Jasmine Care Holdings Limited

Manor Place 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 effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

This inspection took place on 1 and 2 February 2016 and was unannounced. Manor Place Nursing Home provides nursing care for up to 60 older people requiring nursing and/or dementia care. At the time of our inspection 50 people were living in the home, with another three people in hospital. The home is a three storey building, providing care on four designated units for nursing and/ or dementia care. Communal areas were located on the ground floor, and the home was situated around an enclosed courtyard area and secure garden.

The home had 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.

Recruitment processes did not always evidence that people had been protected from the risks of unsuitable staff. Some checks, such as identity and criminal record checks, had been completed satisfactorily. However, the provider had not ensured that investigation into and explanation of gaps in applicants' employment history had always been recorded. Evidence of suitable conduct in previous relevant employment positions had not always been requested.

Environmental risks had not always been addressed, because there was no robust programme in place to maintain regular checks on, for example, water temperatures, smoke alarms or sensor mats. There was a risk that people may be at risk of harm due to unidentified faulty equipment.

Specific risks affecting people's health and welfare, such as the risk of falling, were managed safely. Staff were aware of those at risk, and took actions as required to promote their safety.

People's medicines were stored, administered and disposed of safely. An audit in January 2016 had identified some issues, for example with recording administered medicines. Actions were implemented to promote safe medicines administration.

There were sufficient staff deployed to meet people's identified needs. Rosters and shifts were planned to ensure additional staff were available at times of high demand, for example to administer medicines or support people to rise in the morning.

People were safeguarded from the risk of abuse, because staff understood how to identify and report concerns. The registered manager notified and appropriately managed concerns to ensure people were protected from harm.

The staff training programme had been re-scheduled from 1 January 2016 to ensure all staff were supported to develop and retain the skills required to meet people's needs effectively. Formal and informal meetings

and competency assessment ensured staff demonstrated the required skills to meet people's needs.

Staff understood and implemented the principles of the Mental Capacity Act 2005. They listened to and respected people's wishes. Nurses knew when it was appropriate to assess people's mental capacity to ensure they could make an informed decision about their care. A best interest decision was made for people by those appropriate to do so when they lacked the mental capacity to make the decision for themselves. People's liberty was only restricted when it was lawful to do so, to protect them from harm. Records demonstrated that lawful process was followed in these cases.

People's dietary needs and preferences were known and met effectively. People were supported to maintain sufficient nutritional intake. Nurses liaised with health professionals to ensure people's health needs were reviewed, and care provision effectively supported their identified needs.

People and their relatives described staff as caring and attentive to their needs. We observed caring interactions, where staff promptly responded to indicators of people's discomfort.

People's views and comments were listened to, and relatives were asked for information to inform people's care. People were encouraged to help with daily tasks if they wished, such as gardening and helping in the kitchen.

People's dignity was promoted, and their privacy respected, as staff took appropriate actions to ensure people were treated in a dignified and respectful manner.

People's care needs and wishes were documented and reviewed regularly to ensure changes were identified and addressed. Staff were attentive to changes in people's wellbeing or health. They took appropriate measures to support people's recovery or provide respectful and kindly end of life care.

Activities were arranged daily. A volunteer visited people who remained in their rooms, to ensure they did not feel socially isolated. Complaints had been addressed appropriately. People and their relatives were confident that concerns they raised would be considered and responded to.

The provider's values of welcome into the home and provision of care that promoted people's wishes and independence were demonstrated in the care people experienced. The registered manager and deputy manager were respected by people, relatives and staff. They provided leadership that listened to and acted on the views of others.

Audits were used to identify issues and review the effectiveness of measures put in place to drive improvements to the quality of care people experienced.

We found two breaches 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 this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider's recruitment procedure was not sufficiently robust to demonstrate staff were suitable for their roles. Action was taken following our inspection to meet regulatory requirements.

Environmental risks affecting people and others were not always managed safely, because regular equipment checks were not always in place. Specific risks affecting people's health or support needs were managed through appropriate assessments and actions as required.

People were protected against the risks associated with medicines, because support workers administered their prescribed medicines safely.

Sufficient staff were deployed to meet people's needs.

People were protected from the risk of abuse, because staff understood and followed the correct procedures to identify and report safeguarding concerns.

Is the service effective?

Requires Improvement

The service was mostly effective.

Training in mandatory topics had not been completed by all staff. Actions to address this were planned to ensure people's needs were met. Staff were supported to develop and maintain the skills they required to deliver their roles effectively.

Support workers understood and implemented the principles of the Mental Capacity Act 2005 to ensure people were supported to make informed decisions about their care.

