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# Manton House

## Inspection report

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### Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

# Summary of findings

## Overall summary

The inspection took place on 26 September 2017 and was unannounced.

Manton House provides care for up to 22 people, some of whom were living with dementia. There were 10 people living in the home on the day of our inspection. The building offered accommodation over two floors. On the ground floor there was a communal lounge, reminiscence room and separate dining room where people could socialise and eat their meals if they wished.

Following our last inspection, the manager at that time decided not to register with the Commission. The provider appointed another manager in July 2017. The appointed manager registered with the Care Quality Commission in September 2017. The previous manager continues to be registered for another location for the same provider and offers support to the newly registered manager of Manton House. 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 of the Health and Social Care Act 2008 and associated regulations.

At the last inspection on 22 February and 01 March 2017 the service was rated 'Inadequate.' The report was published in May 2017. At that inspection we identified seven regulatory breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Six of these regulatory breaches were in relation to a lack of person centred care for people. People's privacy was not maintained at all times and there was poor monitoring of the service. The principles of the Mental Capacity Act were not being followed as assessments on capacity to make decisions were not completed in all cases where required. Care and treatment was not always provided in a safe way. Risks to people's safety who were living in the service had not always been assessed. Where they had been, actions had not always been taken to mitigate these risks. Not all areas of the premises had been adequately assessed to ensure the environment was safe for people to use. Some people's medicines had not been well managed. The nutritional and hydration needs were not being met for all people living in the service to sustain good health. Suitably qualified, competent, skilled and experienced staff had not always been deployed in the home. Staff had not always received appropriate training, supervision or support to carry out their role. We took enforcement action to protect people by imposing a condition on the providers registration. We told the provider they could not admit any new people to the home from 12 May 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care.

At the last inspection the provider was also in regulatory breach of the Health and Social Care Act 2008 (Regulated Activities) 2014 due to not having systems in place to assess monitor and improve the quality and safety of the service provided. They had failed to assess, monitor and mitigate risks relating to the health, safety and welfare of people living in the service. An accurate and complete contemporaneous record in response of each person living in the service was not in place. We took enforcement action in the form of a warning notice regarding this failure to meet standards. This required the provider to take

immediate action in relation to assessing the risks to the health and safety of people and the effective governance of the service.

Following the inspection the provider sent us an action plan detailing how the identified breaches would be addressed. This inspection was to check improvements had been made and to review the ratings. We found the provider and registered manager had taken sufficient action to address previous concerns and comply with required standards. As a result, the provider has complied with the Warning Notice and condition imposed.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Since our last inspection, the service had experienced a period of considerable change. It was evident that the new registered manager had effected improvements to the leadership of the service. Although significant improvements had been made to address previous shortfalls raised in our last visit, Manton House is on an improvement journey and these improvements were yet to be embedded and sustained.

At the last inspection we found there was insufficient activity provision and people's preferences were not sought. At this inspection we could see there were improvements, however activities and peoples preferences were not wholly implemented. This is an area requiring improvement.

At this inspection we found systems for monitoring quality and auditing the service had significantly improved and were being used to continually develop the service. However, the frequency of auditing peoples care plans meant the registered manager could not be assured people reliably received all of the care they needed. This is an area requiring improvement.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People who were able to said they felt safe at the home.

People's care records showed risks to their safety were assessed and the action needed to mitigate those risks. These assessments and care plans were reviewed and updated at regular intervals to ensure people's changing needs were met. Accidents and incidents were accurately recorded and were assessed to identify patterns and trends. Records were detailed and referred to actions taken following accidents and incidents.

There were sufficient staff in place to meet people's needs. The registered manager used a dependency tool to assess staffing levels and to ensure they were based on people's needs, were up to date and reviewed monthly. Staff recruitment procedures ensured only those staff suitable to work in a care setting were employed.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely.

Staff received an induction into the service and senior staff checked competencies in a range of areas. Staff had received a range of training and many had achieved or were working towards a National Vocational Qualification (NVQ) or more recently Health and Social Care Diplomas (HSCD). Staff received formal

supervision and annual appraisals from their manager.

People were supported by staff who understood and effectively applied the principles of the Mental Capacity Act, 2005 and the Deprivation of Liberty Safeguards. Staff confidently applied the MCA to make sure that people were involved in decisions about their care so that their human and legal rights were protected. People were supported to have maximum choice and control of their lives and staff assisted them in the least restrictive way possible.

