Windsor Care Limited

The Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The Manor Care Home is a large modern, purpose-built care home with nursing located right on the River Thames. The service is situated in a quiet residential area. It is surrounded by extensive landscaped gardens. The service cares for older adults, many of whom have a dementia-type diagnosis. The service offers people permanent accommodation as well as respite stays. In the last year, the service has decided to link with local hospices, and increase palliative care provision. The service is registered to accommodate 65 service users. At the time of the inspection, there were 62 people at the service. The majority of the time, the service is full. There is often a waiting list of potential new admissions from surrounding hospitals, hospices and the community. This is the only location within the provider's current registration.

At the time of the inspection, there was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had been in post continuously for some time, and knew the service well.

Our last inspection was on 11 and 12 March 2015 under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The overall rating was good, with all key questions rated good, except for 'Is the service effective?' which was rated requires improvement. This was because there was a recommendation about people's covert medicines administration. This was resolved at this inspection. This is our first inspection under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were safeguarded from abuse. There was a system in place to ensure that people's safety was maintained. Staff and the registered manager were knowledgeable about abuse and how to deal with any allegations.

Planning for people's admissions was viewed by the service as an important step in delivering good quality care. After admission, people's care risks were thoroughly assessed, mitigated, documented and reviewed. Appropriate records were kept and readily available to demonstrate this to us at the inspection.

The safety of the premises, equipment and grounds were assessed and managed which protected people, staff and visitors from risk. We viewed maintenance records which demonstrated all required checks for health and safety were completed. We made a recommendation about the prevention and control of Legionella at the service. This was to ensure guidance from the Health and Safety Executive was always used.

There were plenty of staff deployed to support people. People and relatives we spoke with were satisfied that there was sufficient staff. Our observations showed that the staff were neither busy nor task-focussed and this led to them spending time with people promoting their independence and wellness. Staff worked well together in their respective teams, were flexible with the service's requirements and were willing to

assist their colleagues without hesitation.

Medicines were well-managed. We examined the handling of people's medicines during our inspection and found that people were safe from harm. Registered nurses demonstrated good practice, in line with that set by national standards and guidelines. Regular pharmacist and GP input was sought and obtained for the management of people's medicines.

Staff were knowledgeable and competent. They received appropriate levels of induction, training and supervisions. There was a passion for learning and development within the service. This was evident by the employment of dedicated trainers, a focus on ensuring the progression of staff careers and training topics not often used in similar services.

The service followed the requirements of the Mental Capacity Act 2005 (MCA). The recording of consent and best interest decisions meant the service complied with the MCA codes of practice. There was clear information at the service regarding people's applications, reviews and expiry dates for standard Deprivation of Liberty Safeguards (DoLS) authorisations. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

People received ample food which they had a positive opinion about. Hydration was offered to people to ensure they did not become dehydrated. Snacks and treats were available if people wanted or chose to have them. Alternative menus were available. People told us they liked the food and had good choices. The kitchen staff were working towards better presentation of texture-modified food to people with swallowing difficulties.

We found the service was caring. People told us staff were kind and patient. We observed staff were warm and friendly when they interacted with people. Staff smiled and laughed with people, and encouraged them to enjoy their stay.

Responsive care was provided to people. Their wishes, preferences, likes and dislikes were considered and accommodated. The service's complaints procedure was robust but could be better displayed and communicated to all parties.

The service was always well-led. We received a high volume of feedback from contacts of the service who told us they felt the culture at the service was always extremely positive. People's observations of the everyday running of the service had accordingly influenced their opinion about the how it was well-led. Staff told us they enjoyed their roles, felt supported by the management and were encouraged to progress. We found the management team were dedicated, passionate about care and had extensive knowledge of older adults, people with dementia and end of life care. Numerous audits were used to check the quality of care. The service had forged excellent relationships with other local organisations to embrace and embed continuity of care for people, and prevent hospital admissions.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt that they lived in a safe environment and received safe care.

People were protected from abuse and neglect.

People's personal risks were assessed and managed to ensure safe care provision.

Safe staffing recruitment and deployment were in place.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

Staff training, supervisions and performance appraisals were appropriate.

People's consent for care and deprivation of liberty was in accordance with the Mental Capacity Act 2005 (MCA) and associated codes of practice.

People were supported to maintain a healthy balanced diet.

People were supported to have access to healthcare services and receive ongoing support from community professionals.

Is the service caring?

Good

The service was caring.

People were treated by staff with a compassionate approach.

People and relatives told us they felt staff were always kind and caring.

People's privacy and dignity was respected.

People's confidentiality was securely maintained by the service.

Is the service responsive?

Good

The service was responsive.

People's care planning and support provided by staff was person-centred.

People's preferences and dislikes were understood and respected by staff.

People had access to an extensive range of activities and socialisation was encouraged.

There was a complaints system in place and issues were addressed promptly.

People and relatives were asked their opinions of care and able to contribute to any improvements.

Is the service well-led?

Good

The service was well-led.

People's care by the service received consistent praise from a wide range of professionals and organisations we contacted.

People were cared for in a service with an excellent workplace culture and team-based approach.

People's care quality and safety was continuously measured and improved by the service's wide range of audits and checks.

The management team were dedicated to the provision of a high quality service that aimed to exceed people's expectations.

There was an excellent working relationship in place with external agencies to ensure continuity of people's care.

