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Manton House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Manton House provides accommodation and personal care for a maximum of 22 older people, some of whom may be living with dementia. At the time of our inspection there were 15 people living in the home.

This inspection took place on 22 February and 1 March 2017 and was unannounced on both days.

Due to a number of concerns raised about the home we brought forward the scheduled inspection so we could check that people were receiving safe care. At this inspection, we found people's safety was being compromised in a number of areas.

Although some risks to people had been assessed and documented, these assessments were not always adhered to by staff in order to deliver safe care. People's care plans and other associated records did not have the necessary information to reflect people's care needs. Although all people had a care plan in place, plans were very brief and lacked detail.

People's medicines were not managed or stored safely. Some people living at the home did not receive their medicines how the prescriber intended.

Recruitment processes were not always adhered to. Appropriate risk assessments were not carried out where there may have been concerns about a person's suitability for the job role.

Not all staff had received the level of training required to meet the current needs of people who used the service. This meant some people may be at risk of not receiving appropriate care and support. Staff were not supported through regular supervision. Although the registered provider and manager were aware of this, a plan to address this had not been put in place.

The principles of the Mental Capacity Act (MCA) 2005 were not fully understood by all staff and the correct process for making best interest decisions had not been followed in all cases.

There were 16 CCTV monitoring cameras covering the internal communal areas of the service, including corridors, the dining room, kitchen and lounge areas. There were no assessments to show that people who lacked capacity had been considered when installing the CCTV.

People's care records did not always reflect their current needs and care was not always delivered in line with people's assessed needs. Some people had specialist diet requirements, records of support provided however records did not always show that this care had been delivered.

Improvements were needed with regard to the provision of meaningful activities for people to take part in. There were few stimulating activities for people on offer. The environment was not dementia friendly and

did not reflect current good practice guidance.

Our inspection identified serious concerns regarding the management and leadership of the service and the quality of their care delivery. People were being put at risk of physical harm and there was insufficient governance to monitor the care being delivered. There had been a lack of effective leadership and management at the service which had led to a significant deterioration in the quality of the service.

We found the home was in breach of seven regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is Inadequate and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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."

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

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.

Risks to people's health, safety and welfare were not managed effectively which placed people at risk of harm.

People's medicines were not managed effectively which placed people at risk of harm.

A robust recruitment process was not followed to ensure that staff employed at the service were suitable.

Is the service effective?

Inadequate

The service was not always effective.

Staff had not all received the training, guidance and support they needed to enable them to carry out their job effectively.

Assessments of people's capacity to make decisions about their care and treatment were not undertaken in line with the Mental Capacity Act 2005.

Catering staff did not always have access to the information they needed to provide people with appropriate meals. Recording of people's nutritional intake was not consistent to help manage the risks to people's health.

People's health needs were managed effectively. Health professionals were contacted when people became unwell.

Is the service caring?

Requires Improvement

The service was not always caring.

Published guidance about the use of surveillance cameras was not followed and people were not consulted about being monitored.

People were not always supported in a way that upheld their dignity.

Relatives were positive about the care people received from staff and felt that they could visit at times of their choosing.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans lacked important information to guide staff in how to care for people in ways that were safe.

The delivery of care had at times not always met people's individual needs.

There were limited opportunities for people to participate in activities for their physical, social and emotional stimulation.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not established quality assurance and risk management systems to effectively and consistently identify issues or to improve the service.

The provider was inconsistent in monitoring the performance of staff and the provision of staff support.

Manton House

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 22 February 2017 and 1 March 2017 and was unannounced on both days. The inspection team consisted of one inspector and an expert by experience on the first day and two inspectors on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We also reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us. We also requested feedback from the local authority quality assurance team and the local clinical commissioning group.

We looked at the care records of three people in detail to check they were receiving their care as planned. We also looked at records including training records, meeting minutes, medication records and quality assurance records. We spoke with seven people who live at the home; three members of care staff, the chef, the compliance and monitoring officer for the provider, the assistant manager and the home manager. We also spoke with relatives of two people currently living at the home.

Inadequate

Is the service safe?

Our findings

At the last inspection this key question was rated good. At this inspection it has been rated requires improvement. This means that we had concerns at this inspection that we didn't have at the previous inspection.

People were not always protected from avoidable harm. Risks were not always assessed, planned for and monitored to ensure people's safety and wellbeing.

It was recorded in one person's care record that they were at high risk of choking. A healthcare professional had therefore advised that this person was required to receive a diet of soft texture foods. They also advised close supervision of the person by staff when eating and drinking to help reduce the risk of them choking. Records showed, and our observations confirmed, that staff failed to follow the care plan advice in place for this person. This placed them at considerable risk of harm.