People had sufficient to eat and drink and were supported by staff to maintain a healthy diet. Observations of meal times showed this to be a positive experience, with people being supported to eat a meal of their choice and where they chose to eat it. Staff engaged in conversation with people and encouraged them throughout the meal, noting who liked to sit with whom. Nutritional assessments were in place and special dietary needs were catered for.

People's health care needs were assessed monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular health checks.

Caring relationships had been built between people and staff. Staff working in the home were predominantly caring and compassionate. Staff knew the needs and preferences of the people they cared for and people were given reassurance and encouragement when they needed it. Where people needed support in order to make their own day to day decisions this was provided by staff. Where people had short term memory loss staff were patient in repeating choices each time and explaining what was going on and listening to people's stories. People's rights to privacy, dignity and independence were taken into account by staff in the way they cared for them.

People looked comfortable and happy moving around the home, some people stopping for rests or a nap, other people enjoyed having a late breakfast, doing a crossword or reading the newspaper. Staff were always visible to interact or sit with people. Each person's needs were assessed and this included obtaining a background history of people. Care plans and assessments were comprehensive and showed how people's needs were to be met and how staff should support people. Care was individualised to reflect people's preferences.

The home had been decorated and arranged in a way that supported people living with dementia. The service was brightly decorated and stimulating for the people living there. The communal areas of the service were clean and well-furnished with a homely feel. People's rooms were individualised, with personal items such as ornaments, photos and furniture. The outside area was accessible with paths and benches.

Complaints were listened to and managed in line with the provider's policy. Relatives told us that they felt welcomed at the service and people and relatives said that they would be confident to make a complaint or raise any concerns if they needed to.

People and their relatives were involved in developing the service through meetings. People, relatives, healthcare professionals connected to the service and staff were asked for their feedback in annual surveys. All responses were positive from the recent quality assurance questionnaire. Their views were valued and they were able to have meaningful input into the running of the home, such as activities they would like to do, which mattered to them.

Staff felt the registered manager was supportive and said there was an open door policy. Relatives spoke positively about the care their family members received.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good 

The service was safe.

People had detailed care plans, which included an assessment of risk. These contained sufficient detail to inform staff of risk factors and appropriate responses.

People were supported by trained staff who knew what action to take if they suspected abuse was taking place.

Sufficient numbers of staff were provided to meet people's needs. Safe recruitment systems were in place.

People's medicines were managed safely.

### Is the service effective?

Good 

The service was effective.

Staff had received training as required to ensure they were able to meet people's needs effectively. Staff received supervision and appraisal.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

Staff protected people from the risk of poor nutrition and dehydration.

People had their health needs met and were referred to healthcare professionals promptly when needed.

### Is the service caring?

Good 

The service was caring.

The atmosphere in the service was relaxed and friendly.

Staff were kind and compassionate. People's rights to

independence, privacy and dignity were valued and respected; by staff who took time to speak and listen to people.

People were involved with and included in making decisions about their care and how they wanted this to be delivered.

### **Is the service responsive?**

The service was not always responsive.

Staff were working hard to support people to engage in meaningful activities and this was an area that was continuing to be developed.

People's needs were comprehensively assessed and reviewed. Care plans were individualised and reflected people's preferences.

People were aware of the complaints procedure and knew what to do if they were dissatisfied with the care they received.

**Requires Improvement** 

### **Is the service well-led?**

The service was not always well-led.

Although significant improvements had been made to address previous shortfalls such as the monitoring of quality and safety of the service, these improvements were yet to be embedded and sustained.

There was an honest and open culture within the very stable staff team who felt well supported.

Staff told us that the registered manager was approachable and that they were encouraged to discuss any issues or concerns. The provider encouraged people and their relatives to express their views about the service and the provider was open to suggestions for improvement.

**Requires Improvement** 

# Manton House

## Detailed findings

### Background to this inspection

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

This inspection took place on 26 September 2017 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, we received a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. Notifications are events that the provider is required by law to inform us of. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We spent time observing people in areas throughout the home to see interactions between people and staff. We observed people as they engaged with their day-to-day tasks, the care they experienced, including the lunchtime meal, medicines administration and activities.

We spoke with three people who lived at the service, two relatives, the registered manager and the previous manager who was supporting the newly appointed manager. We spoke to two care staff, a senior care worker and the chef.

We looked at the care plans and associated records for four people. We looked at four people's medication records and four people's weight records. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents and incidents, menu's, relative questionnaires, and health and safety checks. Records for four staff were reviewed, which included checks on newly appointed staff and staff supervision records.

Following the inspection we contacted health care professionals and one funding authority to seek their

views.