The Manor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 March 2017 and 31 March 2017 and was unannounced. The inspection was undertaken by three inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had knowledge of care and support provided to older adults.

For this inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we already held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. We asked the local authority teams, clinical commissioning groups (CCG), community-based healthcare professionals, fire authority and environmental health officer for information to aid planning of our inspection. We checked information held at Companies House, the Information Commissioner's Office and the Food Safety Authority.

We spoke with ten people who used the service and five relatives. We spoke with the nominated individual, registered manager, clinical care manager, chef and two kitchen assistants, three cleaners and two maintenance workers. We also spoke with six registered nurses, nine care workers, a training co-ordinator and activities coordinators. Multiple contacts of the service sent us written feedback prior to our inspection.

We looked at 11 sets of records related to people's individual care needs. These included care plans, risk assessments and daily monitoring records. We also looked at five personnel files and records associated with the management of the service, including quality audits. We asked the provider to send further documents after the inspection. The provider sent documents to us after the inspection for use as additional evidence.

We looked throughout the premises and observed care practices and people's interactions with staff during the inspection.

Good

Is the service safe?

Our findings

People told us they felt safe care was provided. They were adamant in their responses that a secure environment was provided for them. For example, one person we spoke with said, "Safety doesn't worry me. They keep my room clean. I just ask if I want a cup of tea. I had a headache this morning. I told them and I got some paracetamol." Another person told us, "I'm on the top floor. There's nothing that makes me feel unsafe. It's nice and big and definitely clean, especially the toilet. They wash me, help me dress and I don't feel rushed." A third person commented, "I'm absolutely 100% safe. There's plenty of staff and the doors are secure. I've never seen anyone badly treated. In summer, they have big umbrellas in the garden to protect us from the sun."

Family members consistently told our inspection team they appreciated how people's care was safe. One relative stated, "It's spotless. I visited other homes which smelled of urine. Not here. I've seen them give dad his medicine and they make sure he understands. It's quite well staffed and there's no rush." Another relative told us, "Mum's a bit 'doddery' but there's always someone around. She's got a call button round her neck, provided by the home. Mum uses it especially when she's in the garden. She uses it to let them know when she wants to go in and when she's ready to leave the garden. They explain what medicine they are giving and I think there is an annual review." We asked a relative how the service kept people safe. They stated, "They use a hoist to get my mum from bed to chair. They talk to mum and reassure her if she gets frightened. Always two of them (staff). The home has changed completely since we came here. It's really clean and it doesn't have that 'home smell'. They give mum her medicines through a syringe."

People were protected from abuse and neglect. We found staff were trained in the protection of people at risk during their induction and on a recurring basis. When we spoke with staff, they were knowledgeable about types of abuse and what to do if they suspected people were at risk of harm. We saw there were suitable procedures in place that protected people from the risk of abuse and avoidable harm. The service had information about the local authority's safeguarding measures which were shared with the staff. We found the registered manager took appropriate action when they identified people who were at risk of harm or had sustained harm. The registered manager demonstrated they liaised with the local safeguarding team to make sure any concerns were fully investigated and action to prevent further harm had occurred.

The service ensured that people were protected from harm that could be caused by the building, equipment and grounds. Appropriate risk assessments were conducted, reviewed and filed. Examples we viewed included the fire risk assessment, gas safety certificate, checks of the electrical wiring in the building, portable appliance testing and period inspections on lifting equipment like the hoists and passenger lift.

There was a Legionella risk assessment completed in August 2016. Recent water sample results showed the presence of Legionella in the water system. The Legionella type found in the water sample does not cause Legionnaire's disease (a serious form of pneumonia in humans). The risk assessment had not been updated by the contractor after the water sample results. When we spoke with maintenance staff, they had not received formal training in the prevention and control of Legionella. We looked at checks they recorded about hot and cold water. We provided feedback to the registered manager at the inspection that the

system in place at the service could place people at risk. We also asked for all documents pertaining to Legionella to be sent to us after the inspection. We examined the records to determine the seriousness of the risk. We found the registered manager and provider were responsive to our findings. The service immediately organised a new risk assessment, dedicated training for maintenance staff, disinfection of the water system, repeated water testing and purchase and installation of equipment designed to better prevent and control Legionella growth.

We recommend that the service ensures continual adherence with the Health and Safety Executive's approved code of practice for the prevention and control of Legionella.

The service used a computerised database for keeping information about people's care. We saw people's personal risks were thoroughly assessed, mitigated and recorded. Prior to admission, the registered manager or clinical care manager conducted comprehensive assessments of people to ensure the service could adequately provide support. We looked at four people's pre-admission assessments. We saw that the service added information about people's conditions that would help staff to understand any health issues upon admission. For example, we saw one person's assessment had specific information about how to manage their heart abnormality. We found appropriate risk assessments included people's risks of falls, chance of malnutrition, risk of developing a pressure ulcer and assessment of people's safety in their bedrooms. Risk assessments were regularly updated by staff at least monthly, and more often is a person's risk of harm changed. People's weight loss or gain was closely monitored. Risk assessments recorded by staff in the computer were printed and placed in people's individual folders, which were securely stored next to staff stations.

Staff who were offered employment at The Manor Care Home experienced a robust recruitment procedure. This meant people could be assured that fit and proper checks of new workers was completed. We examined five personnel files of recent staff that had commenced employment. All of the necessary checks were on record. This included verification of staff identities, criminal record checks from the Disclosure and Barring Service (DBS), checks of conduct in prior employment and the right to work in the UK. Staff were interviewed by the management team and selected based on their knowledge, skills and experience.