People's dietary needs and preferences were known and met to protect them from poor nutrition or dehydration. Effective liaison with health professionals ensured people's health needs were addressed.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were caring and attentive to their needs.

People and their relatives were listened to, and their views informed the care people experienced.

People's dignity and privacy were respected and promoted by the staff who supported them.

Is the service responsive?

Good

The service was responsive.

People's changing needs were identified, assessed and managed responsively.

Activities were provided for people in communal areas, and individually for those unable or unwilling to leave their rooms.

People and their relatives understood the process to raise concerns, and these were resolved appropriately.

Is the service well-led?

Good

The service was well-led.

People and their relatives were welcomed into the home, and their views used to help improve the care people experienced.

People, their relatives, and staff all spoke positively about the availability, approachability and supportiveness of the management team.

Audits were used to identify and drive improvements to the quality of care people experienced.

Manor Place Nursing 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 checked 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.

The inspection took place on 1 and 2 February 2016 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor with clinical experience of nursing and dementia care.

Before the inspection we looked at previous inspection reports and notifications that we had received. A notification is information about important events which the provider is required to tell us about by law. We reviewed information shared with the Care Quality Commission (CQC) by commissioners of care and a nursing advisor. A Provider Information Review (PIR) had been submitted for the inspection in July 2015. A PIR 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 considered this information during our inspection to review the quality of care people experienced.

During our inspection some people were unable to tell us in detail about their experience of the care they received. We observed the care and support people received throughout our inspection to inform us about people's experiences of the home. We spoke with four people and six people's relatives to gain their views of people's care. We spoke with the provider, registered manager, deputy manager, three nurses and three care workers. We also spoke with ancillary and voluntary staff in catering, maintenance and activities roles. In total we spoke with 12 staff members. We use the term 'staff' in this report to refer to a mix of staff roles, including management, care and ancillary.

We reviewed six people's care plans, including their daily care records, and medicines administration records (MARs). We looked at seven staff recruitment and supervision files, and the staff roster from 11 to 31 January 2016. We reviewed policies, procedures and records relating to the management of the service. We considered how people's, relatives' and staff's comments and quality assurance audits were used to drive improvements in the service.

We last inspected this service on 16 September 2014, and did not identify any areas of concern.

Requires Improvement

Is the service safe?

Our findings

We looked at recruitment records for nursing and care staff who had been employed since our last inspection. We found that the required regulatory checks had been not been fully completed. None of the seven records we viewed documented applicants' full employment history. Two records only noted the years of employment for some employment positions, and all seven contained employment gaps within the records. Four staff files did not include evidence of good conduct from previous employment positions within the health and social care industry. There was a risk that staff employed may not be suitable for the care or nursing roles they held.

The provider's recruitment procedure did not ensure that staff employed were of good character. This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other regulatory requirements relating to staff recruitment had been met. For example, identity and criminal record checks had been completed. A health declaration ensured any staff health issues could be supported without impacting on people's care. All nurses' registration was checked to ensure that nurses were on the active register of the Nursing and Midwifery Council.

The registered manager had identified employment history gaps in staff recruitment files prior to our inspection. All staff had been requested to complete a full employment history record before our inspection commenced, and the home's administrator was starting to collate this information. They had asked staff to explain any gaps in employment. Following our inspection, this work was prioritised to ensure people were protected from the risk of support from staff unsuitable for their role in the home.

The maintenance person told us they relied on staff reporting faults or issues, rather than completing regular checks on some equipment, such as testing water temperatures, or checking that emergency lighting and smoke detectors were in good working order. Water temperatures had last been documented as checked in August 2015, and emergency lighting and smoke detectors last checked by an external contractor in October 2015. There was a risk that faulty equipment may not be identified until it was required in an emergency or caused people harm.

Incident reports demonstrated that equipment used to protect people from harm had not always been monitored to ensure it worked. For example, sensor mats were sometimes used to alert care workers when people rose from chairs or their bed, to ensure they were supported safely if they were at risk of falling. One person's sensor mat was not working for one day in November 2015. It had not been charged, and so did not alert care workers, twice in December 2015. There was a risk that this person's risk of falling might not be managed safely, because equipment used to protect them had not been effectively maintained.

The provider's maintenance procedure was not sufficiently robust to protect people from potential risks associated with the equipment used in their care. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other checks were completed regularly. For example, the fire bell was tested weekly, and an external contractor serviced fire extinguishers and ensured staff were trained in fire safety. Portable electric equipment had been tested to ensure it was safe to use. The maintenance log was used by staff to report faults to the maintenance person. Staff told us these were addressed promptly to ensure issues were resolved, and people's safety promoted. The log was updated once repairs were completed, and showed that all reported issues had been addressed at the time of our inspection.