# Is the service safe?

## Our findings

At our previous inspection on 22 February 2017 and 01 March 2017, we found that the provider was in breach of one regulation for this key question, is the service safe? We found people were not always protected from avoidable harm. Risks were not always assessed, planned for and monitored to ensure people's safety and wellbeing. We told the provider they could not admit any new people to the home from 12 May 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care. This was in respect of the breach of regulation, which required the provider to make immediate improvements. At this inspection, we found that sufficient action had been taken and the provider was now compliant with Regulation 12 Health and Social Care Act Regulated Activities Regulations 2014 Safe care and treatment.

People who were able to tell us they felt safe and our observations confirmed people who were unable to initiate communication were regularly asked throughout our visit if they were comfortable. Staff confirmed that people who appeared upset or not their usual selves were firstly checked to see if they were in pain or needed assistance, which we observed.

Risk assessments relating to people's mental health, physical health, personal health, moving and handling, behaviour, skin integrity, nutrition and falls had been completed and were stored within people's care plans. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support.

We looked at risk assessments for four people and these contained advice and guidance for staff on how to manage and mitigate potential risks to people. For example, where people required pressure relieving equipment to maintain their skin integrity, staff ensured cushions, were transferred with the person when they moved. One person's risk assessment and care plan detailed how a behaviour may present, the warning signs, triggers and how to support the person safely. We asked a staff member how this person presented when becoming distressed and they were able to explain in detail what we had read in the care plan. The care plan detailed how to divert the person's attention to an activity they were known to enjoy.

We observed staff support people to move safely throughout our inspection. Staff told us and records confirmed the training they had received in moving and handling. Staff used safe techniques to support people including the use of hoists and standing aids. Staff used equipment cautiously and offered reassurance to people who may have felt vulnerable whilst transferring from an armchair to a wheelchair using a hoist. We noted suitable equipment such as hoists and wheelchairs were available for staff to use and each sling was for one person's use only. This helped reduce the risk of cross infection and the sling was the right size for the person's weight.

People had individual Personal Emergency Evacuation Plan (PEEP) in place on how they should be supported to evacuate the building in the event of a fire. The service maintained a safe environment for people because regular checks of the building and fire evacuation procedures were in place. The service had a fire risk assessment, which included guidance for staff in how to support people to evacuate the premises in an emergency.

Risks arising from the premises or equipment were monitored and checks were carried out to promote safety. Health and Safety checks such as water temperatures were being completed to assess the safety of the premises and protect people from any potential risk of harm. There were no gaps in the records of water safety checks. Other checks included the gas heating, electrical wiring, fire safety equipment and alarms, Legionella and electrical appliances to ensure they were operating effectively and safely.

At our previous inspection on 22 February 2017 and 01 March 2017, we identified the service was not following their own procedures in the safe administration of medication. At this inspection we found improvements had been made. People's medicines were safely managed. There were policies and procedures for the safe handling of medicines. Medicines were administered by trained staff. Records demonstrated arrangements had been made for all trained staff to be competency assessed annually. This is an observation of staff regarding how they safely handle and administer medicines, which is recommended in the Royal Pharmaceutical Society guidance, 'The Handling of Medicines in Social Care.'

The senior carer was observed administering medication on the day of the inspection. We observed medication administered safely and the medication administration record (MAR) chart was seen to be signed and dated. We found no gaps in these records. The senior carer was observed explaining to people what they were doing, gaining their consent and explaining what the medicine included. The senior carer ensured that the medication was given in accordance with the wishes of the person and that it was given safely and that the person was comfortable. We observed that unused medication was discarded safely and in accordance with the administration of medication policy. Stocks of medicines showed people received their medicines as prescribed. When people had their medicines administered on an 'as required' basis there was a protocol for this which described the circumstances and symptoms when the person needed this medicine. The temperature of the medicines storage room was monitored as was the temperature of the fridge used to store medicines. These were within the recommended safe limits.

At our previous inspection on 22 February 2017 and 01 March 2017, we found people were not always protected by robust recruitment procedures. Staff being employed to work in care settings must have a Disclosure and Barring Service (DBS) check. DBS checks identify if prospective staff have a criminal record or are barred from working with adults. One staff member's DBS check had showed they had received a number of police cautions. At that inspection we found no evidence of the manager or provider reviewing these concerns with the staff member or considering any potential risks involved in employing them. At this inspection we found the provider had reviewed their recruitment policy. The policy stated that a risk assessment should be carried out when considering employment of a person with a police caution. The provider has strengthened their staff recruitment procedures and reviewed their records held for staff.

