

Rhodsac Community Living Ltd

Manswick Care Home

Inspection report

2 Oakland Road
Forest Town
Mansfield
NG19 0EJ

Tel: 01623422405
Website: www.rhodsaccarehome.com






Date of inspection visit:
23 September 2021

Date of publication:
25 October 2021

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?	Requires Improvement 

Summary of findings

Overall summary

About the service

Manswick Care Home is a residential care home for people with learning disabilities and/ or autism, providing personal care to up to four people in one adapted building. At the time of the inspection there were three people using the service.

People's experience of using this service and what we found

The provider's quality assurance systems were not always robust enough to ensure the quality of the service. People were not always safe from harm due to risks not being managed and recorded safely. Guidance for staff about people's behaviour and how to manage those was not always in place. Records of people's care were not always individualised and had not always reflected people's needs and preferences. We made recommendation to the provider to review and update peoples care plans.

People were protected from abuse because staff understood the correct procedure to follow if they had any concerns. There were enough staff to support people. Recruitment and criminal records checks had been undertaken on staff to make sure they were suitable to support people. The home was clean and tidy and infection control practices minimised the risks of infections spreading.

Staff received the training and support they needed to meet people's needs. People were supported to maintain their health and to maintain contact with professionals involved in their care. People received food and drink of their choice

Staff were kind and caring and respected people's rights to privacy and to be treated with dignity. People were supported to be as independent as they could be with daily living tasks

Staff and relatives told us the management team were approachable and would address concerns.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. People were supported to stay healthy and well. Staff helped people eat and drink enough to meet their needs and to take their prescribed medicines. People were treated as individuals and

staff promoted people's dignity, privacy and human rights. Staff and management were passionate about supporting people to achieve good outcomes.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

This service was registered with us on 23 December 2019 and this is the first inspection.

Why we inspected

This was a planned inspection based on the previous rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements across the service. However, the manager provided us with some immediate assurances of the actions they have taken to improve the service following our feedback.

Enforcement

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

We have identified breaches in relation to assessing, monitoring and managing risks to people and overall governance of the service at this inspection.

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

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was responsive.

Details are in our responsive findings below.

Good ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Manswick Care Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team

This inspection was carried out by one inspector.

Service and service type

Manswick Care home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider did not complete the required Provider Information Return. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report.

We used all of this information to plan our inspection.

During the inspection

We spoke with two people who used the service about their experience of the care provided. We spoke with four members of staff including the registered manager, deputy manager and support workers. We reviewed a range of records. This included two people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We requested and received feedback via email from a nurse who works closely with the service and from relatives of people who live in the service about their experience of the service.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were at risk of harm because risks to the environment were not always fully considered and managed.
- People who lived on the first floor had window restrictors fitted to prevent them from falling out. However, we found window restrictors in most bedrooms were not locked, and windows were wide open. The provider had no processes for checking window restrictors were in-situ and were locked. This put people at risk of falling from windows. Immediately after our inspection, the registered manager had implemented weekly checks of window restrictors to ensure they were appropriately used.
- People were at risk of scalding from hot water outlets because checks to ensure hot water temperatures were in safe range were not in place. After our inspection the deputy manager told us they had implemented regular hot water checks and bought necessary equipment to carry out these checks.
- Systems for monitoring people's behaviours and incidents were not always effective. We reviewed a range of daily notes and found that logged incidents were very low. However, we found examples of incidents that had occurred within the service which were documented in people's daily records but were not recorded on incident forms and reported to the management to ensure there could be clear provider oversight and analysis of these. This meant reviews of these incidents to look for any trends and to put measures in place to reduce the risk from similar incidents happening again were not happening.
- People who used the service for some time had detailed risk assessments to instruct staff about actions they should take to keep people safe. However, we found risk assessments and care plans we expected to see for one person because of the known risks to them were not in place. This meant we could not see a clear plan of care for that person and how risks associated with their declining needs would be addressed in a timely way.

