South West Care Homes Limited

Manor House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Manor House is a residential care home providing personal care for up to 30 older people who might also be living with dementia. It is owned by South West Care Homes Ltd who own and manage eight other care homes in the South West. At the time of the inspection, 19 people were living at the home. Accommodation is provided in one adapted building. Passenger lifts provide access to the upper floors.

People's experience of using this service and what we found
Prior to this inspection, the service's nominated individual alerted CQC to their own concerns about poor care practice and people's safety. People had been placed at risk of receiving unsafe care. Action was taken to immediately safeguard people. A nominated individual is responsible for supervising the management of the service on behalf of the provider. Following that action, further concerns were raised by the ambulance service over whether people were receiving safe care.
The service was working co-operatively with the local authority's safeguarding team and the police who were investigating allegations of unsafe care. These investigations had not concluded at the time of this inspection. People would not be admitted to the service until the local authority could be assured people were safe. The provider also voluntarily suspended placements at the home.

People could not be assured all risks to their safety arising from their care needs were being mitigated. For example, equipment used to reduce people's risk of developing a pressure ulcer was incorrectly set. Other risks relating to the risk of falls and poor nutrition were being managed well.

Care plans did not provide staff with accurate information about people's needs. This placed people at risk of not having their needs met in a consistent or safe way.

There were insufficient numbers of staff on duty to meet people's needs in a timely way and to keep people safe. However, following the inspection, care staff numbers had increased. We recommended staffing levels were kept under review.

People were not being protected from the risk of cross infection. Large piles of unclean laundry were on the laundry room floor waiting to be washed and the sink in the sluice room, where staff washed commode pans, was dirty. An agency had been employed to undertake a thorough clean of the communal areas and people's bedrooms.

People's medicines were being managed safely. Although we made a recommendation about recording the time people were given pain reliving medicines, as well as storage of medicine stocks.

People told us they felt safe and were happy living at Manor House.

Staff told us they had confidence in the new manager and the senior management team to address issues of

poor practice and to make changes to improve the quality of care people received. Staff said they now felt listened to when they hadn't in the past.

We have identified breaches in relation to safe care and treatment and good governance at this inspection.

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

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

Rating at last inspection
The last rating for this service was good (published 16 August 2018).

Why we inspected
We received concerns in relation to the management of the home and whether people were receiving safe care. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Although the provider has taken action to mitigate risks, this had not yet resulted in a safe service. Please see the Safe and Well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Manor House on our website at www.cqc.org.uk.

Follow up
We will request an action plan from 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Manor House

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.

Inspection team
One inspector undertook this inspection.

Manor House is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 did not have a manager registered with the Care Quality Commission. The provider had appointed an interim manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we had received since the previous inspection, some of which was of a safeguarding nature and was still under investigation. Prior to this inspection, the local authority's safeguarding team and the South West Ambulance Service raised additional concerns over people's safety. We also reviewed the information provided to us by the service's nominated individual following an internal audit.

During the inspection
We spoke with 13 people who used the service about their experience of the care provided. We spoke with six members of staff including the care compliance and quality manager, the interim manager, the training manager, two care staff and the chef.

We reviewed a range of records. This included four people's care records and multiple medicine records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including the gas, electric, fire and equipment servicing and testing, were reviewed.

After the inspection
We were provided with an update about the actions the provider had taken to ensure people's safety.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• Prior to this inspection, the service's nominated individual alerted CQC to their concerns over some poor practice and the safety of people's care. People had been placed at risk of receiving unsafe care. Action was taken to immediately by the provider to safeguard people. Following that action, further concerns were raised by the ambulance service over whether people were receiving safe care.
• The provider's care quality and compliance manager, the manager and staff told us people's safety was paramount and acknowledged people had been exposed to the risk of poor care.
• The service was working co-operatively with the local authority's safeguarding team and the police. Investigation into allegations of unsafe care were ongoing at the time of this inspection and had not yet concluded.

Assessing risk, safety monitoring and management
• Risks to people's health and safety had been assessed. However, management plans did not provide staff with the information they required to care for people as safely as possible. For example, some people were at risk from skin damage due to their frail health and poor mobility. Care plans did not guide staff about how frequently people should have their position changed to relief pressure and protect their skin. Two air mattresses used to provide pressure area relief, were incorrectly set for each person's weight. This meant they would not have been providing the level of relief required to reduce people's risk of skin breakdown.
• The environment was not always safe. We found cleaning materials and work tools had been left in unlocked rooms which were accessible to people.

Failure to provide care in a way that mitigates risk, and to provide a safe environment, is a breach of Regulation 12 of the health and Social care Act 2008 (Regulated Activities) Regulations 2014.

• Information in people's care plans was either out of date or gave staff conflicting advice about people's care needs. This placed people at risk of not having their needs met in a consistent or safe way. For example, one person's risk assessment identified they were at a very high risk of falls. Their care plan stated they required the support of one member of staff when walking with a mobility aid. The care plan also stated the person was able to take themselves to the toilet. However, the manager confirmed this person was unable to walk and required a hoist when transferring from their bed and/or chair. This information was not in their care plan.
• Another person's care plan stated they required a hoist and the support of two staff with their mobility. However, we observed them being supported by one member of staff using a stand-aid, rather than a hoist. The manager confirmed this level of support had been assessed as safe, but their care plan had not been amended.