Staff files showed references were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There were records to show staff were interviewed to check their suitability to work in a care setting.

Staffing numbers were determined by using a dependency tool, which looked at people's level of need in areas such as mobility, nutrition and maintaining continence, although staffing levels remained flexible. Staffing could be changed if required, for example if people became particularly unwell or if a person was nearing the end of their life. We saw that people received care and support in a timely manner. Care plans detailed whether people could use their call bells effectively and monitored people accordingly. Staff were attentive to people's needs, knowing them well and interpreting body language. For example, one person became distressed in the lounge and staff discreetly assisted them, ensuring they were comfortable in a quieter environment, as staff knew this would help the person settle. Staff told us there were always enough staff to respond immediately when people required support, which we observed in practice.

The rotas reflected each day that at least two care staff and one senior carer were on duty from 8am to 8pm. At night time two care staff were on duty 8pm to 8am. The service had a 24 hour on call system in case of unforeseen events and if additional staff were needed. In addition to the care staff, the service had a team of domestic staff and a chef. This enabled the care staff to attend to people and their needs. The activities coordinator was working at another service and staff told us they were providing activities. This was a temporary arrangement until the numbers of people using the service increased. There was sufficient management oversight, with a registered manager and deputy manager in post who when not on shift provided out of hours support if required.

Staff were visible throughout the day and spent time with people and their families. They ensured people were safe, their dietary were met and they remained sufficiently hydrated. Staff supported people to stay active and we observed a ball game and colouring. Staff talked inclusively with people about their experiences and family and had regular contact with people including those in their room.

The registered manager demonstrated understanding of her responsibilities to protect people from abuse and to provide safe care. We asked the registered manager about the systems and processes in place to ensure appropriate action was taken when incidents and safeguarding situations occurred to reduce risks to people. The registered manager explained that all individual incident and accident reports were seen by her, that she then compiled a monthly report, which was reviewed by the provider. This was then discussed and a trend analysis completed. We spoke with staff about the safeguarding of people and each staff member had a good awareness of the principles of safeguarding procedures and who to report any concerns to. Records showed staff were trained in safeguarding procedures and this was included in the induction for newly appointed staff. The registered manager said they had also attended safeguarding training which was provided by the local authority.

## Is the service effective?

### Our findings

At our previous inspection on 22 February 2017 and 01 March 2017, we found that the provider was in breach of three regulations for this key question, is the service effective? We found staff were not provided with adequate induction, supervision, training and on-going support. This left people at risk of receiving care from staff who were not equipped to carry out their duties effectively. We found there to be a lack of decision specific mental capacity assessments for people living at Manton House. We found people who relied on staff to support them to eat did not always receive the support they needed. We told the provider they could not admit any new people to the home from 12 May 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care. This was in respect of the three breaches of regulation, which required the provider to make immediate improvements. At this inspection, we found that sufficient action had been taken and the provider was now compliant with Regulation 18 Staffing, Regulation 11 Need for consent and Regulation 14 Meeting nutritional and hydration needs of the Health and Social Care Act Regulated Activities Regulations 2014.

Our observations showed staff were confident and knew how to support people in the right way. Throughout our inspection, we saw that people, where they were able, expressed their views and were involved in decisions about their care and support. We observed staff seeking consent to help people with their needs. We spoke with a number of relatives who told us they had a growing confidence in the staff's abilities. They said since the new manager had taken over there was greater team work and felt continuity of care had improved. One relative said, "Staff were on the ball and communication had improved." They said previously they had not been confident that all staff knew how to meet their family member's needs but said things had improved. Relatives said previously they had concerns about staff turnover but said this had improved.

All new staff were required to complete a comprehensive induction and covered 15 standards of health and social care topics. The induction was work based awards that were achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. This ensured people received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Inductions also included areas such as the lay out of the home, communication systems, policies and procedures. Induction was followed by a minimum of four shadow shifts. New staff shadowed more experienced colleagues and did not work on their own until they were competent and confident to do so.

The provider maintained a spreadsheet record of training courses completed by staff, which were considered mandatory to providing effective care. This allowed the provider to monitor when this training needed to be updated. These courses included fire safety, infection control, moving and handling, health and safety, food safety, safeguarding people and the Mental Capacity Act (MCA.) Additional training was available to staff in specific conditions such as end of life care and dementia. Records confirmed all staff who had finished their induction, had received this training. Staff confirmed they received training which they said was of a good standard and that they were able to suggest relevant training courses which were then provided. Staff were encouraged to complete various levels of National Vocational Qualifications (NVQ)

or more recently Health and Social Care Diplomas (HSCD). These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability and competence to carry out their job to the required standard.