From the person's records we saw that they had received on occasions, food which was not consistent with a soft diet. This was in direct contravention of their care plan and healthcare professionals' guidance. We asked a member of staff about the types of food this person was offered. They told us that staff were aware of the guidance, however they felt the person should be offered 'treats' and 'food like the other people' in the home were able to eat. They told us that this was because they 'felt sorry for them'. These actions placed the person at serious risk of harm. We also observed that this person ate their meals in a room alone and away from other people living at the home. We saw that whilst staff brought this person their meals, they did not stay with them whilst they were eating and neither did they check on them frequently. This practice did not follow the assessed specialist healthcare guidance that the person should be observed closely when they were eating or drinking. This placed the person at serious risk of harm.

We told the assistant manager of our observations and concerns on the first day of our inspection and asked them to put immediate actions in place to prevent this from re-occurring. When we went back for the second day of our inspection, we found that staff were failing to record in this persons care plan the types of food they were being offered and were eating This meant that it would not have been possible for the provider to monitor this person's safety and ensure that staff were following the correct guidance. However all staff had been made aware of the healthcare guidance in place and told us they were following it now. We saw during the second day of our visit that the lunch time meal offered to this person was in line with their care plan guidance.

We found that other risks to people were not managed safely. For example, a person had been admitted to the home for respite care two weeks prior to the first day of our inspection. The discharge letter from the hospital prior to their admission stated that they were at risk of falls

The risk assessment in place around their risk of falling was very brief and did not contain adequate information about the control measures in place to reduce the risk. We also found there was no information for staff within this person's care record to guide them on how to protect them from the risk of falling and

how they should be supported with their mobility. Records showed that this person had a fall within the first two weeks of their stay and prior to our inspection. During the first day of our inspection we told the assistant manager of our concerns about the lack of care plan in place for this person. When we returned for the second day of our inspection we found that this person still did not have a falls care plan in place, and had fallen again. The manager and provider failed to address a known and highlighted risk which resulted in the person falling again, placing them at risk of harm.

We found that people who used walking frames did not have their equipment named or kept exclusively for their use. We observed that a supply of walking frames was stored within a cupboard at the home and staff accessed these to help people. Walking frames are a mobility aid to help a person mobilise when they are at risk of falls. It is important that mobility aids are adjusted to the correct height for the person for whom they were assessed and supplied for to reduce the risk of further falls.

We observed that one person was placed at risk of harm by a staff member leaving them alone for a period of time whilst supporting them to transfer from their wheelchair to an armchair. The member of staff supported the person, who was living with dementia and at risk of falling, to the lounge in their wheelchair. We saw that the staff member supported the person to be close to an armchair. The staff member then removed the footplates from the person's wheelchair and then left the room to fetch the persons walking frame, which they needed in order to stand and transfer from their wheelchair to the armchair. Whilst the member of staff had left the room, the person stood themselves up and transferred alone to the armchair without using any walking frame or staff assistance. This placed them at risk of falling.

Records showed that hoists to help move and transfer people had been appropriately serviced. We saw however, that the slings which were used with a hoist had information labels on them that had faded and were no longer legible. This was important because the label on a sling tells the user the size of the sling, when it was last serviced and the serial number. It helps staff to identify the correct sling that people have been assessed to use. Staff were not able to identify if they were using the correct sling because of the poor condition of them. We spoke to the assistant manager about this who told us that these slings should not be in use and would be removed. We also spoke to a member of staff who told us that people were sharing hoist slings. Not sharing slings is important because doing so increases the risk of transferring infection. There were no records of checks on the condition of the slings. We asked the manager about this who told us that the checking of slings by a qualified person had not taken place.

We found that a number of people's bedrooms and en suite bathrooms had exposed pipework leading to the radiator. The pipes were very hot to the touch. A number of people living at the home were at risk of falls and therefore the exposed pipework presented a serious burns risk to them should they have fallen near them. We spoke to the home manager about this who told us they had not previously identified this as an issue. We asked them to risk check the whole building for exposed hot water pipe work. We also asked them to put in place any relevant mitigating actions to ensure it was safe in relation to the risk of people burning themselves. We received confirmation on 3 March 2017 that all hot water pipe work had been covered appropriately.