Using medicines safely

- People's medicines were not stored and managed safely.
- People's medicines were kept in locked 'office style' wooden drawers in the main lounge. The drawers were not attached to the wall and the locking mechanism was not robust. This meant that anyone could easily break into these and access medicines. After our inspection, the deputy manager had moved these drawers into a more secure room.
- People had medicine administration charts (MAR) in place, however they were not always fully completed. For example, there was no record of the amount of booked medicine and no evidence to show who had booked new medicines in. This meant that the provider could not be assured that appropriate checks, to ensure the right quantity of medicine had been completed at the time when the medicine was booked in.
- People who required medicated creams had no 'topical medicine administration chart' (TMAR). TMAR inform staff of the location on a person's body where creams should be applied.

- The service did not have appropriate systems in place for returning excessive stock of medicine back to the pharmacy. We found excessive stock of some medicines were stored together with current medicines.
- Staff who were responsible for the administration of medicines had completed appropriate training, however we found their competencies were not assessed in line with the providers medicine management policy.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed and the provider failed to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People who were at risk of leaving the service and/or going missing from the service had "The Herbert protocols" in their care plans. These protocols contain information about people including their recent photograph to help the police if the person goes missing.
- After our inspection, the registered manager told us they had contacted their local pharmacy and returned excessive stock of the medicines. The registered manager also told us they had requested the pharmacy to provide the service with weekly medicines 'blister packs' to improve management of medicines. This will help staff keep track of medicines.

Staffing and recruitment

- People were supported by a sufficient number of staff; however, the providers recruitment checks were not always robust.
- We reviewed four staff recruitment files and found these to lack documents such as fully completed application forms or interview notes. This meant that checks to ensure new staff were suitable for their roles were not always recorded. We spoke about this with the deputy manager who told us interviews were always held, however some of the interview records were misplaced and they were unable to find them.
- We looked at staff rotas and found there were enough staff to meet people's needs. Staff told us they felt there were enough staff on duty. One staff said, "I feel there are enough staff on duty, we don't use any agency and can cover any sickness or staff shortage between us. Service users always get the required support."
- One professional who worked with the service told us, "Whenever I visit there are always plenty of staff around and I have always been impressed by this."
- At the time of our inspection we observed there were enough staff to support people to access their local community and to encourage people to take part in daily tasks and activities.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse.
- Staff had been trained in how to safeguard adults and were knowledgeable about different types and signs of abuse. A pathway for reporting safeguarding concerns was easily available to staff and staff were aware of reporting processes. One staff told us, "I would report any concerns to the deputy manager or registered manager, if nothing was done, I would report it to the provider or call social services."
- People told us they were safe at the service. One person said, "Yes, I am safe and they [staff] are looking after me well."

Preventing and controlling infection

- We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Upon entering the building staff had not followed the government guidance to ensure the inspector had completed their lateral flow test or was screened for signs of COVID-19.

- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were somewhat assured that the provider was using PPE effectively and safely. At the time of our inspection we observed staff wearing PPE in line with the guidance, however staff told us they did not always wear face masks when supporting service users inside the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were not always fully assessed prior to them moving into the service.
- We looked at the two most recent pre-admission assessments and found them to be lacking important information, such as people's life histories, social interests, hobbies, information about culture or religion. This meant staff had limited information of people's backgrounds to support them effectively.
- People's care and support was not always designed in a way which improved the quality and safety of the care provided. For example, one person who was known to display behaviours that challenged others did not have a support plan informing staff about the triggers for their behaviour, or information on how staff should respond to these behaviours. However, staff were aware of the signs they needed to look out for and the action they might need to take to prevent or de-escalate people's behaviours. A professional told us, "The staff are always friendly and polite and knowledgeable about my patient who they have a good relationship with."

We recommended that the provider review their processes for reviewing people's care plans to ensure all necessary background information about people is captured.