People received good support and treatment because there was excellent staff deployment. We spoke with people who used the service, relatives and staff about the amount of staff and ability of them to undertake care for people. There was positive feedback about the staff deployment. Some people required one-to-one support continuously. This was sufficiently provided by the service to ensure people were safe from harm. Although we found there was a small number of vacant posts for care workers, and some agency staff were used, the permanent staff levels were generous. The management told us that staffing was calculated on people's dependency levels. However, this was not the only method used to determine sufficient staffing on each shift. The service had considered people's behaviours, and that a good ratio of staff meant that social isolation could be avoided. We found the service had a minibus and staff could escort people to appointments rather than relying on ambulances. The clinical care manager, who was a registered nurse, also worked on regular occasions with staff that provided care. This ensured that the service knew if staff levels were safe or required alteration. We observed people did not have to wait for staff assistance and call bells were answered promptly. This included when one person had a fall during our inspection.

People received their medicines safely, at times specified by the GP. Medicines were dispensed to each person directly from the medicines trolleys. The medicines administration records (MAR) were correctly completed. Regular medicines audits were completed by senior staff and external audits completed by a pharmacist. Medicines that require stricter controls by law were securely stored and accurately documented. All staff were trained in the administration of medicines. Robust procedures were in place in

the event of medicine errors. We found there was good stock control with counting of medicines to ensure accuracy and to quickly detect any mistakes. We observed three registered nurses complete their medicines administration. They were confident and competent in their approach with people. They did not allow themselves to become distracted by other events in the service which surrounded their task. They followed a good process in their administration technique, which as in line with best practice. One registered nurse we spoke with was in post for only a short period of time, but demonstrated she knew the people's medicines and how they were assisted or supported.

Good

Is the service effective?

Our findings

At our last inspection on 11 and 12 March 2015, we rated this key question as 'requires improvement.' The service was effective although some of the recording around consent for covert administration of medicines required improvement. We have checked this at our inspection and found that the service took steps to improve the management of covert medicines. Where a person would refuse their medicines and did not have the capacity to understand the need for them, staff tried again and encouraged the person to take them. Where a person consistently refused, a mental capacity assessment was used to document the person's inability to decide to take their medicines. A best-interest discussion was held and a pharmacist and the GP were included in the decision to administer medicines covertly. We looked at a small number of people's records where covert administration of medicine took place. We saw this was adequately documented and specific instructions to registered nurses was included for the purpose of administering the medicines. At this inspection, the rating for this key question has therefore changed to 'good'.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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.

We saw written consent was obtained by the service for a variety of reasons. This included financial consent, consent to care or treatment, the use of bed rails, disclosure of relevant documents including photographs to external healthcare professionals and bodies, podiatry, smoking and vaccination. We reviewed the forms and found these provided the relevant information for the person to consider before they decided to provide consent. Paper consent forms were scanned and electronically stored with the person's computer-based records. This meant if the consent form was missing, the record was still available on file. We reviewed seven care records for people's consent decisions. We saw that people of relevant others had provided consent correctly. One of the forms did not always have the signature of the staff member who attained the consent. We pointed this out to the registered manager who was receptive of our feedback and assured us this would be communicated with staff. A relative confirmed staff asked for consent during care practices with people. They told us, "The staff do ask for permission and consent. This morning they asked if he wanted to go to exercises. When helping him the carer said 'I'm going to bend your knee'. They used the hoist and explained it all to him. He seems comfortable and is not bothered by the hoist."

Staff showed an understanding of the consent process. They were readily able to explain the principles of implied and verbal consent, and the basic requirements for written consent. Staff also knew that people may need a mental capacity assessment more than once, especially when someone's capacity to consent was fluctuating over time. When people could not give consent, and this was documented using a mental

capacity assessment, staff knew who had enduring or lasting powers of attorney (EPAs and LPAs) and that the relevant person was able to legally consent for people. When we checked, copies of most people's attorney documents were present at the service. The registered manager explained that sometimes it was difficult to obtain them from family members or solicitors. However, they were able to explain how to check for EPAs and LPAs, and kept records of their requests.

When people did not have the capacity to consent, there was no attorney or court-appointed deputy, best-interest decision making was correctly used at the service. The service ensured that decisions were specifically worded and applied only at the time of the best-interest discussion. We saw that relevant others like relatives and healthcare professionals were included in the decision-making, even if the discussion was via telephone or e-mail communication. We found the least restrictive option was selected, in line with the provisions of the MCA. An example we heard was when people with dementia wandered into other people's bedrooms. There was a risk that confrontation between the two people could occur. The service had installed red barrier ropes across the bedroom door for a few people. This was to protect people and divert someone from entering another person's room. We saw this worked effectively. In the care file examples we viewed, this decision and technique was well-documented.

We checked with one local authority whether people who used the service had DoLS applications, assessments and authorisations in place. We compared the information provided by the local authority with the information at the service. We saw that these lists were alike and that the management team kept a continuous record of DoLS applied for and granted. Copies of the DoLS applications and outcomes were on people's files and in the registered manager's office. DoLS applications were made for the correct reasons when people were deprived of their liberty. Examples we saw included people who were under continuous supervision and were not able to safely leave the building and for people with bedrails installed. All DoLS outcomes were notified to us by the registered manager, in line with the relevant regulation. The management team showed a good understanding about the principles and practices regarding MCA and DoLS.