We found that there were a number of windows above ground floor at the home which did not have restrictors on them. There were no risk assessments in place which covered using or not using window restrictors. We spoke to the home manager about this who told us they had not previously identified this as an issue. We asked them to risk assess the whole building for windows above ground floor without restrictors and to put in place any relevant mitigating actions to ensure it was safe. After asking the home manager to respond to this concern we received confirmation on 3 March 2017 that all upstairs windows had been fitted with restrictors.

The environment was not always safe for people who lived with dementia. We found an open bag of powdered building filler left in a communal hallway. This was removed immediately by inspectors and handed to the home manager.

We had a number of concerns relating to the risks associated with poor fire safety management. We saw that a designated fire door in a high risk area was secured open using a piece of wood. This was despite a clear sign on the door stating 'fire door keep shut'. This presented a risk to people living at the home in the event of a fire. We found that a fire door had a bolt added to it following a failure in the key pad door entry system approximately nine months previously. When the key pad entry was repaired, the additional bolt had not been removed. If the bolt had been used to lock and close the fire door, this may have prevented a quick exit through the door in the event of a fire. We found that a piece of the homes fire evacuation equipment had been stored underneath a number of hoist slings. This meant that it was not easily visible and may have presented a risk if it was needed in the event of an emergency. We spoke to the fire safety officer following our inspection who told us they would visit the service to discuss arrangements for fire safety.

Health and Safety checks such as water temperatures were not always being completed to assess the safety of the premises and protect people from any potential risk of harm. There were gaps in the records of water safety checks from January 2016 until September 2016 in two people's bedrooms. There were no health and safety checks in two further people's bedrooms between January and October 2016. We found that no health and safety checks had been completed during January and February 2017. The manager told us that they were in the process of implementing a new recording chart for this purpose.

We found several concerns in relation to the management of medicines. We found a number of unattended prescribed topical medicines which had been left in people's bedrooms and not securely stored. Some of these prescribed medicines had exceeded the expiry date. Some had the dispensing label removed, some were not dated when opened and others we found were not in the correct room for the person for whom they were intended. Some of these were prescribed for people who had since passed away, but had been put into use by staff for other people. The manager told us they were not aware that prescribed topical medicines could not be reused within the home by other people if no longer required for the person for whom they were prescribed. We requested that immediate action be taken and these prescribed medicines be removed from people's room during our inspection.

We reviewed the processes which were in place for 'as and when required' (PRN) medicines. We found on the first day of our inspection there were no PRN protocols in place. PRN protocols inform staff where people had PRN medicines in place what the medicine was for, the signs they would need to look for to show a person may require the medicine or the desired effect the medicine would have. The assistant manager told us that the supplying pharmacist had supplied the home with some blank PRN protocols when they had visited the home two weeks earlier. We found that these still had not been implemented.

The administration and application of people's topical creams were not recorded. Therefore, we could not be sure that people were always receiving these medicines as prescribed.

MAR charts did not always contain up to date information on the quantity of medicines stored within the service. During our audit of medicines we compared medication records against quantities of medicines available for administration. In all instances we found amounts of medicines carried forward from one month to the following were not recorded so it was not possible for the provider to audit them fully.

All of these concerns amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected by robust recruitment procedures. Staff being employed to work in care settings must have a Disclosure and Barring Service (DBS) check. DBS checks identify if prospective staff have a criminal record or are barred from working with adults. One staff member's DBS check had showed they had received a number of police cautions. We saw, however, there was no evidence of the manager or providers reviewing these concerns with the staff member or considering any potential risks involved in employing them. We asked the manager about this person's recruitment however due the management changes they were not able to tell us. We did view in the provider's recruitment policy that a risk assessment should be carried out when considering employment of a person with a police caution.

Most people we spoke to were unable to tell us about their experiences of living at Manton House. This was because they were living with dementia or other conditions which limited their ability to fully engage with us. People who could communicate with us told us they felt safe living at the home. One person said, "I feel very safe here, it's very pleasant. They always turn up quickly if I press my buzzer." Another person told us, "I feel safe here and have no concerns."

We found that people were supported by staff that were knowledgeable about safeguarding. Staff told us the process for raising a safeguarding concern; they were all clear on who they would contact if they had any concerns. One member of staff said, "I would report it to the senior staff on duty, the police or safeguarding if needed."

People told us that there were sufficient numbers of staff available to support them. One person said, "They [care staff] always turn up quickly if I press my buzzer." Staff told us that staffing levels were appropriate for the numbers and needs of the people currently being supported. One member of staff said, "I think there are enough staff. We manage okay." Our observations during the inspection indicated that the deployment of staff was suitable to meet people's needs and staff were available to people when they needed them. We were told by the assistant manager that staffing was a challenge at times due to three staff leaving employment at the home around the same time however any gaps in the rota were covered through staff working overtime or staff from one of the providers nearby homes covering. We viewed staff rota's and found that they were covered with the number of staff that the manager had assessed were necessary to meet people's needs.