Risk associated with people's health and welfare were assessed prior to their admission to the home, and monitored to identify any changes. A relative told us nurses were "Right on the ball" managing their loved one's health needs, as they reacted "Within seconds" to manage seizures. A 'daily summary of care needs' ensured care workers were aware of changing risks affecting people's care, and the actions required to promote their safety. For example, guidance ensured care workers understood how to use equipment safely to support people's mobility and transfer them between chairs and their bed. Care workers were reminded to monitor the location of people at risk of falling, and were alerted to those who forgot or were disinclined to use their walking supports. Other risks, such as dietary or pressure care needs, were similarly noted. This prompted care workers to be attentive to risks that could affect people's safety and wellbeing.

Plans to manage emergency situations that could affect people's care, such as an outbreak of infectious disease, extreme weather or utility failure informed staff of the actions to follow to protect people and others from harm.

A medicines audit was conducted in January 2016 to review people's medicines administration records (MAR), medicines storage and stock checks. This had identified some issues regarding explanation of gaps on MARs, as the reason for administration omissions was not always documented. This was reflected in our own review of MAR records for January 2016. The audit noted that the reason for administering PRN medicines was not always documented. These are medicines prescribed to be given as necessary, for example to manage intermittent pain. One box containing a person's medicine had not been notated with the date of opening. There was a risk that this medicine may be used past its end of use date. One medicines stock record was inaccurate. The issues identified had been reported to the registered manager, who had addressed these with the nurses as appropriate. Issues had been identified and actions implemented to protect people from the risk of unsafe medicines administration.

People's medicines were safely stored and disposed of appropriately. Some prescription medicines are controlled under the Misuse of Drugs Act 1971. These medicines are called controlled drugs or medicines. Controlled medicines were administered and disposed of safely. Two nurses worked together to review controlled medicines, to ensure people were administered the right dose safely. People's medicines were checked against their medicines administration record (MAR) to ensure people were administered their required prescribed medicines. We observed MARs were signed when people had taken their medicines. Nurses reminded people what their medicines were for. They knew how people liked to take their medicines, for example using a spoon or cup, and supported people to take their medicines as they preferred.

Nurses were trained and assessed to ensure they administered people's medicines safely. One new nurse told us they were impressed with the medicines administration training provided during their induction. Another nurse spoke positively about 'Safe Administration of Medication' training delivered by professional pharmacists at least once a year, or more often if there were changes. Nurses confirmed that the registered or deputy managers assessed and reviewed their competency to administer medicines. This ensured that nurses maintained the skills to administer people's medicines safely.

Relatives told us staffing was mostly sufficient to meet people's needs, although they also commented "Staff often seem to be rushing around", and there wasn't always sufficient time for staff to spend time with people. One relative stated "It's busy, but there is always someone watching". A nurse told us it was "Always a rush to get the job done", and staff told us that although staffing was adequate, they would benefit from additional staff to be able to spend more time with people. We observed staff were busy throughout the day, but people were attended to promptly during our inspection.

Staffing levels had been impacted by an unexpected loss of staff in summer 2015. This had resulted in a requirement for an increase in agency staff use, particularly to cover nursing shifts. The number of admissions to the home had been restricted by the provider to ensure people's needs could be safely met at this time. The deputy manager explained that they had now fully recruited to all nursing and care worker positions, with some staff still undergoing induction at the time of our inspection.

The roster we reviewed demonstrated that the staffing levels identified by the registered manager to meet people's needs were planned, and mostly delivered. There had been occasions when this was affected by short notice unplanned absence. The deputy manager was trained and available to provide additional nursing cover as necessary, and agency care workers were used when required. Shift hours were overlapped to provide additional staffing at times of high demand, for example with medicines administration or to help people get up, washed and dressed in the morning. When people required an escort, for example to attend health appointments, care workers were allocated on the roster to provide this. This ensured that sufficient staff were available to meet people's care needs.

People told us they felt safe with staff, and relatives told us their loved ones were safe at Manor Place Nursing Home. Comments included "I have no worries at all" and "The staff are kind". Staff told us they would report any safeguarding concerns to the registered manager, and were able to describe examples that would concern them. They understood how to identify and report abuse. Information regarding safeguarding was displayed on notice boards for people's and staff's information. The whistle blowing policy was displayed for staff attention. This meant staff were informed of the process to raise concerns outside of the home if they felt this was required.

The registered manager had submitted notifications and taken actions to address safeguarding incidents as appropriate. People were protected from the risk of abuse, because staff understood and followed the required safeguarding processes.