We found people were provided with appropriate nutrition and hydration, and most opinions about the food choice and presentation were positive. One person told us, "The food is very good. I eat in my room. I don't get a written menu; they (staff) just come and ask me. I don't know about an alternative menu. I press the bell if I want a drink." A relative commented, "I've sat with dad for meals. They're hot and he has a choice." Another relative told us, "There's plenty to eat and drink and they offer alternatives. They weigh mum every week and she has maintained her weight.
We can reserve a small room if we want to have a family meal together. Mum gets a drink whenever she wants one. They'll make her a cup of tea. If she wants another she gets one." A further relative commented, "Mum gets pureed food which looks like stodgy blobs. She got dehydrated once but liquids are offered freely and they monitor fluid input and output." Some people had modified texture diets, if they had swallowing difficulties. We found special moulds had been delivered to the kitchen the day prior to our inspection and the chefs told us they were keen to start using them after training. This would make the food look like standard presentation and better encourage people to eat pureed meals.

We saw that people had drinks in their rooms and were offered drinks regularly. Jugs were replenished regularly. We checked with staff in one unit their understanding in thickening people's fluids where there was a risk of choking. Staff knew the information specific to people's needs, and what consistency the fluids should be altered to. The thickening powder was individually prescribed for people and securely stored away by staff. When we checked staff understanding of how to prepare thickened fluids, they were able to explain the concept. We asked about how various products were used but the staff we spoke with were not aware of the contrast in preparation of different products. We explained this to the management team who

accepted our feedback and assured us they would have a speech and language therapist or pharmacist provide further information and training. The registered manager also contacted each manufacturer of the product to gain additional information at the point of the products' use by staff.

We found various professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. People at the service were actively supported to maintain good health. As far as possible, people were supported by the service to attend all necessary medical and healthcare appointments away from the service. The service had a minibus to ensure that when transport to services was not available, appointments were still attended. Sometimes, people would refuse their appointments, tests or examinations. Staff told us they encouraged people that good healthcare was necessary, and made repeated attempts to ensure the tests or visits occurred. Examples of good support to people related to healthcare included ensuring at least annual GP visits. We saw from records that a multitude of other healthcare professionals attended the service on occasions. Staff we spoke with were knowledgeable about people's ongoing health matters, diagnoses. The service ensured that people could access opticians, dentists, podiatrists and diabetes specialist nurses. There was a clear objective at the service to ensure people received the best healthcare.

A family member we spoke with thanked staff for ensuring a person's condition improved. Their comment included, "If I am honest, I didn't really think I would see her on her feet again. Perhaps managing from wheelchair to armchair or dining chair, but not actually walking." On the occasions where people had to attend hospital appointments the service ensured each unit had a travel bag. This contained where applicable, people's resuscitation decision forms, continence products, completed transfer information forms; sandwiches and drinks. The registered manager stated invariably outpatients appointments sometimes run late and to ensure people were hydrated and nourished sandwiches and drinks were also packed in preparation.

The service was wheelchair accessible inside and outside the building. Various aspects of the internal environment were changed or modified because people's dementia was considered and acted on by the service. This included multiple tactics and pieces of equipment to distract or divert people's attention, prevent wandering and encourage engagement. Large murals were painted along entire unit walls to encourage people to stop, look and talk with staff about the pictures. An old-time sweet shop was installed, which allowed people to complete shopping for treats and also purchase personal hygiene goods. A 'garden' room was set up in one unit. The room enticed people who liked the gardens, but were unable to go outside, to sit down and enjoy the surroundings. The room included grass, birds, butterflies, plants and associated furniture. We saw people use these areas freely during our inspection, and enjoy their time with staff.

Good

Is the service caring?

Our findings

People were happy to reside at The Manor Care Home. Staff constantly smiled and laughed throughout the inspection and tried to encourage people to be involved and enjoy themselves. We saw extensive personalisation of all people's rooms, including outside the door in 'memory boxes'. Our observation during the inspection demonstrated that staff were gentle and patient with people, spoke clearly and made eye contact when they communicated with people. Staff bent down or sat down when speaking with people, and did not lean over them or call out across the room or down the hallways. When we checked, staff were aware of the needs of each individual they cared for and helped people in an appropriate fashion. We saw there were a large volume of relatives and friends at the service who visited people. The service had no restrictions on visiting times.

People gave us consistent positive feedback about the attitudes of staff. The first person we asked said, "The staff are great. If I need anything I get it. There's nothing that I don't like about here. Oh no, nothing. The family can come whenever they like and there's been no problems with visiting". The next person told us, "I like my golf. There is dancing and I can be more active at other times. We go to Windsor or Slough for the shops. The Staff know us and they let us get on with our own business and don't interfere." Another person commented, "I like a shower at 6am in the morning and they help me with that." A further person stated, "I've got [a terminal illness] and not long to live. I moved here to be near my family and they can visit whatever time they want. The staff are very relaxed with me and I like that. They are very helpful, very caring...I've not noticed a difference in staffing at weekends and nights. I still get looked after. They help me wash. I wash as much as I can – they don't take over."