All care providers must notify the Care Quality Commission (CQC) about certain changes, events and incidents affecting their service or the people who use it. The CQC had not been notified by the manager of a safeguarding concern at the time it occurred. We received this information as a concern from a third party directly to us prior to our inspection. When we contacted the manager about this they were not able to tell us whether this had been reported to the local authority safeguarding team. They later discovered it had not been reported. We requested that they report it immediately. The home manager has still not reported this to the CQC although it is a statutory requirement to do so. One member of staff we spoke with told us that they had no recollection of having received any training in safeguarding adults against the risk of abuse and harm.

Inadequate

Is the service effective?

Our findings

At the last inspection this key question was rated requires improvement. At this inspection it has been rated inadequate. This means that we had even more concerns at this inspection than we did at the last one. At the last inspection we had concerns that staff competency to carry out their roles was not checked. We continued to have these concerns.

The provider did not ensure staff had received the training they considered necessary to care for people in a safe and effective manner. The manager told us that all of the staff training records had been either lost or destroyed by a previous manager. This meant that it was not possible for them to establish when staff last undertook training that the provider considered mandatory and essential for their job role. We saw from records over the past five months that staff had begun completing training again using a workbook issued by the provider. We saw however that training had not been prioritised in order to meet the needs of the people currently living in the home. For example one member of staff had completed training in supporting people who may have had behaviour which challenged others. The home however was not caring for anyone who had challenging behaviours. The care staff were however preparing food for people and the member of staff had no record of having received this training. People had been placed at risk as they could not be assured that they were being supported by staff who had skills and knowledge of best practice. Following our inspection the manager located the missing record of training dates and sent them to us. The records showed that whilst staff had undertaken the training the provider deemed necessary, they had also undertaken a lot of training courses on one day. For example, one member of staff undertook training in challenging behaviour, safeguarding, fire safety, food hygiene, health and safety and infection control all on one day.

The assistant manager told us that staff did not undertake the Care Certificate when commencing employment at the home; however some staff were undertaking vocational qualifications. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care. It should be completed within the first 12 weeks of employment and as part of staff induction.

Staff told us they had not been receiving any one to one supervision. They told us that the manager who had just left was not approachable and had not been supportive to them. The same staff told us that they felt confident that this would improve now there had been a change of manager. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff or manager. Staff should receive appropriate support, training, supervision and appraisal as is necessary to enable them to carry out their role. The provider could not demonstrate staff received sufficient support and supervision to carry out their roles and responsibilities effectively.

We spoke to the homes manager about the lack of training and supervision for staff during the past year. They told us they had been aware of this for some time as they had been providing support to the home because they are also a manager at another home, operated by the same company. The manager told us that they had not yet implemented a plan to address the shortfalls in training, and had not yet established

which staff still needed to do this. There was not yet a schedule in place to ensure that staff received supervision.

The failure of the service to provide staff with adequate induction, supervision, training and on-going support left people at risk of receiving care from staff who were not equipped to carry out their duties effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can 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.

At our last inspection during April 2016 we found that capacity assessments did not cover specific decisions and allow for varying capacity. We found at this inspection that improvements were still needed to ensure compliance with the MCA.

Staff had limited knowledge of the MCA. Not all of the staff we spoke to could tell us the implications of MCA or DoLS for the people they were supporting. The sample of records we reviewed showed that there was an inconsistent approach to the application of the principles of the MCA and DoLS at the service. There was confusing information recorded about people's capacity to make decisions. The provider had a tool to help ensure staff acted in the assessed best interests of people who used the service. However this this had also been used inconsistently and they had not included this information in the latest care plans that staff were accessing.

There were a number of bedrooms which had been divided in to two sleeping areas using a curtain. We saw the aim of this was so that two people could share a bedroom. We found that two unrelated people were sharing a bedroom at the time of our inspection. Both of these people lacked capacity to make a decision about whether they wished to share a bedroom. We were told after the inspection that relatives had been consulted about this decision. However, no mental capacity assessments had been carried out and no best interest decision making process had been followed with regard to this decision. In addition, there was no guidance for staff on how their privacy and dignity should be promoted whist they were sharing a room.

