Care Quality Commission

Manor Park Care Limited

Manor Park Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Manor Park Nursing Home is a residential care home providing personal and nursing care for up to 52 adults with a diagnosis of dementia. Four people under the age of 65 who did not have a diagnosis of dementia had also been admitted. There were 50 people living at the service at the time of the inspection. The service recently added an additional eight-bedded unit and planned to extend further. The service specialises in providing care for people with dementia.

People's experience of using this service and what we found
We found three people who were placed at the service did not have all their needs identified and met. These people had a primary diagnosis of mental health and did not have dementia. There were no nursing staff trained in supporting people with mental health problems. These three younger people shared social space with people living with dementia, this meant they were not placed with people within their peer group which impacted on their opportunities for social engagement. One of the younger people had experienced significant avoidable harm at the home.

Risks to people were not always assessed and plans were not always in place to guide staff on how to keep people safe. We found some bedroom furniture was in poor condition which meant it could not be thoroughly cleaned. Some communal areas of the service could not be thoroughly cleaned due to the on-going building works.

Areas where the refurbishments had been completed were clean and bright; the environment had been adapted for people living with dementia. The provider had a range of communal spaces which aimed to group people by compatibility and their need for similar levels of support.

Staff adhered to infection prevention and control measures in line with Covid-19 guidance.

Quality assurance systems in place had not identified a poor culture which was identified following a serious safeguarding concern. Systems in place had failed to identify infection control risks within bedrooms. Systems had failed to identify the lack of appropriate risk assessments in place to keep people safe.

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 (published 03 March 2020).

Why we inspected
The inspection was prompted due to concerns received about staffing, allegations of neglect, poor nutrition and fluids, culture of bullying and staff feeling unable to raise concerns to managers and because we received a notification of a specific incident. This incident is subject to a criminal investigation, so we did not

examine the circumstances of the incident during the inspection. A decision was made for us to carry out a focussed inspection on the Safe and Well-led key questions to examine those risks.

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 improvements. Please see the Safe and Well-Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

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 managing risk, cleanliness and infection control and monitoring the safety and effectiveness of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Care Quality Commission

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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 two inspectors.

Service and service type
Manor Park 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.

Notice of inspection
This inspection was unannounced.

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 and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with the provider, registered manager, and a registered nurse.

We reviewed a range of records. This included two people's care records, five further people's records on the electronic system accessible to staff and medication records. We looked at two 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 confirm evidence found. We looked at training data and quality assurance records and other information sent by the provider. We spoke with five staff by telephone.

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.

Assessing risk, safety monitoring and management
● The provider had not always carried out an assessment of risk to people or developed a care plan to guide staff on how to reduce any risk identified. For example, one person had specific behaviours that placed them at risk of harm. There was no guidance for staff on how to support this person to remain safe. Another person who was at risk of choking did not have a clear plan in place to guide staff on how to protect them from this risk.

Learning lessons when things go wrong
●One person living at the service had been involved in four incidents of actual or attempted self-harm. Their risk assessment had not been updated and there was no guidance for staff on how to prevent a recurrence of this behaviour.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection
● We found some areas of the home were not clean and some bedrooms had furniture with a damaged surface. Some people had bedframes with chipped surfaces which meant they could not be thoroughly cleaned as bacteria could lodge in these areas. One bedroom had a very dirty window, another had a rusty commode frame which could not be thoroughly cleaned. We found one commode cover was ripped and could not be cleaned; we asked the manager to dispose of this. We showed these to the manager.

● Other areas of the home had exposed brickwork and no floor covering which meant these surfaces could not be thoroughly cleaned. There was a risk of infection from bacteria lodged in these areas.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We carried out checks in respect of preventing the transmission of Covid-19
● We were not always assured that the provider was meeting shielding and social distancing rules as one lounge had more than 10 people which the registered manager told us was the agreed number to allow for social distancing. No furniture had been moved to allow for social distancing.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Staffing and recruitment
● The service had admitted three people with complex mental health needs. There were no qualified and experienced Registered Mental Nurses employed at the service and staff had not received training in how to support people with complex mental health needs. There were no staff employed at the service with suitable skills or experience to provide appropriate mental health support.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff rotas showed that rotas planned for between 12 and 15 staff. However, staff we spoke with told us that often some members of staff called in sick. Whilst the registered manager aimed to cover these shifts with bank staff it was not always possible which meant shifts ran on short staffing. This meant that the numbers were lower and left staff feeling under pressure. For example, one member of staff said, "People do receive good care, but this is rushed, there is not enough time to sit with people and showers are not as enjoyable as they should be because staff are rushing." Other members of staff confirmed this.