Relatives were also keen to speak with our inspection team. Again, they provided only positive feedback to us when we asked. On relative said, "I find it lovely here. I like the staff who do a wonderful job. When dad came back from hospital the staff welcomed him back. They were genuinely pleased to see him. I've been feeling guilty and anxious (about dad being in a home) but now I know he is in good hands." The next relative stated, "We've made the room home from home. It has an ensuite shower and it's big. We were encouraged to bring in pictures and furniture. We know there is a care plan and when [the person suffered a fracture] our son was involved in the review. There's a notice and photograph of a key worker on the inside of the wardrobe door. It's like home. We bring the dog in and take him for walks together and we leave our muddy boots in the porch when we come back. [Our loved one] had a birthday party last week organised by the home. It is home from home."

Through the dedicated and individual care, people's health had improved. Relatives felt that people's health had improved when they moved to The Manor Care Home. One told us, "Mum's health has improved dramatically since being here. The [pressure] sore has gone, she has a special bed and has the creams applied. She's well looked after. She is eating well because of their care. Before she was not eating properly. They close the door when they're doing private things but Mum likes the door open and they always knock on the door. They had to call an ambulance once and the staff screened off the area while the paramedics attended." Another relative stated, "Staff are very caring – extremely so. I come most days and the cleaner chooses a time when mum is out of the room. I've attended a 'best interests' meeting. The staff are

knowledgeable of her personality and they seem tuned in to everybody on the floor."

People's dignity and privacy were preserved. People we spoke with and observed in communal spaces were well-groomed and dressed. People could choose what they liked to wear and when unable to decide, staff would demonstrate clothes from their wardrobe as suggestions. We saw some people liked to wear make-up and staff assisted them every day to have this applied. Another example was a person who liked to consistently wear formal clothing most days. Despite taking longer to prepare the clothes and assist the person to put them on, staff ensured the person's choice was satisfied. When personal care took place, this was behind closed doors and staff were observed to knock when any door was closed before entering the room. Staff that cleaned the premises were also mindful of people's care. One told us, "We always knock on the doors and we come back if residents are engaged. We don't ever wake residents up and if they're in bed all day, we wait until they get up. We might quietly clean the shower and toilet."

Some people told us they decided they did not wish to participate in care planning or decisions, and preferred staff to make the choices for them. However, we noted despite this, staff always sought to engage the person even if they did not want to participate. Relatives and friends of the person were involved in decision-making at each step, even before people started to live at the service. Most people and relatives knew their key workers and the registered nurses, and could name them or point them out. When we spoke with staff, they knew relevant information about people and their relatives. Staff told us they liked to learn about people's social history and encourage them to think about their past and what they had accomplished or experienced in their life. The activities team made particular use of this task as a routine part of the support provided to people.

Confidentiality of people's information was maintained, including electronic records and communication. We noted that all computers required a user password to log in. Personal information was protected by computer systems because they promptly logged off if left unattended. Computers were at staff stations paper-based records were stored and locked in staff offices.

At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. This meant the service ensured that confidential personal information was handled with sensitivity and complied with the legislation.

A quotation from a relative taken from the complimentary register stated, "Thank you again for the care and compassion you've shown to [my loved one] at such a tough time. I wouldn't have got through it without you."

Good

Is the service responsive?

Our findings

The service used an electronic system of care planning which recorded a comprehensive assessment of each person's risks and needs and took account of physical, medical and social needs. Daily records were also recorded on this system. A copy of each person's most recent care plans and risk assessments were printed out and kept in individual care files which contained additional documentation and information, such as correspondence from health care professionals.

We found there was a good overview of personal information and a summary of care needs at the front of care files followed by detailed plans for each aspect of care. We saw that staff had recorded people's needs, risks and actions required along with individual information on preferences and routines. Care planning included an introductory section with the person's recent photo, name of their keyworkers and chosen GP. The service then documented any special needs like swallowing difficulties or allergies. Specific personalised information was documented to ensure staff had effective knowledge of the individuals they cared for. Person-centred information included their preferred name, reason for admission, nationality, marital status, ethnicity, religion, dietary likes and dislikes, medical background or conditions and their social history.

Family members and relatives were asked to complete 'homework' about the person before they were admitted. This was a document with a series of open-ended questions intended to help the service better understand and prepare for the needs of each person. The service encouraged the family or relatives to work through the questions with the person, so accurate information was included and the person felt involved from prior to their accommodation. We found this document was a good example of capturing information that may be missed on admission or after care commenced. The document also allowed staff to get to know the person before they arrived at the service for care. We saw it included family history, what the person wanted in their end of life arrangements, legal considerations and a person's life story. During the inspection, we found staff had good knowledge of the person from the document and often referred to it when conversations were started with the person or when talking about social lives with us.

People's needs were extensively assessed and documented. Relevant risk assessments and care plans were in place for each different aspect of people's care. These included communication needs, emotional support, respiration (including information on influenza vaccinations), nutrition and hydration with monthly risk scores and weights plus other information related to malnutrition such as swallowing concerns or assistance required to eat effectively. Other risk assessments and care plans we saw included elimination and continence, personal hygiene, mobility including moving and handling, social care and activities, privacy and dignity and end of life care or advanced directives.