Requires Improvement

Is the service effective?

Our findings

Staff told us training opportunities had been affected by short-staffing, but this had recently improved. They said training was regularly refreshed to ensure they maintained the skills required to meet people's needs effectively. As well as mandatory topics including safeguarding people from abuse, moving and handling and food safety, additional training was provided. This included managing behaviours that challenge. One care worker explained how this had provided them with the understanding to use distraction techniques and negotiate with people to manage their needs and promote their wellbeing. Nurse training ensured they completed and retained knowledge relevant to their role, for example to take blood and provide catheter care.

We reviewed a staff training list that demonstrated training opportunities had been made available to enable staff to refresh their required skills. However, not all staff had completed or refreshed their required training to keep up to date. For example, 15 staff, including nine care and nursing staff, had not refreshed their manual handling training within the past year. Safeguarding training had not been refreshed or completed within the last two years by 18 staff.

A review of people's falls and related incidents identified that people had not always been supported effectively when care workers used a hoist or otherwise helped people mobilise. The deputy manager told us they had reviewed and updated training to move and re-position people in response to this. They had consulted the regional nurse specialist to ensure mobilising techniques were safe and effective. Not all staff had updated this training at the time of our inspection.

The deputy manager told us training had been "Erratic" the previous year, as they had struggled to release staff to attend training as well as meeting people's daily care needs, because of the unexpected reduction in staff. The training programme had been prioritised from 1 January 2016, when staffing vacancies had been fully recruited, to ensure all required training would be completed or refreshed by all staff. The registered manager explained the planned programme of training to meet this.

The deputy manager regularly reviewed staff skills when working on shifts. Where poor practice was identified, staff were required to immediately refresh their training. This ensured staff retained the skills required to meet people's needs. The deputy manager confirmed "I am confident we are on top of this". We did not observe poor mobilising techniques during our inspection, as hoists were used safely and staff were observant of people's mobilising needs.

Nurses were supported to gain and maintain the skills required to retain their professional qualification. For example, courses in pressure ulcer prevention, managing controlled medicines and management of gastro intestinal tube care were completed or booked. Gastro intestinal tubes are feeding tubes used to provide nutrition directly into the stomach of people unable to eat due to health issues. Staff were trained to ensure they had the skills required to meet people's needs effectively.

Staff told us, and records confirmed, that face to face individual supervisory meetings did not occur

regularly. Although formal opportunities for staff to discuss developmental concerns or aspirations with managers on a one to one basis were limited, all the staff we spoke with confirmed they had attended individual supervisory meetings. Role specific and general staff meetings provided the opportunity for staff to meet to discuss issues and share learning. Minutes from a nurses meeting held on 12 January 2016 demonstrated discussion of booked training. They had discussed and agreed allocation of nurses' roles and responsibilities, including care plan reviews and completing care worker supervisions. The deputy manager told us staff meetings were planned bi-monthly, or more often when required. Staff were supported to raise and resolve issues to help them effectively manage people's care.

New staff were required to complete the provider's induction. For care workers this included completion of the Care Certificate, which sets out the learning outcomes, competences and standards of care that care workers nationally are expected to achieve. New staff shadowed experienced peers in the same role on day and night shifts. The deputy manager worked alongside new staff to assess their competency before they were permitted to work alone. New staff were appropriately inducted to ensure they had the skills and knowledge to meet people's needs.

Staff understood and implemented the principles of the Mental Capacity Act (MCA) 2005. We observed staff listened to people's wishes, and respected their decisions, for example about meal or activity choices. A nurse explained the actions they would follow if a person refused their medicines, as this was their right. One person had refused medical intervention to manage a health issue. They had the mental capacity to do so, although their family did not agree with their decision. Staff liaised with the family on the person's behalf to ensure the person's decision was respected. People's care plans demonstrated that people were supported to make decisions about their care.

The MCA 2005 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 make particular decisions, any made on their behalf must be in their best interest and as least restrictive as possible. People's care plans documented the process of mental capacity assessment and best interest decision-making. Staff understood the requirement to assess people's mental capacity if they were concerned the person was not able to make an informed decision about their care. They knew when it was appropriate and lawful to discuss people's care with others, and when others should be consulted to make a decision in the person's best interest if they lacked the mental capacity to do so for themselves.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, 29 people had DoLS applications. These people lived on the dementia unit. This unit was locked to ensure those at risk did not leave the care of staff who monitored their wellbeing. Some people were able to operate the locking system unsupported, and were able to leave or enter the unit as they wished. This meant that only those whose safety was at risk without staff support had their liberty restricted. Manor Place Nursing Home demonstrated that restrictions to people's liberty were implemented in accordance with the MCA 2005.

