W & S Red Rose Healthcare Limited

Morley Manor Residential Home

Inspection report

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Morley
Leeds
West Yorkshire
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Date of inspection visit:
26 July 2022
03 August 2022

Date of publication:
27 September 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Morley Manor Residential Home is a care home which provides personal care to people. The home is registered to support 33 people. At the time of the inspection, the home was providing personal care to 22 people, most of who were living with dementia.

People's experience of using this service and what we found
People and relatives shared positive feedback about the care provided. However, during this inspection, we were not assured the service provided was always safe and we found widespread shortfalls in the way the service was managed and we were not assured the service was safe.

The provider failed to implement effective processes to assess and monitor the quality of the service and to identify the issues found during our inspection. Records related to people's care were not always complete or contemporaneous. Management were not following regulations, best practice guidance or their own policies and procedures.

We found several issues with the management of medication and risks to people's care were not fully assessed, planned for or documented. We identified environmental hazards, including fire safety concerns. We found examples of incidents not being investigated or reported to the safeguarding team. During this inspection, we identified and asked the registered manager to submit safeguarding referrals, as appropriate.

Staffing levels and staff deployment was not effective to ensure people's needs were met in a timely way. We received mixed feedback regarding staffing levels at the service.

Staff were not always recruited in line with requirements. Staff had not always received the appropriate training to care for people safely.

We found examples of unnecessary restrictions on people's movement. The registered manager took immediate action when we raised these concerns. We found inconsistency in the application of the principles of the Mental Capacity Act. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible. There were policies and systems in place, but these weren't always being followed in practice. We made a recommendation for the provider to review their practice.

People did not always receive person centred care. There were a lack of meaningful activities and interaction being offered to people.

Care plans lacked detail in relation to specific areas of people's care. People and relatives shared positive feedback about staff being caring and kind in their approach. Staff spoke kindly about people and knew

about their preferences and needs. We found examples of staff's recording not being centred on people's needs.

We saw evidence of good partnership work with other professionals, to meet the needs of people living at the service.

The registered manager was receptive to the inspection findings, told us they were willing to learn and improve and shared the actions that had taken or would take to address the issues found at this inspection. People, relatives and staff shared positive feedback about the management of the service.

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 on 7 March 2018).

Why we inspected
The inspection was prompted in part due to concerns received about staffing, person centred care and the management of the service. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Responsive and Well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
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 and will take further action if needed.

We have identified breaches in relation to person centred care, safe care and treatment, safeguarding, good governance, staffing and fit and proper person's employed at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe. Details are in our safe findings below.	**Inadequate**
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 not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Morley Manor Residential 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 Health and Social Care Act 2008.

Inspection team
This inspection was conducted by two inspectors, a pharmacist inspection manager and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Morley Manor Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Morley Manor Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 26 July 2022 and ended on 8 August 2022. We visited the location's office on 26 July and 3 August 2022.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We reviewed information we held about the service including information about important events which the service is required to tell us about by law. We requested feedback from other stakeholders. These included the local authority safeguarding team, commissioning team, infection and prevention control team and Healthwatch Leeds. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with four people living at the home and 14 relatives about their experience of the care provided. We observed care in the communal areas to help us understand the experience of people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We received feedback from three healthcare professionals.

We gathered information from several members of staff including care workers, the registered manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included three people's care plans, risk assessments and associated information, and other records of care to follow up on specific issues. We also reviewed multiple medication records. We looked at three staff files in relation to recruitment and training. A variety of records relating to the management of the service, including policies and procedures and quality assurance records were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We gathered further feedback from staff. We shared the main findings of this inspection with the local authority safeguarding team, infection and prevention control team and with commissioners of care from the local authority. We also shared concerns with the Fire Safety Authority.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- During this inspection, we found environmental risks including fire safety concerns. We found fire doors propped opened with a chair and equipment required to open emergency fire exits not being in place. An external fire risk assessment noted recommendations for improvement; these should have been acted upon on specified timescales but evidence suggested this had not all been completed timely as required. We reported our concerns to the Fire Safety Authority.
- Other environmental risks identified included, in one of the bathrooms we found equipment and sanitary products had been stored in a way that could pose a risk of falls. The door sill in another toilet facility needed fixing and also was a trip hazard. We observed hot water kettle being left unsupervised in a communal area where a person living with dementia mobilised; this could pose a risk of scalding.
- There were risk assessments in place for some areas of people's care, but we also found examples when these were not in place or lacked detail. For example, people's moving and handling risk assessments and care plans lacked detail. Staff were using the same moving and handling equipment for different people including one who had not been assessed to use this equipment.
- We found examples of incidents between people not being investigated or reported to the local safeguarding team. We discussed this with the registered manager, and they reported these incidents. We found a lack of evidence that unexplained bruises had been investigated; we asked the registered manager to investigate this.