Staff told us they received regular supervision sessions and that they felt supported by the team and registered manager. Staff told us additional support was offered through handovers during the day, staff monthly meetings and residents' monthly meetings. Minutes of these discussions demonstrated staff discussed residents' needs, activities, changing policies and procedures, safeguarding and training needs. Without exception, staff told us this worked for their service and that the registered manager had an open door policy where they could talk to them anytime they needed to.

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

People and their relatives said staff consulted people and gained their consent when providing care where this was possible. We observed staff gained people's consent before supporting them using their assessed communication method. Our observations confirmed people were able to make choices and were in control as much as they could be in the day to day decisions being made. For example what people wanted to wear, where they wanted to sit, what activity they wanted to do and what level of interaction they wanted with staff. Records confirmed that staff had completed training in the MCA and had a good understanding of this topic.

Appropriate DoLS applications had been made and staff acted in accordance with DoLS authorisations. Where Deprivation of Liberty Safeguards decisions had been approved, we found that the necessary consultation had taken place. This had included the involvement of relatives and multi-disciplinary teams. We checked people's files in relation to decision making for those who were unable to give consent. Documentation in people's care records showed that when decisions had been made about a person's care, where they lacked capacity, these had been made in the person's best interests.

People were supported to have sufficient to eat and drink and to maintain a balanced diet. We talked with the chef who explained how they catered for people's dietary needs. For example, for those who required a soft diet. We observed good communication between kitchen staff and care staff, who advised the chef of changes made to people's diets following input from visiting professionals, such as dieticians and speech and language therapists. People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The registered manager had completed these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for this purpose. Plate guards were used, where needed, to help people to eat their meal independently. We observed people's likes and dislikes were documented and kept in the kitchen, accessible to staff. The chef received written information from care staff about people's preferences and requirements when someone came to live at the home.

We observed the lunchtime meal in the dining room. The atmosphere was calm and relaxed and there was music playing which people told us they enjoyed. Staff engaged in conversation with people and encouraged them throughout the meal, noting who liked to sit with whom. Staff assisted people who

required support with eating their meal in a discreet and unhurried way. A relative told us they had no concerns about their family member's relative. They described the food as, "Very good." They said the dining room had been revamped and people encouraged to eat there. People's food and fluid intake was routinely monitored, whether or not they were at risk of malnourishment. We observed that drinks were freely available at mealtimes and throughout the day in people's rooms and communal areas.

People were supported to maintain good health and had access to a range of healthcare services and professionals. Care records documented the involvement of healthcare professionals such as the GP, chiropodist, district nurse or optician. If needed, staff would support people to attend their hospital appointments. Each person had a transfer to hospital file which provided information that would be required if the person needed to be admitted to hospital. This helped to make sure that other professionals would have information about people's general health, how they communicated and any specific wishes regarding their healthcare.

At our previous inspection on 22 February 2017 and 01 March 2017, we recommended that the provider refers to current guidance about adapting the environment for people living with dementia. At this inspection we found the colours and décor of the home supported people living with dementia to orient themselves in their surroundings. For example, there were objects placed around the home for people to pick up and engage with. We observed people walking around with various items that were of interest to them, such as knitted items, which some people enjoyed holding and putting on. The provider had recently invested in improving the physical environment of the service. A reminiscence room had been designed which included furniture being purchased; in a contrasting colour to the carpeting, and warm colour tones used on walls, which were easier to see. There was a radio, books and other items for people to engage with and prompt memories. The service had matte surfaces and slip resistant flooring; avoiding patterns, speckles or sparkles that can be confusing. We saw that staff working in the service were supporting people to be involved in making decisions about colour schemes, furnishings and décor. There were handrails along the corridors for people to steady themselves and rest if needed. The communal areas of the service were clean and well-furnished with a homely feel. People's rooms were individualised, with personal items such as ornaments, photos and furniture. The outside area was accessible with paths and benches.

## Is the service caring?

### Our findings

At our previous inspection on 22 February 2017 and 01 March 2017, we found that the provider was in breach of one regulation for this key question, is the service caring? We found people's privacy was not maintained at all times and monitoring measures (the use of closed-circuit television - CCTV) had not been properly considered. We told the provider they could not admit any new people to the home from 12 May 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care. This was in respect of the breach of regulation, which required the provider to make immediate improvements. At this inspection, we found that sufficient action had been taken and the provider was now compliant with Regulation 10 Dignity and Respect of the Health and Social Care Act Regulated Activities Regulations 2014.

