to reduce the risk of reoccurrence. Staff told us they had concerns for people using bedrails as they continued to climb over them. The incidents were documented; however, no actions had been taken by the managements team to reduce the risks and people remained at risk of harm.

● The provider had failed to ensure actions were taken to mitigate the risk of falls. Where people had fallen there were no actions taken to review people's care plans and protect them from further injury and people were left at risk of harm.

● The provider had failed to ensure staff had enough guidance to ensure people had their medicines administered as directed. For example, there was no guidance for staff on when to administer medicines for people with diabetes.

● There was limited assurance that all staff knew when to administer some medicines as there was a high use of agency staff.

● Medicines administration records were incomplete and there were missed medicines, for example one person had 25 missed applications of a topical cream. One person had a missing MAR chart for their medicines which meant we could not be assured these had been administered.

We found the provider had failed to ensure people were protected, guidance was either not in place or not followed by staff to keep people safe and people were left at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to the findings by submitting an action plan to us and placed a voluntary suspension to admissions from people who self-fund their own care. The provider accepted immediate support from the local authority to manage and mitigate further risks. The local authority, CCG and CHC placed a suspension for further admissions to the service.

Staffing and recruitment

● People were not supported by enough permanent staff. People and relatives we spoke with gave mixed feedback on staffing levels at the service. One person told us "(Staff) are ran off their feet, some of them." A relative told us "(staff) are pushed to the limit, but nothing is too much for them and they respond immediately." However, there was a high use of agency staff in the home. Using agency staff led to inconsistency in care provision, recording of information and reporting of concerns. For example, one person experienced deterioration to their skin. Care staff we spoke with said they had informed an agency nurse of this, however no action was taken or recorded, leading to a delay in effective treatment being sought.

● Staff told us they didn't think there was enough staff and sometimes the agency staff were ineffective.

● Rotas showed some nurses were working long hours each week. This meant improvements were needed to the numbers of permanent staff available to ensure people had consistent support available to them.

Inadequate

# 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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had failed to ensure incidents of abuse were effectively identified and reported to the appropriate body. The provider had not identified where safeguarding referrals had not been made to the safeguarding authority.
- The inspection team identified 10 potential incidents of abuse and made referrals to the safeguarding authority, this meant people were left at risk of continued harm.
- The providers systems had failed to review incidents and take action to prevent incidents from reoccurring. Incidents including falls and distressed behaviour were not reviewed and actions taken to minimise the risks of reoccurrence. This meant people were left at continued risk of harm.
- The providers systems had failed to identify where medicines administration records were missing and where there was no guidance in place for staff. This meant people were left at continued risk of not receiving medicines as prescribed.
- The provider's systems had not identified gaps in people's medicines administration records which meant people were at continued risk of not receiving their medicines which could cause harm.
- The providers systems had failed to identify where DNACPR decisions were unclear to staff. This meant people were at risk of not receiving care and treatment in line with their wishes, and placed people at continued risk of significant harm.
- The provider's systems had failed to identify where peoples care records did not show their needs had been met. The provider told us there was a specific system to identify where people did not have their needs met, however this was not effective. For example, one person required prescribed toothpaste and mouthwash which staff were to monitor and encourage the person to use daily. Over a 14-day period, oral care was only recorded on five occasions. The system had not identified the gaps in care needs, leaving the person at risk of harm.
- The provider did not have a system in place to identify where inconsistencies were present in risk assessments and care plans. This meant these were often misleading for staff with conflicting information and people were left at risk of continued harm.
- The providers systems did not provide oversight of service users who required isolation due to COVID-19. This meant people who should have been isolating were mixing with others in communal areas which placed people at risk of contracting COVID-19.
- The provider's systems had failed to ensure staff were following government guidance in the safe and effective use of PPE, which meant people were exposed to the risk of infection from COVID-19.

We found systems and processes had not been established and operated effectively to keep people safe. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider submitted an action plan to us and accepted the immediate support from the local authority in reviewing their systems and processes. The provider commissioned advice from an external consultancy agency to improve quality assurance practices.

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

●Relatives told us they received regular contact from the home and were involved in people's assessments and reviews. However, there was no system in place to obtain formal feedback from people and their relatives which meant there was no opportunity to share their views about the service and drive improvement. One relative told us "I haven't been asked for formal feedback. If I had an issue I'd bring it up."

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

●We could not be assured the provider was sharing information with relevant people when things went wrong. Incident records did not evidence any contact with people's relatives.

● The provider had no system in place to ensure statutory notifications were made to CQC and there were delays in responding to further information requested.

Working in partnership with others

● The registered manager had not consistently worked in partnership with external agencies. There had been failures to monitor people's health and seek external health professionals support and potential abuse had not been reported to the safeguarding authority. This meant people had been exposed to continuing risk of harm.

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Systems in place were not effective to ensure risks at the service were effectively managed. The provider had failed to ensure people were protected from the risk of harm. |

**The enforcement action we took:**

We imposed a condition on the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Systems in place were not used effectively to protect people from harm. Potential safeguarding incidents had not been reported to the local authority or the Care Quality Commission (CQC). The provider had failed to ensure people were protected from the risk of abuse. |

**The enforcement action we took:**

We imposed a condition on the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure systems in place identified and addressed shortfalls. People had been placed at risk of harm and abuse. |

**The enforcement action we took:**

We imposed a condition on the providers registration.