People and relatives were mostly positive about the quality and choice of meals. At lunchtime, one person said "That looks good" when presented with their meal of choice. A staff member explained that for people unable to verbalise their choices, they asked relatives about people's favourite foods, or used picture cards. We observed people were offered plated options to chose the meal they wanted. People were provided with condiments and sauces to season and flavour their meals as they wished, and meals were nutritious and healthy. The daily and weekly menu was displayed for people's reference, including meal options to meet

people's preferences. Feedback on meals and menus was encouraged through resident and relatives meetings, and meals were varied in response to this.

Care workers were aware of people's specific dietary needs, for example to meet diabetic needs, as well as the need for fortified, soft or pureed meals. They knew when people were able to eat independently, or required prompting and encouragement to maintain sufficient nutrition. Staff support was prioritised at mealtimes, particularly for people living with dementia. This was to ensure they were supported to eat sufficient amounts to maintain their dietary needs. Mealtimes were lengthy to ensure people who required a lot of prompting or ate slowly were not rushed. Care workers were aware of people who had eaten well at breakfast. This influenced the amount of encouragement they gave people to eat their lunch, as staff understood whether people were likely to have a good appetite or still be full. For people with a low dietary intake, they provided a range of options to try to support people to take in sufficient nutrition.

The chef understood people's dietary needs and preferences. They had been trained in food safety and nutrition, and championed people's nutritional health. They spoke passionately about the importance of protecting people from the risks of malnutrition or dehydration, and explained how they prepared meals individually for each person. Meals were plated and labelled to ensure care workers offered each person their planned meal, and there were sufficient alternatives to meet people's preferences. The chef helped to serve meals on the dementia unit, and supported people to eat. This meant they were able to identify changes to people's preferences, were aware of meals particularly enjoyed or otherwise, and could discuss people's preferences directly with them at a time that was meaningful to them.

The chef told us there was good liaison with the speech and language therapist (SALT) and dietician to ensure people's dietary needs were met. People's meal presentation included soft or pureed meals to address known health issues such as difficulty swallowing, on the SALT's recommendation. People were effectively supported to meet their nutritional needs.

The GP visited the home weekly, and daily handovers identified people who should be seen on weekly GP visits or as a matter of urgency. People newly admitted to the home were registered and visited by the GP to review their health needs. Nurses reviewed people's health care needs at least monthly, to ensure they received the care and nursing they required. Care plans were updated to reflect people's current needs, and daily allocation sheets ensured care workers were aware of any changes required to meet people's health or emotional needs.

People's care plans evidenced that they were supported to access professional health care as required. For example, one person's care plan demonstrated input from a physiotherapist and Parkinson's nurse specialist to manage their health needs. People were visited by the GP following falls as necessary to identify any required changes to their care. Advice and changes to people's care were documented in their care plans, shared at handover and updated on care worker allocation sheets. This ensured all care workers were aware of people's current care needs. People's health needs were effectively supported through nursing care, referral to and advice from health professionals.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the caring nature of staff. One person told us staff were "Lovely" and "Nothing is too much trouble". Another person referred to staff as their friends. Relatives' comments included "The care is very good here" and "The staff are kind". One relative told us they "Couldn't speak highly enough" of the care their loved one experienced, and described staff as "Like family". Another relative told us her loved one's care was "Absolutely excellent", and staff "Go out of their way to help you".

Staff were attentive to people's needs. A relative told us staff often "Popped into" their loved one's room. The person's health meant they spent a lot of time in their room, and visits meant they felt less socially isolated. One person in a communal lounge commented that they had forgotten to bring their glasses when they left their room. A care worker immediately offered to fetch them. People were listened to, and responses demonstrated that their wishes mattered to staff.

Staff were attuned to people's emotional needs. During handover, staff discussed ways to support a person who was missing their spouse, and how to support another person who's actions did not promote their dignity. Where people's improving health meant they were able to be more independent, the nurse reminded care workers of how to encourage them to join in with social events while ensuring known risks were managed safely.

A person had previously been distressed because they wished to be assisted to rise earlier in the morning. Staff allocation had been adjusted to ensure this was accommodated, and the nurse reported at handover that this had improved the person's wellbeing. Care workers were aware of people who had booked hair appointments during the day. They ensured people's hair was washed in readiness for their appointment. They understood it was important to people's wellbeing to keep up their appearance.

The chef explained that people's dietary preferences and needs were shared with them prior to people's admission. On the day of their arrival, the chef prepared a favourite meal for the person in readiness, and ensured this was refreshed to remain appetising regardless of the time of their arrival. This meant people felt welcomed, and reassured them that their preferences were known and accommodated.