At the previous inspection we found the placement of video surveillance screens did not protect people's privacy or dignity. At this inspection we found the statement of purpose had been updated to inform new admissions to the home of its usage. As part of people's mental capacity assessment this had been considered and included in DoLS requests. There was clear signage around the service informing people, staff and visitors of its presence. This included that it did not record sound. The footage was only accessible by the registered manager and provider. Relatives meetings included the use of CCTV and reflected their views.

Without exception people could not speak highly enough of the caring and compassionate nature of the service, staff and management team. They told us that every member of staff demonstrated this approach consistently and without fail. We observed staff sitting with people and talking to them about their known interests. We observed staff laughing and telling jokes to people. People responded well and visually appeared happy and entertained. We observed a staff member adjusting someone's glasses so they were comfortable. At lunch the staff provided support to people who needed it. They responded when people wanted different meals according to their choice. Staff spoke to people warmly and interacted well with those who needed help.

One person told us, "yes the staff are very kind, but I'm very independent." Another person told us, "I would give the home 100% staff are really kind." Staff were observed interacting regularly with people and being inclusive. One staff member told us, "I am a mother and a grandmother." They spoke to people about their children and childhood and supported people with their own memories. Staff encouraged people and sat with them making conversation and eye contact.

During our inspection a person passed away. Staff were respectful and provided necessary support to their family and other people using the service. Staff remained professional and were discreet and sensitive. Throughout our visit there was a strong emphasis on family. People, their relatives and the care staff described the home as an extended family that they all felt an important part of.

We saw that genuine and meaningful relationships had developed between people living at the home, their relatives and staff. This extended clearly to the registered manager who was very visible around the home



during our visit. We saw relatives arrive to be warmly greeted and in some cases receive reciprocated hugs from staff. Relatives told us they were able to be as involved in the person's care as much as the person wished them to be. The staff we spoke with demonstrated commitment and motivation in offering a person centred service. Interactions between people and staff were good and it was clear staff knew people, and people knew staff. A person showed us how their nails had been done that morning and indicated the care worker had helped them to do it in the way they wanted.

On the day of the inspection we met with people with and without dementia. However, there was no evidence of any negative behaviours you might see if people were distressed as staff were observed to interact with people with kindness, gentleness and warmth. The senior carer and carer both described how they gave people choice, explain what they were doing employing simple questions and rephrasing the questions to ensure the person had understood the question and was able to make an informed choice.

The staff induction included instructions for staff in treating people with dignity, maintaining people's independence and treating people as individuals. Each person had a person centred care plan which was personalised to reflect people's preferred routines and choices in how they spent their day and how they wished to be helped. People confirmed they were able to choose how they spent their time. Care plans also included details of how staff should support people with emotional needs. Staff told us care was provided based on what the individual needed and that choices were available to people.

Family meetings were held. Staff created a safe space for relatives to share ideas and explore their feelings in relation to the care their relative was receiving. Relatives met regularly and set the agenda for their meetings. Relatives were encouraged to participate in events and activities within the service and relatives were consulted regularly about the care provided. Relatives gave us positive feedback about the service. A recent meeting had resulted in a change in the menu as people had requested a wider variety.

All those we spoke with told us they were treated with respect and that their dignity and privacy was maintained. One relative told us how staff always explained what they were doing when assisting their family member to mobilise. During our inspection we observed this consistently. We saw that staff asked people's permission before assisting them to mobilise and that they gave them time to understand what was about to happen. We saw staff comfort, reassure and explain to people throughout this process. We observed staff ensure bedroom doors were closed before giving personal care. We saw that a screen was also used to protect people's dignity when the use of moving and handling equipment was required.



## Is the service responsive?

### Our findings

At our previous inspection on 22 February 2017 and 01 March 2017, we found that the provider was in breach of one regulation for this key question, is the service responsive? We found there was a lack of person centred care for people living at the home. We told the provider they could not admit any new people to the home from 12 May 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care. This was in respect of the breach of regulation, which required the provider to make immediate improvements. At this inspection, we found that sufficient action had been taken and the provider was now compliant with Regulation 9 Person Centred Care of the Health and Social Care Act Regulated Activities Regulations 2014.