Supporting people to live healthier lives, access healthcare services and support, Staff working with other agencies to provide consistent, effective, timely care

- Information about people's health conditions was not always included in people's care plans. This meant staff did not have access to written details of people's health conditions and up to date information and guidance to support people with their health needs. For example, one person used inhalers, however information about their health need and why the inhalers were needed was not available. Regular staff knew why the inhaler was needed and the person had capacity to use this themselves, however this information was not recorded in case new or agency staff were required to work at the service.
- The deputy manager told us people were supported to access healthcare services, such as dentist or optician when this was required.
- People were encouraged to manage their health needs independently. One person told us they needed new glasses, they told us they will, "go and sort it out in their own time".
- Staff supported and encouraged people to lead active lives to help maintain a healthy weight. One person had regularly attended swimming sessions.

Staff support: induction, training, skills and experience

- People were supported by staff who were trained, skilled and experienced.
- Staff who were new to the service, had received robust induction training and were asked to complete a

number of specific training courses based on people's needs.

- Staff told us they took part in regular team meetings and were given regular opportunities to discuss any concerns, suggestion and development needs during one to one supervision with the deputy home manager.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to eat and drink food of their choice.
- Each person who lived at Manswick Care Home had their own 'food budget'. Staff supported one person to complete weekly menus and weekly groceries shopping. Other people decided not to have any menu plans and they did their own food shopping as and when this was needed.
- The kitchen was clean and all appropriate food safety checks, such as checking fridge and freezer temperatures, or checking hot food temperatures, were completed and recorded.

Adapting service, design, decoration to meet people's needs

- Each person had their own bedroom. Bedrooms were spacious and clean. People were able to decorate their bedrooms.
- There was a good size garden which was frequently used by all people.

Ensuring consent to care and treatment in line with law and guidance

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.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- DoLS were sought when needed and were monitored.
- People were asked to consent to their care, and this was recorded. MCA assessments and best interests' decisions were used when people were unable to consent themselves.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- We observed staff treated people well and had developed good and professional relationships with them. There was a very relaxed atmosphere throughout the day of our inspection.
- People were positive about their staff and told us staff listened to them and supported them well. One person told us, "Staff are nice here. I like [name] the most."
- Staff talked about those they supported with fondness, compassion and genuine positive regard.
- A relative told us, "Staff are excellent with our [relative] treating them with great respect. When [person] feels anxious they[staff] will sit with [person] and try to calm [person]."

Supporting people to express their views and be involved in making decisions about their care

- Staff fully understood people's communication needs and supported them to communicate their needs.
- People were taking part in regular 'house meetings' where staff had discussed different activities or menus with them.
- People were involved and encouraged to make decisions about their care and daily choices.
- People were encouraged to take part in activities of their choice. These included going swimming, local walks or social clubs and events such as "Dove Dance" night.

Respecting and promoting people's privacy, dignity and independence

- People were treated with dignity and their privacy was respected.
- People's interests were promoted by staff who were committed to look for positive outcomes and opportunities for people to experience and enjoy. Because of the setup of the service and low number of people living there, staff had ample time to spend with people.
- A professional who regularly visits the service told us, "My patient is given the right amount of choice for his individual needs and they spend a lot of time encouraging him to make positive lifestyle choices, but also help [person] to understand and accept the consequences of less good ones."
- People were able to develop their independence, such as shopping, preparing some of their meals and using public transport. Some people who lived at Manswick Care Home were able to go out and access their local community and pubs without any staff support.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Support plans did not always reflected people's needs, likes and dislikes.
- Most people who lived at the service had comprehensive support plans and risk assessments in place to provide staff with information on how to support people in a person-centred way. However, support plans and risk assessments for one person who was new to the service, lacked person centred information. Despite this staff knew people very well and knew how to support them in a person-centre approach.
- The provider had placed emphasis on achieving positive outcomes for people. The number of serious incidents for one person had reduced since they moved into the service, because staff had built very good and positive relationships with this person. A relative told us, "Since our [relative] has been at Manswick they have worked with [person] to limit these incidents and the results are amazing. There have been very few incidents for several months and those that have happened were not serious."
- Staff knew people and their care needs well. This was evidenced in our conversations with staff. Staff were able to tell us about people's life histories, their families, as well as their care needs and how they like their care to be delivered.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Staffing was planned to support people with activities and hobbies they enjoyed. People attended a range of recreational activities which they enjoyed. We saw evidence of people going to local parks, trips to the seaside or bowling alley.
- People chose how to spend their time. Some people preferred to spend time in their bedrooms, whilst others were seen using the garden space or in front of the service.
- People were protected from the risks of social isolation. Staff recognised the importance of social interaction and family contact. We observed staff spending time with people in the communal areas sitting and chatting with them or watching movies people had chosen.
- People were supported to maintain relationships with people important to them. Throughout the lockdown people were able to communicate with their relatives through video-calls.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- At the time of our inspection visit there were no people using the service identified as having communication needs. The service was aware of the Accessible Information Standard and the deputy