● Staff had completed the care certificate and the service employed registered general nurses. People received a good standard of physical nursing care. Observations showed staff understood how to communicate with people living with dementia in a warm and compassionate way.

● Staff were safely recruited. Disclosure and Barring Service (DBS) checks had been carried out to check whether staff were suitable to work with people in care homes. The registered manager was actively recruiting to additional posts including a kitchen assistant and wellbeing leads. They said they were in the process of reviewing 17 applications.

Systems and processes to safeguard people from the risk of abuse
● There were systems in place to identify and report abuse. The registered manager was proactive in contacting the local safeguarding adults' team when she identified any concerns. However, information from some members of staff showed they had not always been listened to when they raised concerns.

Using medicines safely
●Staff used an electronic system for recording when medicines were due and when they were given. This included alerting the nursing staff if medicines were missed. Various audits were available which used the electronic system to ensure medicines were being managed safely.

● Regular checks were completed on stock levels to ensure people had access to their medicines in a timely manner. A member of staff told us they had experienced some delays with prescriptions going to the

pharmacy, but they were working closely with both the GP surgery and the pharmacy to make improvements.

● All staff administering medicines had received relevant training and were assessed as competent as seen at the inspection in March 2020. Nurses supported people with their medicines.

● Medicine storage arrangements were suitable. Temperature checks were completed regularly to ensure the clinic area, medicines cabinets and the fridge were maintained at the correct temperature.

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
● We identified shortfalls in safety and staff skills and experience which had not been identified by the provider's quality assurance systems.

● There was a lack of understanding of the risks of younger people with mental health problems who had recently been admitted into the service. Staff used an electronic 'tablet' to access guidance on people's care needs. There was no information on this system to advise staff of risks and how to manage them. The lack of guidance had not been identified by checks of care records.

● The home manager told us the service was currently transferring records from an old system to the system now in use. However, essential records about risk, such as how to prevent choking, had not yet been transferred. Quality assurance systems had not identified this gap.

● The provider had failed to ensure they were able to safely care for people with assessed mental health needs. They had not carried out suitable assessments to determine the skills and experience of staff at the service. This meant they had not adequately assessed the needs of three people with complex mental health.

● The provider had a system of audits in place to monitor the running of the service, however these had not identified concerns with care records or environmental concerns.

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

● However, other audits had been carried out effectively. Staff who carried out the audits had identified areas of shortfalls. Following this an action plan had been completed. The most recent action plans had not yet been completed. However, we saw examples from the previous month where actions had been identified and signed off.

● There was a business continuity plan in place which incorporated the 2020-21 Winter Plan. The provider had a system in place to monitor staff training and supervision.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff had received training in the Butterfly model of care which aimed to deliver the best outcomes for people living with dementia. The registered manager was passionate about this model of care. We saw that environmental work was in progress to improve the environment for people living with dementia.

● We reviewed the responses from the provider's survey of relatives. All of the 10 relatives who responded felt their relative received good care

● A recent staff survey in respect of the service response to Covid-19 found all staff felt supported in respect of Covid-19. However, only 22% of staff who responded felt there were enough staff. Staff we spoke with said that high levels of sickness could impact on how well they were able to carry out their role.

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
● When the registered manager became aware of any concerns is respect of care at the service she acted openly and honestly to report this. Relatives were informed of any concerns with regard to their loved ones.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People living at the service had their individual preferences and choices respected. The provider was undertaking a great deal of work to improve the communal environments. The completed areas showed the environment was designed to support and stimulate people living with dementia.

Continuous learning and improving care
● The registered manager had plans in place to continue to improve the experience of people living at the service. Currently the provider was recruiting staff for a new role to support well-being of people.

● The provider was undertaking a large scale refurbishment and expansion plan.

Working in partnership with others
● The service worked with care commissioners and local health service providers.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12(2)(a) Risk assessments relating to the safety and welfare of people were not always completed and reviewed regularly. 12(2)(h) Not all infection risks had been identified and mitigated

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 17(1) The provider did not operate effective systems and processes to ensure they monitored their service against Regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing 18(1) The provider had not deployed staff suitably skilled and experienced to support service users with complex mental health needs. No training was provided to staff to support service users with these care needs