However, although staff were working hard to support people to engage in meaningful activities this was an area that was continuing to be developed and required improvement. We highlighted this to the registered manager who showed us documentation they had sent out to relatives on the 19 September. The documentation asked relatives about their loved ones interests and hobbies. The registered manager told us they recognised this was an area requiring improvement and once these records were returned a more personalised activity schedule would be arranged.

Most people could not tell us about their experiences but we observed their care throughout the day and found people were content and received good care. The regular interaction between staff and people helped enhance people's well-being. This was supported by relatives, one relative said, "There aren't many activities, and there is more going on today than usual." The activities programme was restrictive and did not demonstrate how it met people's individual's needs or hobbies.

People did not have opportunities to go out other than the garden and were reliant on relatives to take them out. There were no volunteers and most visitors to the service were either relatives or people known to the staff such as their immediate family. Given the proximity to the town and local colleges, we felt more engagement with the community would increase people's sense of belonging and help them to participate in things they enjoyed.

We observed people and staff together in the communal areas. They chatted and joked with each other continuously. One person watching on old black and white film and this sparked a conversation about what films people liked. Staff gave people some colouring to do and played a game with a ball which people clearly enjoyed. We observed some people using the dining area to do knitting and read a paper. We observed other people chose to sit in the reminiscence room to chat. Staff responded well to those who gestured for help because they did not have verbal communication. There was laughter and free communication between staff and people.

Each person had a communication care plan, which gave practical information in a personalised way about how to support people who could not easily speak for themselves. The care plan gave guidance to staff about how to recognise how a person felt, such as when they were happy, sad, anxious, thirsty, angry or in pain and how staff should respond. Care workers and the registered manager communicated with people in

an appropriate way according to their understanding.

People's needs were comprehensively assessed at the time they were admitted to the service. This included communication needs, personal care, continence, mobility and nutrition. Further assessments were carried out regarding moving and handling and any risks to people. They were legible and securely stored. They were person centred and people's choices and preferences were consistently documented. The care plans we looked at contained meaningful information about people's social and personal histories. It was possible to 'see the person' in these documents.

Each person's care plan contained detailed information about people's care needs and actions required in order to provide safe and effective care. We noted some people were assessed as being at risk of developing a pressure sore due to immobility. We noted risk assessments had been made concerning the person's skin integrity, in addition to possible contributory factors, such as mobility, continence, nutrition and hydration. They had been placed on an air mattress, the pressures of which were calibrated and regularly checked. Care plans and risk assessments were reviewed at regular intervals and were updated to show changing needs were addressed.

Staff completed daily records for people, which showed what care they had received, whether they had attended any appointments or received visitors, their mood and any activities they had participated in. The daily records gave clear information about how people were so that staff on each shift would know what was happening. Staff were responsive to changes in need and referred people to appropriate health professionals in a timely way, for example, in relation to chiropody, eye care or GP. Staff used clear body maps to monitor people's skin and to show why and where topical creams were required.

People had consent forms in their care plans, which asked when people would want their loved ones to be contacted. People who used the service had monthly meetings where they discussed topics that were relevant to them and the service such as social activities and meals.

The complaints policy included clear guidelines on how and by when issues should be resolved. It contained details of relevant external agencies, such as the Local Government Ombudsman and the Care Quality Commission. The provider responded to complaints effectively and in line with their complaints procedure. There was an accessible complaints procedure in place and on display in the communal areas. People knew who to speak with if they had any concerns or complaints. People confirmed they could talk to staff and felt listened to. Staff said that if a person told them something was upsetting them, they would try to resolve things for the person straight away. If they could not do so, they would report it to the registered manager. Staff told us some people could not verbalise their concerns, but changes in their behaviour would alert them that something was not right that might need further investigation. To help people understand the complaints procedure, it was discussed with the person as part of their monthly resident meetings in a format the person was able to understand.

Relatives spoken with said there was clear leadership in the home but this had not always been the case. This had given them renewed confidence and relatives said they knew how to complain. One relative said when they had complained satisfactory actions had been taken to address their concerns.

## Is the service well-led?

### Our findings

Following our last inspection, the manager at that time decided not to register with the Commission. The provider appointed another manager in July 2017. The appointed manager registered with the Care Quality Commission in September 2017. The previous manager continues to be registered for another location for the same provider and offers support to the newly registered manager of Manton House.

At our previous inspection on 22 February 2017 and 01 March 2017, we found that the provider was in breach of one regulation for this key question, is the service well-led? The systems in place to assess, monitor and improve the quality and safety of the service were not effective. An accurate and complete contemporaneous record in response of each person living in the service was not in place. We issued a Warning Notice for the provider to make immediate improvements in this area. At this inspection, we found that sufficient action had been taken and the provider was now compliant with Regulation 17 Good Governance of the Health and Social Care Act Regulated Activities Regulations 2014. We also found that sufficient steps had been taken and the requirements of the Warning Notice had been met.