manager told us they would make appropriate adjustments in response to any identified need.

- Staff had received training covering communication needs. They were fully knowledgeable in how each person communicated through their own individualised ways.

Improving care quality in response to complaints or concerns

- A system was in place to manage complaints with information available to people using the service on how to complain.
- A complaints policy was available. The service had received two complaints which were actioned by the registered manager in line with the providers complaints procedure.

End of life care and support

- There was nobody receiving end of life care at the time of the inspection.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care

- The service had a registered manager who worked in the service three days per week. The registered manager told us this was because of the low number of service users, and once the service is full, they will increase their hours to full time. There was a deputy manager who was in the service five days per week.
- The service had failed to complete a 'provider information return'. CQC ask registered managers and providers to send us information about the service including any changes made to the service and how they make sure that the service is safe, effective, caring, responsive and well-led. The registered manager told us this was an overnight on their behalf.
- The deputy home manager completed various quality audits to ensure the service was operating safely and effectively. However, we found shortfalls which were not identified by the deputy manager. For example, the deputy manager was not fully aware about what safety checks should be completed.
- The provider and registered manager had not completed any additional checks to ensure the quality of the service was maintained. The registered manager had some oversight over the service and was able to remotely monitor care plans and reported incidents, however we did not see any evidence to demonstrate whether any actions had been identified as a result of this monitoring.
- Local authority had completed a quality check audit in July 2021 and had found some shortfalls. An action plan had been generated by the quality contract officer and shared with the service. At the time of our inspection, we noted actions were still not addressed and we found the identified shortfalls remained outstanding.

We found no evidence that people were being harmed but inconsistent management and a lack of robust oversight and governance processes placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Relatives and staff were asked for feedback about the service through a survey. The general feedback was positive. The comments from staff included, "There is strong management at Manswick, they deal with queries promptly and efficiently", and "I feel management are good with dealing with issues concerns."
- One relative told us they were very happy with the service and they felt their loved one received 'excellent' support from staff. They told us, "They (staff) all do their best to give our [relative] a good life. They think of and suggest things that are best for [person]."

- Staff were clear about their roles and responsibilities and felt supported by the registered manager when they visited the service and deputy manager throughout the week. Staff comments included, "If I have any concerns, I know I can always speak with [deputy home manager] or I will speak with the registered manager when she comes over."
- A professional who regularly visits the service told us, "This is the best home I have been to, it's staffed by people who genuinely care and can see the person behind the illness and the behaviour. I no longer have to worry about my patient and that says it all."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager understood their responsibility to report significant events to the Care Quality Commission and Local Authority safeguarding team to protect people.
- The registered manager understood the Duty of Candour which aims to ensure that they are open, honest and transparent with people, their relatives and others in relation to care and support

Working in partnership with others

- The service worked well with other organisations. They had good relationships with local services, social care professionals and advocacy services.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always effectively managed.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of oversight at the service to ensure effective governance.