This meant there was a lack of decision specific mental capacity assessments for people living at Manton House.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who relied on staff to support them to eat did not always receive the support they needed. We viewed the records of people who were at risk of weight loss. We found that staff were not routinely recording the foods that people had eaten within their records or accurate information about the amounts

eaten. We also saw that where people who were at risk of weight loss had not eaten their meal staff had not recorded any attempts to go back later in the day to prompt the person to have something to eat.

People we spoke with were not satisfied with the food they received at Manton House. One person said, "The food is alright but can be a bit of the same. Some changes would be nice. I have suggested a bit more fish, but nothing has changed yet." Another person said, "The food is alright but it's always cold when I get it. I often leave more than I eat." Another person told us on the day of our inspection that they were not eating their lunch as it was too cold.

We were told by the home manager that there was one person living at Manton House who was diabetic and had this controlled through their diet. We looked at this persons care plan and found that there was no diabetes care plan in place. We asked staff about whether there were any changes to this persons diet required as a result of their diabetes and were told that they 'ate what everyone else did'.

We spoke to the chef who was working at the home on the first day of our inspection. They told us they were a 'bank' chef and did not work permanently at the home. They said they had been covering a number of days recently at the home whilst recruitment to the permanent chef post took place. When we spoke to the chef they were not aware of the specific and specialist diets of some people. They told us that they were not supplied with information about specific diets or requests, only the menu for the day.

We observed the dining experience that people received at lunch time on the first day of our inspection. There were no condiments on the tables and no written or picture menus in use to help people living with dementia to make independent choices. We saw that people who did not want to eat their meal were not offered an alternative choice. One person, who had experienced weight loss in the past three months, ate all of their meal and then began scraping their plate to eat as much as possible. We saw this person was not offered any more to eat by staff that cleared their plate away. Only after an inspector asked if the person would be offered more, did staff do so. Once offered more the person ate another plate of food.

All of these concerns amounted to a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw drinks were not freely available to people who sat in communal areas unless they asked for them. Staff brought a trolley of drinks round to people once during the morning and once during the afternoon. We saw that people in their bedrooms had access to drinks however there were no drinks that people could help themselves to within the communal areas.

We saw that parts of the home were in need of repair and refurbishment. There were stains on carpets, damage to walls in communal areas and broken fixtures and fittings such as a large hole in a radiator cover in one of the lounges. A large roof light on the first floor was very dirty and a ceiling fluorescent strip light was full of dead moths and insects. The housekeeper told us they had no means of reaching these to clean them. Despite people living with dementia there was little in the way of signage and familiar items to help people navigate themselves. The garden area was run down and inaccessible to people who had mobility support needs. This was because the garden ramp led directly onto a grassed area. On the day of our inspector we saw that the garden was overgrown in areas and was an area that staff used for their smoking breaks as there was a large container full of cigarette waste. The assistant manager told us that they had plans to improve this external space to offer people the opportunity to enjoy their garden.

We recommend that the provider refers to current guidance about adapting the environment for people living with dementia.

People received support to keep them healthy. They were able to access the appropriate healthcare support such as the GP, speech and language therapist and community nurse to meet their on-going health support needs. One person told us, "I am hoping to go to the dentist at the end of the month." Another person said, "I can see a nurse if I need one." Relatives we spoke with were also confident that their family member received appropriate healthcare support. One relative said, "My [relative] can see the district nurse and the doctor anytime they need it. [Relative] can also access a chiropodist to keep their feet in good condition."

Requires Improvement

Is the service caring?

Our findings

At the last inspection this key question was rated requires improvement. At this inspection it has been rated requires improvement again. At the last inspection we had concerns that the home did not always promote people's privacy and dignity. We continued to have concerns in this area at this inspection and found that no improvement had been made.

The provider had a Closed Circuit Television system (CCTV) installed throughout all communal areas of the home. This amounted to a total of 16 cameras which were installed along the corridors, dining room, kitchen and both lounges. Most people lived with a dementia related illness and did not have the capacity to understand that they were being observed and recorded. One person did however tell us, "I don't like the cameras but I suppose we have got to have them."

The home manager told us that this had been raised with people verbally and that people, who were living with dementia and lacked capacity to understand, were aware that the CCTV had been installed. The home manager told us people were aware of it being there because they had seen it being installed. We found there was no evidence to show us that people had been consulted about its use and how their consent for this had been obtained.

The manager told us that there were signs on display throughout the home informing people and visitors that there was CCTV in use. We checked the premises and found that there was only one small external sign informing people there was CCTV in operation. The signage was not clear in informing people that the CCTV was in operation inside the service as well as outside. Additionally it did not inform people why the CCTV was being used.