Although significant improvements had been made to address previous shortfalls such as the monitoring of quality and safety of the service, these improvements were yet to be embedded and sustained.

Since the last inspection the provider had implemented an audit schedule which meant people's care packages would be audited once every four to five months. We noted that these audits had been detailed and had helped to identify shortfalls in the running of the service. For example, when staff were not following particular care plans, or staff documentation needed to be improved due to gaps in people's records. However, we found the auditing was not regular and not everyone's care was being audited. The registered manager told us she received regular feedback from staff, people and their relatives on all aspects of the service, for example medication and people's care plans weekly, but had not always documented or recorded this. Therefore, the registered manager could not demonstrate actions taken to ensure the quality and safety of the service. The registered manager told us she was aware this was a shortfall and had intended to do these audits monthly for all people residing at Manton House. The registered manager told us she was still getting used to the systems but had met with the provider to discuss this specific audit in the small timeframe she had been with the company. Before the end of our visit the registered manager confirmed these audits would be completed monthly.

The registered manager completed a range of other quality monitoring audits. These included medicines, accidents, incidents, safeguarding, pressure wounds, complaints and health and safety. On the audit form there were details in relation to date, name, details, action taken, explained or unexplained, if safeguarding or CQC notification raised and details, outcome i.e. closed, on-going, no further action. The form also included a section for recording any details of any trends developing and noted actions taken. Records demonstrated that information from the audits was used to improve the service and information recorded used to reduce risk of untoward events occurring.

The registered manager had raised the bar and had gained the confidence of staff, relatives and people

using the service. One relative said, "She seems to be making a difference." Some refurbishment had been undertaken but parts of the environment still needed some care and attention. One relative said, "It's not a posh home but it comfortable and homely." This was echoed by a second relative. One said the porch needed refreshing. Improvements had been made to the garden but this was in need of weeding. We noted some areas of the home had odours either from the floor or soft furnishings which needed deep cleaning or replacement. However the registered manager was aware of these areas and had a plan of action which they could demonstrate to us with the end of November being a target for completion of works and deep cleaning

We contacted Norfolk County Council for feedback regarding the quality monitoring of Manton House. A quality assurance officer emailed us to confirm they had undertaken a visit to the service in September 2017. The purpose of the visit was to review the progress of actions identified as part of the action plan following our last inspection visit. The quality assurance officer included, 'I found [registered manager] to be receptive to my visit. She engaged constructively with discussions, listening to feedback and discussing her actions. [Registered Manager], as agreed, emailed me the following day with a list of actions that we had discussed. I encouraged [Registered Manager] to develop professional relationships outside of Manton House. This is to reduce her working in silo so she can develop her knowledge and networks by liaising and meeting with others. She has since attended the West Suffolk Provider forum and the Registered Managers meeting.'

The registered manager told us, "the provider has been in constantly to offer me support. She is in at least twice a week. The provider is a very good owner and contactable at all times."

We asked staff about the vision and values of the service. One staff member said, "Our aim is to provide a safe and caring environment. To meet the needs of people in an individualised way." Staff demonstrated the importance of offering each person a personalised service and each person being highly valued.

Staff said that they felt fully supported and that the registered manager was approachable. Staff confirmed that the registered manager operated an 'open door' policy and they felt able to share any concerns they might have in confidence.

Staff told us they attended staff meetings where they could discuss the care of individuals and any updates to policies and procedures. Staff said they felt supported and said there was a culture where they could ask for support and training to enhance the standard of care they provided.

Information was available to people and visitors in the hallway of the service. These included the provider's Statement of Purpose, the last CQC report and satisfaction survey forms for people to complete. This facilitated communication channels between people and the service's management.

Information from the recent survey showed that people and their relatives were consulted about their care. Information was provided to people and their relatives about how to raise concerns and there were opportunities to attend relative meetings or speak to staff / management about any concerns or compliments they might have. This meant the service was responsive to people's needs. We noted all expressed a high degree of satisfaction, particularly in the areas of staff attitudes and quality of care. Where issues were identified, people and their relatives stated that they were listened to and those issues were resolved in a timely manner. Staff told us the new registered manager had sought their ideas and had introduced changes which were mostly viewed as positive. Records had been brought up to date and people's unmet and changing needs had been highlighted so they could be addressed.