It was one person's birthday during our inspection. Care workers ensured they were able to watch their favourite film, and had a birthday cake to celebrate. Another person had a specific dietary preference for meals. All the care workers were aware of this, and were able to describe how this person prepared the meal for themselves from the ingredients provided. This had improved their dietary intake as well as promoting their independence.

We observed some very caring interactions between people and the care workers supporting them. Staff listened when people spoke, and provided gentle encouragement or reassurance. One care worker danced with a person to enjoy their happy mood with them. Staff did not always appear to have time to sit and chat with people during our inspection, but were prompt to meet their care needs.

A relative told us they had explained their loved one's history, likes and dislikes to staff when the person was admitted to the home. This information was used to inform their plan of care to ensure their wishes were known and respected, and their interests could influence activities offered.

We observed staff knew people's wishes and preferences, and listened to people's comments to ensure they supported them as they wanted. People's rooms were decorated to their taste, and included personal items to make them 'homely', such as family photographs or small furniture items from the person's previous home. Many of the residents took pleasure from views of the garden from their rooms. Photographs, names and roles of all the home's staff were displayed in the home. This assisted people and their visitors to be informed of and recognise those caring for them.

Nurses listened to people's comments about how and when they wanted their prescribed medicines. They understood and met people's preferences. If people were disturbed to ensure they took their medicines at a specified time to manage their health, nurses did so respectfully. For example, one person did not like bright light in the mornings. The nurse prepared their medicines in the light outside of their room, then opened the curtains in their room slightly, to provide sufficient light to support them to take their medicines. Once the person had taken their medicines, the nurse checked with them whether they wanted their curtains drawn again, and followed the person's direction.

The deputy manager explained how people had been encouraged to take on household tasks if they wished. The chef told us one person helped them in the kitchen, and we observed this during our inspection. Some people gained satisfaction from completing actions they were familiar with, such as gardening and clearing up. They chose when they wanted to engage in these activities. Staff thanked them for their assistance, demonstrating this was valued.

Care workers were attentive to people's needs, for example providing blankets or opening windows in response to people's body temperature and wishes. They noticed when people appeared uncomfortable, and helped them to re-position to alleviate discomfort. Staff understood and met people's preference for male or female care workers. This promoted people's dignity.

People were encouraged to hold keys to their rooms if they wished. This meant they were able to lock their doors for privacy as they chose. Pictures of reference were used in the home to help people to orientate to specific rooms, such as toilets and bathrooms. People could chose to sit in lively communal areas or quiet lounges, or seek privacy in their rooms, as they wished. Staff knocked on people's doors before entering, and respected people's wishes for privacy.

Good

Is the service responsive?

Our findings

An assessment of each person's health and mental wellbeing was completed before people were offered placement in the home. This ensured staff were informed of each person's specific needs. Nurses confirmed that comprehensive assessments prior to people's admission ensured that their care and emotional needs were accommodated on their arrival. For example, people with reduced mobility were usually housed on the ground floor to reduce the risk of falls. This enabled staff to settle people into the home quickly, because they knew people's needs, preferences and interests.

Staff recognised when people's needs or wishes changed. A relative explained that "If there are any concerns they phone me straight away. I have a good relationship with them all". The person's health condition meant they required specific placement of pillows when they rested. The relative told us photographs in the person's room ensured care workers were informed how to arrange these to meet the person's needs. The relative said "The carers here are so lovely. They all know his needs".

We observed staff were attentive to changes in people's health or wellbeing. One person was very sleepy, and difficult to rouse at lunchtime. The care worker asked a nurse to check the person to ensure they were not unwell, and the person's wellbeing was monitored. A care worker explained how charts were used to record people's health or wellbeing if their health or anxieties indicated this was required. Charts were reviewed by nurses or health professionals to ensure people were supported appropriately, for example through changes to their care or medicines. Staff were responsive to people's needs.

A 'daily summary of care needs' documented each person's support needs to manage their mobility, diet and continence care. This noted the number of care staff required, for example to use hoists safely to transfer people between their bed and chair or bath. Repositioning needs to prevent pressure ulcers, and fortified or special dietary needs, for example to protect people from malnutrition, were documented. Where people required thickened fluids to reduce the risk of choking, guidance ensured care workers used the amount required to support the person's safe fluid intake. The 'daily summary of care needs' also noted people's preferred rest area, for example in lounges or the privacy of their own room. One person's preference for only female care workers was documented, to ensure their preference was respected. People's current needs were known and met.