We found care plans were comprehensive and very person-centred with clear and detailed information on particular health needs, likes, dislikes and preferred routines. There was good evidence that choices were documented and were respected. For example, we found there was information on sleeping and waking routines including whether the person liked their door shut at night, bedside lights on or drinks required at bedtime. In one example we reviewed, we saw that a person's care plan detailed preferred radio stations to

listen to at night. We also found there was detailed documentation on dietary preferences, with likes and dislikes clearly listed, any physical requirements or impairments such as assistance to eat or the need to have modified food textures. An example of a person's preference we reviewed was a person had requested small portions, to be cut into small pieces. Another person's plan stated they had a large appetite and wished to have brown sauce served with all meals. When we checked this at meal times, we saw the two people's preferences were respected by the staff serving them. There were also records of any food allergies in the care plan and kitchen. There were no cultural-based food requirements at the time of our inspection but staff and the chef said this could be accommodated when requested.

People's right to choice in their care was maintained at the service. We found a number of examples when we reviewed the care files and spoke with people. For example, one person had a pressure ulcer but had asked not be disturbed at night to turn or change their position. This choice was respected and was documented in the care plan with a reasoned assessment of risk. The person was found to be able to move sufficiently and that an undisturbed night was not seen as a significant risk. We also saw one person had lost weight and the care plan recorded that they were switched to a softer diet, to make food more palatable. This person had gained weight as a result, which lessened their risk of malnutrition. Another person had used bed rails at night but changed their mind and no longer wanted them. The care plan recorded that bed rails were removed in response to the person's own decision.

Care plans and risk assessments were evaluated monthly by staff and any changes incorporated. All care plans we reviewed were up-to-date and monthly assessments were clearly recorded. There was good evidence of response to changes in people's needs. We noted changes identified in daily notes were recorded on the front of the care plan to show when a change had occurred and how the care plan had been adjusted. This helped staff to immediately recognise significant changes about each person. We found daily notes about people's care were recorded electronically but relevant information but also highlighted on care plans if a change in condition or care needs had been identified. Daily notes were detailed and relevant and it was possible to see that care needs and preferences recorded in the care plans were delivered correctly.

All of the staff we spoke with were familiar with people's needs and personalities and were able to explain their routines, risks and how they were cared for. This mirrored information in the care plans we viewed and it was clear that plans were being used effectively to deliver appropriate care. For example, one person was admitted prior to our inspection with enduring severe pain. On the first day of our inspection the person's pain was monitored hourly and analgesia given if necessary. The registered nurse had raised the person's pain management at the morning meeting, which we observed. The registered nurse confirmed in the afternoon that a referral had been made to the palliative care team and a visit was planned for the next day. We visited the person the following day and they told us they had a 'good' night's sleep and that they were expecting the palliative care team later in the day.

There were four activities coordinators at the service and one to one sessions were scheduled for people who remained in their rooms. There were boards on each floor showing an extensive schedule of activities for the week, including weekends. Staff reported that the activities staff visited those who remained in their rooms and spent time conversing with them, bringing them reading materials and conducting social activities relevant for the person. A relative told us, "Mum's been out on trips and plenty of activities are offered. She watches TV and likes the quiz programmes. Activities people visit the room and encourage her. There was a special day on Mother's Day with flowers and chocolate from the home." A person who used the service said, "Every month I get an email about activities from the activities manager so I know the daily routine." The management team told us of their plan to further increase the use of outdoor spaces surrounding the building. This included construction of a pergola at the front of the service, and a path to

the River Thames with a viewing platform, including accessibility for people with mobility problems. The provider and management team had taken feedback from people and relatives and used this to further increase access to outdoor areas.

The complaints, suggestions and compliments policy and procedure was seen in the reception area. We found it was not clearly displayed and as it was a print out of the policy document, it was not especially accessible people who used the service with visual impairment or those with a diagnosis of dementia. No other information on how to make a compliant or raise a concern was seen within the service. There was no information on the complaints procedure in the 'service users' booklet. One relative told us, "I've not read about complaints but if I had one I'd raise it directly with [the registered manager] or at one of the meetings. We're asked to fill in a form at the beginning of a meeting and I've filled in survey forms. I don't recall feedback from those." Another relative told us, "I don't know how to make a complaint but I'd go to [the registered manager] or the nurse on the floor. They are all very approachable." A further relative said, "I raised a concern at a well-being meeting and felt the response was proper. I've not seen complaints advice. Depending on the level of complaint I'd speak to the senior nurse on the floor or the key worker and then [the managers]. It's easy to contact the office by email or phone. I've filled in a feedback form – I think it's annually. Last one was just before Christmas. The results were fed back by email." A person who used the service explained, "I know there are resident and relative meetings. I've not been asked for feedback formally but [the registered manager] stops and talks to us all the time."

We reviewed the complaints log and documentation for complaints received from 2016 to the time of our inspection. We looked at a total of eight complaints to check how they were investigated and managed. We saw the complaints log registered the date of a complaint, name of the complainant (and person who used the service), how the complaint arrived, the subject of complaint, and whether the complaint was resolved, including what action was taken to ensure closure. The subject of the complaints were mixed, with no trends or themes identified. Further documentation on each complaint was sometimes inconsistent. In one case we saw a response was clear and chronological with a copy of the letter of apology and agreed resolution. However, for another complaint the documentation was not ordered with duplication and omissions. We saw there was an e-mail that invited the relative to discuss the complaint but no further record was recorded, although the complaint was marked as resolved.