We looked at the service users guide given to people and their relatives when they were deciding if they wished to move into the home and this did not specify CCTV was being used in the home. This meant there was a risk people would not know about being recorded when they made the decision that this was the right care home for them.

Staff we spoke with told us they used the CCTV to 'keep an eye on people all at once' so they could see at a glance what people were doing. This meant that staff were choosing to observe people from the home's office, where the CCTV viewing screens were installed, as opposed to engaging with them directly. The manager told us that the CCTV kept people safe at the home as people could be viewed by staff.

We found that the use of the CCTV had not been subject to proper consideration in line with current published guidance about the use of surveillance and whether other, less intrusive arrangements could be made to enable staff to monitor people. We considered that this was an invasion of people's privacy and was not the least intrusive way to minimise risks to people's safety. There was also no evidence on the day of our inspection to suggest that the impact on people's privacy had been considered, however after our visits the provider sent us a copy of their CCTV code of practice. They told us that they had explained the use of the CCTV to everyone living in the home at that time, November 2016. However, no mental capacity

assessments were carried out for those people who were not able to make an informed choice about this. In addition, no best interest process was followed to ensure that people's views were appropriately sought and considered.

We saw there were missed opportunities for staff to engage and socialise with people who used the service. We observed it was practice that a member of staff sat in the communal lounge, however they sat on the edge of the room and did not engage with people to any extent. We also saw numerous times where staff were in conversation with one another as opposed to involving people who lived at Manton House.

Staff did not always maintain people's privacy and confidentiality. We observed on a number of occasions that staff did not always maintain discretion when they were discussing people. They did not lower their voices or close doors and could be heard from the staff office into one of the lounges. On other occasions we heard staff talking amongst themselves but in front of people about the support needs of some people.

We found that one person was called a different name by staff to their given first name. Staff told us that they had always called this person that name since they had moved to the home. We noted that a visitor to this person called the person by a shortened version of their Christian name. We asked the person what they preferred to be called. Despite living with dementia and having fluctuating capacity they were clear with us that they wished to be called by the shortened version of their Christian name.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed some kind and caring interactions between staff and people who lived at the home. All of the people we spoke with told us they felt staff were caring in their approach. One person said, "The [care staff] do care for us well and are polite." However not all relatives were as positive about the care their family member received. One relative told us, "The care [relative] gets is okay but nothing special."

Staff were confident when talking about how they promoted people's rights to privacy and dignity. They told us they always shut curtains and doors when assisting people with personal care and made sure people were covered up as much as possible when having personal care. However none of the staff that we spoke with were aware that they were not promoting people's dignity and privacy when they talked about them in communal areas or used the CCTV to observe them.

People told us that staff knew how they liked to be helped and their preferences. One person said, "The girls are very caring here they are always there to help me. They are all very polite. I can do what I want to do." Another person said, "I think they [staff] look after me really well and are very patient with me."

We asked people who lived at the home if they were involved in the planning of their care. None of them could remember being involved in the development of their care plan. However they did tell us that they were involved in making decisions about their care such as when they got up and when they went to bed. One person told us that they were confident staff knew them and what they liked. This person said, They [care staff] know what I like and what I don't like." Another person said, "I can't remember seeing a [care] plan but my memory is not so good."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection this key question was rated requires improvement. At this inspection it has been rated requires improvement again. At the last inspection we had concerns that the home was not responsive to people's needs. There was insufficient activity provision and people's preferences were not sought. We continued to have concerns in this area at this inspection and found that no improvement had been made.

Although some people and visitors told us they were happy with the standard of care provided and that it met their needs, our observations identified that staff were not always responsive to peoples' individual needs.

People's needs were not appropriately assessed or planned for and this had the risk of potential impact on their health and wellbeing. We looked at the assessment for one person admitted to the home for respite care. We found that their assessment of need was brief and did not contain sufficient information. This meant that this person's care was not safely planned. Assessments did not cover the areas where specific support was required. Another person was at high risk of falls however a mobility care plan had not been put in place. Another person had diabetes and again there was insufficient detail in their care plan about how this needed to be monitored and managed by staff. This meant staff did not have enough information about people's needs to guide them in supporting people safely. This was particularly important where a person was at the home for respite care as staff would not know the person as well as people who were living at the home permanently.