Failure to maintain accurate records of people's care need and treatment is a breach of Regulation 17 of the health and Social care Act 2008 (Regulated Activities) Regulations 2014.

• Other risks were being managed well. For example, some people were at risk of falling from their bed. Where bedrails had been assessed as not safe to use, people were provided with beds that lowered close to the floor. An additional mattress placed next to their bed protected them from injury should they fall.
• One person was at risk of not eating and drinking enough to maintain their health. The service had sought guidance from the person's GP and detailed in their care plan the foods and drinks the person liked to eat.

Preventing and controlling infection
• People were not being protected from the risk of cross infection. Large piles of unclean laundry were on the laundry room floor waiting to be washed. The sink in the sluice room, where staff washed commode pans, was dirty. The sealant around the sink had come away and the work surface had water damage, making this a difficult area to keep clean. This sink was used by staff to wash their hand after disposing of soiled continence aids.

Failure to prevent and control the risk of cross infection is a further breach of Regulation 12 of the health and Social care Act 2008 (Regulated Activities) Regulations 2014.

• The service had identified some other areas of the home were not clean and had employed an agency to undertake a thorough clean of the communal areas and people's bedrooms. Some bedrooms were also being redecorated.
• The manager told us the laundry room was to be moved and contractors were present in the home preparing the new room. A member of staff was being recruited to undertake laundry duties which would mean the care staff would no longer have to undertake this task. Following the inspection, the nominated individual confirmed a new washing machine had been purchased.

Staffing and recruitment
• There were insufficient numbers of staff on duty to meet people's needs in a timely way. Eight of the 19 people living at the service required the support of two care staff to meet their care needs. In addition to the manager, there were three care staff and a team leader on duty. Staff did not complete supporting people with their personal care until lunchtime. We observed people asking for their breakfast, a drink and their medicines throughout the morning as staff had not been able to attend to them in a timely way. The team leader was administering people's medicines and was not in a position to support people with their personal care. The morning medicine round was not completed until after 10:30am.
• People's safety could not be assured as there was not enough staff available to ensure people received the supervision they required. We observed people walking around the home without staff support and we had to intervene to prevent one person from entering the kitchen.
• Staff told us they were tired and overworked, and they felt they were not meeting people's needs properly. One said they were not able to ensure people were having enough to drink.
• As the service was reliant on agency staff, the manager told us that whenever possible they requested the same agency members of staff to allow them to become familiar with people's needs.
• Following the inspection, the nominated individual acknowledged that where staff were less familiar with people, support with personal care would take longer. In response, the number of care staff available had been increased.

We recommend the number of care staff available should be kept under review to ensure people's safety is maintained and their needs can be met in a timely way.

Using medicines safely
• We observed the team leader administering people's medicines and their practice was safe.
• The manager undertook weekly audits of medicines held in the home. We checked a sample of medicines and found the balances to be correct.
• Medicine administration records were completed with no gaps in recording. However, for those people who were prescribed pain reliving medicine to be taken four times a day, the service did not record the time this was administered. It was not possible to ascertain from the records that a safe time period had elapsed before people received another dose.
• Not all medicines held by the home could be stored in the lockable trolley, some were on a shelf in the medicine room. Although this room was locked when not in use, medicines should be stored in an additional locked cupboard in line with best practice guidance.

We recommend the provider seeks guidance from a reputable source, such as the National Institute for Health and Care Excellence (NICE), and reviews medicine practices to ensure the service is compliant with best practice.

Learning lessons when things go wrong
• The service's care quality and compliance manager and the nominated individual had acted to safeguard people. They had reflected upon how the service's safety and quality of care had deteriorated since the previous inspection and developed a management plan to address this.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. There were breaches in regulations.

In September 2019, a new nominated individual began working for the provider. Their role includes Director of Operations; they have a team of four staff with their own quality assurance responsibilities. CQC have met with this new team in October 2019 and will continue to meet with them every six weeks.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 service did not have a manager registered with the CQC. An experienced deputy manager from one of the provider's other care homes had recently been appointed to take over the management of the home following the concerns over unsafe care. They were being supported by the service's care quality and compliance manager and the nominated individual. All were aware of their responsibility to inform people's relatives, the local authority and the CQC of significant events within the home relating to people's health and safety.

• Action had been taken to review practices and to make improvements. However, risks were not yet being safely managed.

• The service was working with the local authority to review several people's needs and to support them to move to alternative accommodation.

• No new people would be admitted to the service until the local authority could be assured people were safe. The provider also voluntarily suspended placements at the home.

Failure to mitigate risks to the health, safety and welfare of people is 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

• People told us they felt safe and were happy living at Manor House.

• Staff told us they had confidence in the new manager and the senior management team to address issues of poor practice and to make changes to improve the quality of care people received. Staff said they now felt listened to when they hadn't in the past.

• The manager and staff were reviewing people's needs and updating people's care records to provide more detailed and person-centred information.

Continuous learning and improving care; Working in partnership with others

• The senior management team were currently reviewing the service's support needs and practices to identify how poor care had developed. A review of staff's training needs and skills was underway, and a number of training events had been planned.

• The manager had consulted with health and social care professionals to seek guidance about people's care needs.

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 associated with people's care were not being mitigated. The risk of cross infection was not being safely managed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had not properly assessed, monitored and mitigated risks to people's health, safety and welfare. The service had not maintained accurate, complete and contemporaneous records in relation to people's care and treatment.