A compliments register was also maintained by the service. There were many instances of positive feedback. We found there were 39 compliments in 2016 and 13 in 2017 up to the time of our inspection. A satisfaction survey was conducted annually. We reviewed results published in January 2017 for the most recent survey. They indicated a high level of satisfaction with the care and service provided by the home. The questionnaire covered 28 separate measures and there was no poor responses or disagreement with any. For example, 100% of respondents recorded the service as safe and that they would recommend The Manor Care Home to others. In other areas, people recorded that they found the kindness or caring was of staff excellent and good, and that staff were well-trained. Responses to the 2016 survey we viewed were similar. A satisfaction survey box was set up in the service to collect responses.

Good

Is the service well-led?

Our findings

As part of our inspection, we received a variety of consistently positive feedback from various sources about the care, leadership and management at The Manor Care Home. This included feedback from people who used the service, families, healthcare professionals, contractors to the service, local authorities and healthcare agencies who worked with the staff and management to manage people's care.

There was consistent praise from people and their families for the staff and management team. One person said, "[The managers are] in charge and there are two named seniors on the floor. I do have a voice because when I said that I didn't like the TV left on blaring out the news in the orange sofa room, they changed it to a [service] where you can choose what you want like music and films." A relative told us, "I see the kitchen has been done up and they've extended the dining room area. We had a meeting recently when they told us about putting in a wheelchair path down to the River and installing CCTV. I think the staff do what is a difficult job well." Another relative commented, "Yes, I would recommend this service because it's run efficiently with caring staff. I feel confident I can carry on with my job and I don't panic and feel I have to ring every day. They instil confidence in me; especially the [management team]". A third relative stated, "[The registered manager] seems to know everyone in [the local hospital] which gives me confidence. I feel [the registered manager] has her eye everywhere and knows what's going on."

Many healthcare professionals provided extensive feedback to our request for information about the service's management and leadership. With regards to the management, one GP stated, "Without hesitation I would commend the leadership attributes demonstrated by the [registered manager]; her demeanour to residents, visitors, families, and staff is welcoming, professional, compassionate, caring and person-centred. I observed the attention to detail and time that was dedicated to learn about the individual residents and their interests, which was then incorporated into their care plan and living arrangements. More than occasion I witnessed [the registered manager] advocating for both residents and their families ensuring they received the highest standard of care..."

Another GP wrote to us about the service with sincere praise for management. They commented, "[The registered manager] is an excellent leader - it is clear that she is resident-focused, leads with compassion and holds staff to account on delivering the organisation's objectives. The owners are supportive of her leadership. Staff often go the extra mile. It has supported me in managing their medical care. [I] have no hesitation in recommending this care home. There have been several patients with complicated end of life care needs where professional networks and communication have been a key element to ensuring safe, effective care. There are many outstanding examples which I hope you shall be able to find out during your visit."

An external trainer also contacted us to express their positive views about the service. They wrote, "I have provided a variety of training sessions for the team at the Manor over the past few years...most recently I delivered two days on 'compassion fatigue awareness' which [the registered manager] asked me to teach to help the staff cope better with the stresses of their roles. This is a proactive training designed to equip the staff with a toolkit of self-care measures to help them become more resilient and the results after three

months showed that it had been very effective in helping them. During my time at the home I have also witnessed some excellent care and compassionate attitudes from staff towards the residents who at times can be very challenging." The management team had considered the staff's dedication to their respective roles, and took care to ensure staff did not develop or endure work-related fatigue.

Staff told us about the vision and values of the service and said they found management to be open, accessible and attentive. Comments included, "We care for residents, always value their opinions and treat them with respect" and, "[The registered manager's] door is always open and she would always listen to what you have to say."

Staff said they knew how to raise concerns and report poor working practices ('whistleblowing'), and felt confident to do this. Comments included, "I have not had to do this but if I did have any issues I would go straight to the appropriate manager" and, "I observed a resident was not being moved correctly. I spoke with [the registered manager] and [clinical care manager] and they brought this to the staff member's attention. I felt supported during this process." A whistle blowing policy and procedures were in place to support staff and guide them of the steps to follow when reporting poor work practices.

Staff members were complimentary about the leadership of the service and said they received regular feedback. The registered manager was described as someone who was fair, reasonable and would introduce changes in response to staff feedback. For instance, a staff member told us the registered manager responded positively when the staff team presented an issue they were facing and detailed how it affected their work practice. The staff member commented, "It's the way you approach the manager that determines how they respond." The registered manager spoke to us about the 'off duty and carers' request book'. This was introduced in response to staff requesting if they could be made aware of extra shifts on offer. This showed the service listened and responded to feedback received from staff.

Staff team meetings occurred on a regular basis. This was supported by our review of minutes of meetings. For instance, we noted discussions were held about quality standards in the service and how staff members would achieve this. A care workers' meeting held on 18 January 2017 covered amongst others, shift start times at the nurse's station and reporting sickness. We also saw a meeting held with nursing staff on 26 January 2017 covered safe medicines administration and daily medicine audits, care plan reviews, dress code, staff supervision sessions and appraisals. This enabled the service to monitor their progress against plans to improve the quality and safety of care provided to people.

In recognition of staff achievements, the service introduced annual awards. The registered manager told us senior staff voted for the staff members they thought deserved to be rewarded due to their work practices. A poster was clearly displayed entitled, 'The Manor Staff Oscars 2017'. This listed the names of staff members who were recognised on the day. Photographs of staff receiving their awards were on display. This showed the service recognised staff for their contribution to ensure there were improvements to the quality of service people received.