The provider had an electronic care planning system in place which had been implemented at Manton House in November 2016. We found that the electronic care plans had not been completed in full and there were a number of sections of it not used. We also found essential healthcare information had not been transferred to specific sections of people's care plans. This meant there was a risk people could receive unsafe and inappropriate care. These records were the live documents which staff were completing as the daily record of a person's care. During our inspection the manager and assistant manager told us that some care planning documents remained in the previously used paper based system. However some of these paper care plans had already been archived. When we asked staff if they could access the previous care plan records, not of all of them knew where they were stored. This meant that staff could not easily and readily access the information they needed in order to provide the appropriate care to people.

The provider did not have systems in place that included people in planning their care.
Care plans contained very basic information. People who had high support needs did not have these needs clearly explained to staff. Therefore staff did not have the knowledge or direction on how to care for them effectively. This placed them at risk because staff did not know how to provide their identified care and support needs.

Most of the people we spoke with expressed the view there was not much activity in their daily routine. One person said, "I would like to go out but there is nobody available to go with me." Another person told us, "We don't get out to have a change of scenery."

Relatives confirmed that there were a lack of activities available for people to participate in. One relative told us, "Activities are non-existent. Trips out are non-existent and I think [people] would appreciate the chance of going out." Another relative told us, "I don't think people who live here get out much."

We observed that people who lived at the home were sat in the lounges or dining room with very little stimulation or activity. Our observations were that people spent most of their time sleeping or just watching passively in the lounge areas. There was very limited planned stimulation and the television was constantly on in the background. We saw on one occasion a member of staff playing dominoes with a person. The assistant manager told us that due to three staff leaving employment at the home, the activities co ordinator had moved to providing care. This meant that there was now no one employed to provide activities.

We also noted when there was a member of staff in the lounge, they sat by the door to the lounge and next to one person but they did not engage with people to any extent. They had limited conversation with people and did not undertake any activity to promote involvement. This was a missed opportunity, as the time available could have been spent undertaking meaningful activity or interaction with people. This meant that people had not received person centred care that reflected their individual needs and preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to maintain relationships with people who were important to them. We observed people visiting throughout the day. Visitors told us they were always welcome at the home. They told us they were able to visit whenever they wished.

Staff told us that people received personalised care in terms of the times that they were supported to get up and go to bed. One member of staff said, "People can get up and go to bed when they choose. We have enough staff to support that." One person's relative told us that they felt staff knew their relative well and their preferences. They said, "I think they know what my [family member] likes and does not like."

A complaints procedure was in place and displayed in the reception area of the home. We noted that this was developed in a large accessible format using symbols and text. People living at the home told us they had not used the complaints procedure and felt that there was nothing specific for them to complain about.

We reviewed the complaints log which recorded one complaint that the current manager had dealt with in December 2016. We saw that no other complaints were recorded on file. One person's relative told us they had raised concerns with the manager however they were not satisfied with how the complaint was dealt with and the outcome. They told us, "I did complain that another [person] was wearing my [family members] clothes, but said that they could not control that." We were not assured that all complaints were recorded and that outcomes had been communicated to the complainant.

Inadequate

Is the service well-led?

Our findings

At our last inspection in April 2016 we rated Manton House 'requires improvement' in well-led and overall. Since that last inspection we found that the provider had not increased or tailored the quality monitoring to identify the shortfalls we found at this inspection.

During the first day of our inspection we met with the assistant manager of the home who had been in post as assistant manager for two weeks. We didn't meet with the home manager because they were away on leave. We planned our second day of our inspection when we knew that the home manager would be there.

The home had a manager in post who told us they took over the management of Manton House in January 2017; however they were not registered with the Care Quality Commission (CQC). At the time of this inspection they had not yet submitted their application to the CQC to become the registered manager of the home. The current home manager was also managing another care home for the provider within the same county. The home manager however could not tell us what the providers expectations were in terms of how much time they were to spend at each of the homes.

The previous registered manager left the home in July 2016 and deregistered with CQC in September 2016. Another manager took over the management of the home from July 2016 up until they stopped being the manager in January 2017. They were not registered with CQC during that time.

During this inspection we found a number of concerns about the management of the home and the lack of effective systems in place to ensure that the care people received good quality care. We were told that no one from the provider company had been responsible for line managing the previous manager or providing them with supervision and therefore there was no effective management oversight of the home.'

We found there had been a decline in the standards at the home. There was insufficient quality assurance in place and this had failed to fully identify shortfalls in the quality of the care. Issues that had been identified had not yet been addressed, and there was no planned approach to do this in a timely way.