Handovers between shifts were used to share information regarding each person, to ensure staff were aware of the requirements to meet their health and emotional needs. For example, people's sleep pattern, food and liquid intake, emotional wellbeing or anxieties and health were discussed. Where an action impacted on the person's health, care workers were informed to enable them to change the care provided. For example, one person with diabetes had a raised blood glucose level as they had been given squash during the night. Care workers were reminded to offer water instead. A person was expected to return from hospital on the day of inspection. Staff were reminded to ensure their room was prepared for them, and to complete a body map on their arrival to ensure any concerns were identified and addressed quickly.

We observed that all staff commented during handover meetings if they had additional information

regarding a person's needs or wishes. Care workers requested guidance if they were unsure of how to support a person. The registered and deputy manager specified additional measures as necessary, such as referral to the GP, or liaison with the pharmacy to prepare medicines for people's planned trips. This ensured that all staff were aware of the actions required to respond to people's changing needs.

Staff were aware of people requiring palliative care for end of life conditions. People and those important to them where appropriate had discussed their wishes for end of life care, for example whether they wanted to remain in the home. Staff discussed and documented people's wishes, to ensure people were treated with dignity, and experienced the level of intervention they wanted and needed, for example for resuscitation or to manage pain. Regular reviews of those experiencing palliative care ensured the actions implemented continued to meet people's wishes and needs. People's end of life care was provided with empathy by trained staff.

People's specific care needs were documented. For example, areas of care including skin integrity, falls risks, and communication and orientation were recorded and regularly reviewed. Where people's needs changed, for example following a fall, the care plan documented the actions put into place to support their needs, such as referral to a health professional, increased observation or support to mobilise, and safe use of mobilising equipment, such as hoists.

People's care plans were regularly reviewed and updated to document changes required to their care and support. The deputy manager explained that when people were unable to inform the nurses of changes they wished or required, they were represented by their families or social worker as appropriate. Care workers updated people's daily logs throughout the day. Nurses reviewed people's care plans and listened to care worker's comments to ensure declining health was addressed promptly.

People's comments on the activities available varied, but people generally appeared to enjoy what was offered. This included bingo, jigsaws, musical entertainment and discussion of newspaper articles. One person told us the entertainment was "Really good", while another told us activities were "OK", and some told us they would appreciate more choice or regularity. A relative told us their loved one was assisted to sit in the communal lounge to enable them to participate in activities more fully. A volunteer visited people who remained in their beds during the day, because of their health needs or through choice. This helped to alleviate social isolation.

Planned activities were displayed on notice boards for information, including planned trips to the local garden centre once the weather improved. Weather boards, displaying the date and outdoor weather, helped people to orientate to the time and place, and ensured that those going out were prepared for outdoor conditions.

People told us they were comfortable raising issues or concerns with staff, and confident that they would be listened to and action taken. One person stated "The staff treat me alright and if they didn't I would have no problem in saying something". One relative told us the registered manager's door was "Always open". Relatives felt able to share concerns with staff as necessary.

Compliments had been compiled into a folder, demonstrating relatives' appreciation of people's care. Complaints had been managed in accordance with the provider's complaints policy. Responses demonstrated prompt investigation and response to the complainant, including an invitation to meet and discuss issues that could not be resolved immediately. People's concerns were responded to and addressed.

Minutes from a residents meeting held in January 2016 were displayed in the home, with a plan of the actions in response to this. For example, it was noted that people had asked for more activities, and in response staff had provided additional quizzes and poetry reading. The registered manager listened to and acted on people's feedback.

Good

Is the service well-led?

Our findings

The provider's mission statement stated people would experience a 'welcoming and homely atmosphere, with open, honest and approachable staff'. It noted people would be encouraged and supported to maintain their independence and make choices, and would experience high quality person-centred care respectful of their dignity, privacy and independence. We found Manor Place Nursing Home to be homely, and staff were welcoming and caring.

Communications books were placed in each person's room. These were used by people and their relatives or visitors to raise any issues or request actions if they did not wish to, or were unable to do so directly with staff. The deputy manager told us these were checked daily to ensure requests were implemented or responded to promptly. Care workers and nurses also used these books to communicate with relatives, for example to request additional toiletries for people. People's needs and views were treated with importance in the home.

People's birthdays were noted on display boards to ensure staff were aware of and celebrated people's special day. The chef ensured birthday cakes were available for people to enjoy with others. Photographs of celebrations and events in the home were displayed to help people remember special times they experienced together.