The service had established very effective quality assurance systems to assess, monitor and improve the quality and safety of people's care. We found audits undertaken covered areas such as infection control, care plans, medicine audits and health and safety. We noted recommended actions were followed up and completed by the relevant staff. Various analyses of accidents, incidents, infections, GP visits, end of life care plans in situ, advance directives and expected deaths were undertaken. Reports identified results of care provided to people and areas for improvement at the service. These were clearly displayed to staff outside the registered manager's office. The registered manager then told us they would adopt the principle of complete transparency by consulting people, relatives, staff and others about where best to display results.

Weekly training reports detailed the work carried out by the training coordinator. This covered staff inductions and workplace shadowing, competency assessments and supervisions. Training presentations covered areas such as Skills for Care's Care Certificate, end of life care, head injuries, mental capacity and patient-centred care plans. This demonstrated the service had systems in place to enhance the learning and development needs of staff.

There were effective communication systems in place to ensure people who used the service received safe and appropriate care. Weekly multidisciplinary team meetings (MDT) occurred with nursing staff. On the morning on the first day of our visit we attended an MDT meeting. The nurses that were present demonstrated a very good understanding of people's care needs and shared relevant changes in people's health and any necessary actions that needed to be taken. This information was shared with staff and those who needed to know, such as other health professionals that had been contacted to provide additional support to people.

A 'prompt sheet' developed by the management team was given to support staff to ensure they provided detailed and accurate documentation in peoples' care records. The 'prompt sheet' gave specific instructions and examples of 'the level of detail and information required in each entry.' This was in relation to peoples' behaviours, interactions, sleeping patterns and daily activities. A health care professional that commented on a person's recent admission complimented the registered manager for their cooperation and documentation provided which, "...was very comprehensive and helpful facilitating the review process." This showed that records relating to care were detailed, accurate and fit for purpose.

The service had an appropriate duty of candour policy in place which gave clear and specific instructions for management to follow when the duty of candour requirement was triggered by safety incidents. We saw letters that had been sent to relatives apologising when incidents of serious injuries had occurred. It is a legal requirement for providers to submit statutory notifications to us when events that affect people's health and safety had occurred. We reviewed the accidents and incidents which resulted in serious injuries and saw the relevant statutory notifications were submitted in a timely manner to us. In conjunction with notification requirements, the management team also developed a collegial working relationship with us and the local authority to keep all parties informed of the progress of any relevant cases.

We noted transparency in matters with the local safeguarding team, police and healthcare professionals. On more than once occasion prior to our inspection, we requested additional information from the management about particular events. This was so we could understand what the service had implemented to ensure recurrence and ensure people's care was not compromised. The service sent detailed information promptly, which always included investigations, action plans and researched ways of preventing similar cases. In addition, and without our prompt, the service always sent case outcomes to our national customer service centre. In one, we noted police were 'impressed' with the handling of a particular matter and stated the service handled the situation in the best possible way they had encountered.

The service sought the views of people and their relatives through various methods. This was supported by a satisfaction survey completed by people and their relatives in January 2017. We noted people and their relatives felt the manager was open and invited everyone to be involved in discussions and planning before any changes took place. They felt the registered manager lead a strong culture of good quality, safety, respect, compassion and dignity which was followed by the whole staff team. Minutes of relatives' meetings documented relatives provided feedback on various aspects of the service and the service providing updates. 'The Manor Satisfaction Survey' box was visibly displayed in the reception area of the home. Visitors to the service were able to (by use of coloured tokens) provide feedback on various departments. Visitors were given the opportunity to place tokens in feedback boxes which indicated whether the relevant

departments were excellent, good, requires improvement and inadequate.This meant the management team had enabled the service to review and make further improvements to the quality of the service provided.

The service had forged a close working relationship and partnership with the local hospice and hospital. This meant people and families who desired a respectful and meaningful end of life process were prioritised for admission to the service. The service's management communicated frequently with the external partners to understand when the best time for admission was. The service, hospice and hospital worked together to ensure people's admission process and care would be carefully thought out. There was a waiting list for admissions. During the inspection, we observed the management team prioritising which person should be admitted when a vacancy was available. We also noted staff between the three services visited each other's service to ensure people knew about the care processes between transfers of any care.

The partnership between The Manor Care Home and external agencies was well-known by local healthcare professionals. Community partners were able to provide multiple examples of how the team management of the service had successfully worked in collaboration. A care manager who wrote to us, stated, "My experience with The Manor Care Home has always been positive. The care home continues with the excellent care standards, flexibility, person centred and holistic approach to their residents and outstanding quality of care. [A person] who [was] placed at Manor Care Home with less than a three month diagnosis has actually improved to the point [where they are] no longer eligible for their funding. Other service users as well as their families have always provided me with the positive feedback."

Another example of working together with the local healthcare professionals was a person who moved into the care home but wanted to spend their end of life care at own home. The person had a debilitating illness that meant care at home would be particularly difficult. The management team told us they held multiple meetings with the person and relevant healthcare professionals to organise the move back into the community. The planning of the person's discharge took three months and required extensive oversight of the continuity of care management by the service. The person successfully moved back to their own home. We were told they were able to spend their end of their life at home and the service had facilitated their final wishes. The family members of the person expressed their gratitude to the service's management and their commitment to work with external healthcare agencies in an unusual situation.