At our last inspection in April 2016 we rated this key question as requires improvement. At this inspection we found that the home continued to not be well led and the quality of care had deteriorated. During this inspection we identified failings in a number of areas. These included managing risks to people, insufficient care plans and poor record keeping. Records at the service were not always up to date. These issues had not been identified by the management team at the service

During the second day of our inspection the provider's compliance and monitoring officer visited the home. We were shown by the home manager a copy of 'Manton House Action Plan' which they told us had been put in place two weeks previously. We found that this action plan was actually in response to the CQC previous inspection during April 2016. We looked at this plan and saw that it did not highlight most of the concerns and discrepancies we found. We saw that despite our previous inspection being approximately 11 months previous none of the actions on the action plan had been recorded as completed.

During this inspection, we found there were continuing significant shortfalls in respect to the need for consent, person centred care and good governance. In addition we identified a number of significant safety concerns.

After our visits we were sent a copy of a quarterly home audit completed in July 2016 by the compliance and monitoring officer. We were told that this was the most recent audit as the one completed in October 2016 had been lost when there had been a theft of the computer on which it was stored. We were told that the audit report from January 2017 had not yet been completed. We saw that the audit from July 2016 recorded that the service was compliant and that documents and processes that we identified as missing, were present. There were no systems in place to identify the issues and therefore no measures had been put in place to ensure they were rectified.

The provider's quality assurance process had not identified shortfalls in a wide range of areas. These included people's safety being at risk as some care plans were lacking in specific information, which had the potential to cause harm to the individual. Essential training for all staff could not be evidence as records had been lost or destroyed. Staff had not received regular supervision or yearly appraisals. This meant staff were not being appropriately supported to undertake their role and improve care practices. This was confirmed by the unsafe care practices observed during the inspection process. The audit used had failed to highlight any of the concerns and discrepancies we found. We concluded that the quality assurance systems in place were not effective.

There were gaps in the records of checks in relation to the safety of the premises. We saw also that they had failed to identify that there were a number of risks to people's safety. These included hot, exposed pipes which presented a risk to the people living in the home and windows above ground floor without appropriate restrictors on them. We also found some areas of the home and equipment people used was unclean. Therefore, the system in place to monitor the safety and cleanliness of the premises was not wholly effective.

People's records were not always detailed or accurate and this placed people at risk from inappropriate care. We found people's medicines were not always managed safely and properly, risks to people health and safety were not always assessed and mitigated.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us that morale at the home had been low for a number of months and that whilst they really enjoyed the caring side of their job role, they felt let down by the lack of support and previous management that they had found unapproachable.. Staff told us they felt positive that with a change in manager and assistant manager that improvements would start to be made at the home. One staff member said, "Morale here is getting better with [manager] and [assistant manager] here. Before they started it felt dreary here and you could cut the atmosphere."

Providers are required to send the CQC statutory notifications to inform the CQC of certain incidents, events and changes that happen within the service. The manager had sent in statutory notifications to the CQC for the events that happened at the service. However prior to our inspection we were told about a safeguarding incident. We found that the manager had not raised a safeguarding alert with the local authority and had not notified us either in respect of this incident. We have still not received notification of this concern.

We found that staff understood and were confident about using the provider's whistleblowing procedure. There was a whistleblowing policy in place and staff were aware of it. Whistleblowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. They can do this anonymously if they choose to.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a lack of person centred care for people living at the home.

The enforcement action we took:

We told the provider they could not admit any new people to the home from 12 May 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy was not maintained at all times and monitoring measures had not been properly considered.

The enforcement action we took:

We told the provider they could not admit any new people to the home from 12 May 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the Mental Capacity Act were not being followed as assessments on capacity to make decisions were not completed in all cases where required.

The enforcement action we took:

We told the provider they could not admit any new people to the home from 12 May 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. Risks to people's safety who were living in the service had not always been assessed.

Where they had been, actions had not always been taken to mitigate these risks. Not all areas of the premises had been adequately assessed to ensure they were safe. Some people's medicines had not been well managed.

The enforcement action we took:

We told the provider they could not admit any new people to the home from 12 May 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs were not being met for all people living in the service to sustain good health.

The enforcement action we took:

We told the provider they could not admit any new people to the home from 12 May 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess monitor and improve the quality and safety of the service provided and to assess monitor and mitigate risks relating to the health, safety and welfare of people living in the service were not effective. An accurate and complete contemporaneous record in response of each person living in the service was not in place.

The enforcement action we took:

Issued the provider with a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Ssuitably qualified, competent, skilled and experienced staff had not always been deployed in the home. Staff had not always received appropriate training, supervision or support to carry out their role.

The enforcement action we took:

We told the provider they could not admit any new people to the home from 12 May 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care.