Minutes from a family and friends meeting held in March 2015 described an introduction of new staff to attendees. This ensured that relatives were informed of new staff in the home. Meeting minutes noted discussions including the opening of a new unit and feedback from a recent survey. Issues raised by attendees were discussed. Relatives told us these meetings often included guest speakers such as a speaker on Alzheimer's, or celebrated special events such as a summer BBQ. People's relatives were kept informed of events in the home, provided with information to understand people's health conditions, and offered opportunities to share their experience with others. This provided an inclusive and supportive environment.

The chef told us informal staff parties were arranged to welcome colleagues who had joined the service "About quarterly". This provided the opportunity to get to know each other and promote a cohesive work force. One care worker told us they appreciated changes made to the handover meetings that invited staff to raise and discuss issues or concerns. Staff meetings were used as an opportunity to share the provider's business and future plans with staff. Staff were thanked by the registered manager for their hard work. Staff effort was recognised and valued.

One relative told us the registered and deputy managers had been particularly supportive to their family during a difficult experience. Another relative said "I get on very well with them [the registered and deputy managers]. We have a very good relationship". They spoke with affection of the support the managers provided.

One member of staff told us they "Cannot fault" the registered manager or provider for the support and encouragement they experienced. They said "If we come up with ideas we do it there and then". The deputy

and registered managers were described as "Open and friendly" by staff. One staff member commented "They give you a nice welcome, they speak to you rather than ignore you". All the staff spoke positively about the support and guidance they experienced from the home's managers, and held the registered and deputy manager in high regard. One new member of staff said "The way she [the registered manager] talks, the way she led the interview, makes you know that this is where you want to work".

Nurses told us the deputy manager was available and approachable to discuss clinical issues. They were committed to their work, and felt supported to maintain their nursing registration. All the staff told us they felt comfortable expressing their views, as the registered and deputy managers listened to them and responded to their concerns or ideas. The management inspired confidence in the workforce. They provided a clear leadership for staff in all roles. They used feedback, audits and reviews to identify and drive changes required. For example, following feedback from our inspection they explained the changes they had made to recruitment and equipment checks to ensure issues identified were promptly addressed.

People were invited to provide feedback on the quality of care they experienced. The last survey had been undertaken in September 2015. The results from this were summarised and displayed in the home, with responses from the manager explaining the actions they would be taking to address any concerns or suggestions from the survey. For example, additional activities were planned in response to a request for these, and meal arrangements to meet people's preferences were noted. The registered manager also thanked responders for positive comments included on feedback. People's and others' responses were appreciated and used to drive improvements to people's care.

The deputy manager explained how staffing shortages had impacted on maintaining records in the last quarter of 2015. They told us "We really struggled", as agency nurses had not always met management expectations. The deputy manager told us they had addressed this by engaging the same nurses from one agency, to promote consistency of care and record keeping. The deputy manager had worked with them to demonstrate the quality expected, and had now employed sufficient nurses to remove the need to use agency nurses regularly. They told us "We are nearly on top of it [record keeping] now".

Audits were used to assess the quality of care people experienced, and identify where improvements could be implemented. Some audits had not been completed as regularly as the provider's policies required. For example, medicines audits had not been completed monthly between October and December 2015. This coincided with the period of staff absence and high use of agency nurses. Medicines audits had been reinstated in January 2016, and demonstrated effective identification of issues to drive improvements in recording medicines administration.

The falls audit ensured that post fall observations and protocol were used effectively to reduce the number of falls people experienced. People were monitored for potential health issues associated with falls, and actions put into place to reduce the risk of further falls. Because of the high number of falls people experienced during 2015, the deputy manager told us they "Went back to the basics" to identify any trends, such as location or time of day. They ensured required equipment was in place to alert staff to people's movements, and to reduce the risk of harm should they fall. They had reviewed people's dietary requirements and intake to ensure this had not adversely affected their mobility. They had reviewed people's health to ensure infections had not contributed to people's unsteadiness. Audits were used appropriately to identify changes required to improve people's care.

Post fall actions noted referral to people's GP, reminders to use the equipment provided such as walking aids to support people's mobilisation, and observations to monitor people's health. This demonstrated that staff followed the provider's guidance to promote people's health and wellbeing. The falls audit

demonstrated a falls reduction between October and December 2015, indicating that the falls audit had been effectively used to address identified risks and improve the quality of people's care.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People had not been protected from harm because equipment used had not always been regularly checked to ensure it remained safe to use. Regulation 12 (2)(e) HSCA 2008 (Regulated Activities) 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People had not been protected from the risks associated with staff employment. Satisfactory evidence of conduct in previous employment positions in health and social care had not always been identified or verified, and a full employment history, with explanation of gaps, was not always documented. Regulation 19 (1)(a) (2)(a)(3)(a) HSCA 2008 (Regulated Activities) 2014