Systems were either not in place or robust enough to demonstrate safe care. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager and nominated individual told us they would act on all the issues identified. In relation to some of the environmental risks, we found improvements on our second visit.
- People told us they felt safe living at the service and relatives also thought their loved ones received safe care. One person said, "Yes, I feel safe." Relative's comments included, "Yes, [person] is safe" and "Got a lovely alarm mat on the floor, we have got complete peace of mind, [person] is safe and being cared for."

Using medicines safely

- Medicines were not always administered safely as prescribed. For example, one person did not have their pain relief patch applied at the right time for at least the previous two months so there was a risk their pain might not have been controlled. We asked the registered manager to report this incident to the local safeguarding team.
- Rotation charts for medicated patches were not being used so there was a risk they would not be applied

safely.
● Time sensitive medicines were not always given safely. For example, one medicine that should have been given before food and not with other medicines was unsafely administered.
● Cream application was not always recorded so we could not be assured they were being applied properly.
● The medicines fridge temperature was monitored but the maximum and minimum temperatures were not recorded as per national guidance so there was a risk medicines might be stored unsafely.
● Audits of medicines were not effective and had not identified the concerns found during this inspection.

Medicines were not properly and safely managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After our inspection, the registered manager updated us in the action they had taken in response to our findings.
● Staff's competency to administer medication had been assessed regularly.

Staffing and recruitment
● Staffing levels were not always adequate to meet people's needs.
● We received mixed feedback about staffing levels at the service. Staff's feedback was that shifts were very busy and additional staff was required. One staff member told us, "We would like to do it [offer people a bath or shower] more often but with the staffing issues it has been difficult."
● Although the service was using a dependency tool to considerer people's needs and the staff hours required, we observed several instances where communal areas were not supervised during our visits and people required support. For example, we observed people asking for a drink or commenting that they wanted to have their breakfast, but staff were busy supporting other people with their needs.

Systems were either not in place or robust enough to demonstrate safe care. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People did not raise concerns about staffing levels or staff's response time to call bells. Relatives told us, "Always plenty of staff when I go, I always see them about;" "I have not felt concerns [about staffing levels], there is not always a lot [of staff] seen around but [people's] needs are met" and "Staff are absolutely brilliant, very caring but they are busy, often short staffed."
● The registered manager told us they had identified the need for more staff in one of the units and they were making changes to the rota to ensure this was in place.

● Recruitment of staff was not always completed safely. Some staff had started working before relevant references from previous employment in social care being sought or evidence of DBS checks completed.

Recruitment systems were not working effectively, and this placed people at risk. This was a breach of regulation 19 (Fit and proper person's employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● On our second visit to the home, we found progress was being made in this area and the provider had developed a staff file audit to prevent the issue occurring again.

Systems and processes to safeguard people from the risk of abuse

● During this inspection, we found examples of unnecessary restrictions on people's movement.
● Referrals had been submitted when some incidents had happened, but we also found instances when incidents had been recorded in incident forms but not escalated to the safeguarding team.
● Several members of staff did not have up to date safeguarding training.

Systems were not working effectively to protect people from abuse and improper treatment. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The registered manager took immediate action when we raised concerns about unnecessary restrictions on people and submitted the relevant referrals without delay, following our request.
● There were safeguarding policies and procedures in place.
● Staff knew how to identify signs of abuse and what actions to take if required.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.

● 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.

● 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 somewhat 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.

Visiting in care homes
● Relatives and friends were able to visit their loved ones and the provider was aware of relevant guidance around visiting.

Requires Improvement

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- The provider did not always ensure staff had the appropriate training.
- Staff had not received adequate moving and handling training. Some staff had completed online training but there was lack of evidence of face to face training being offered and documented. The registered manager told us they had trained and supervised staff in completing moving and handling tasks but no evidence was provided of their qualifications in this area.
- Several staff members had not received training to support people in a safe way and in case of emergency; this included safeguarding and fire safety training.
- On review of staff's records of supervision and appraisal, we found records did not evidence this was always completed regularly.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured staff had the qualifications, competence, skills and experience to care for people safely. This placed people at risk of harm.

- After our inspection, the registered manager confirmed staff had been booked to complete this moving and handling training face to face externally.
- Staff told us they felt supported by the registered manager who was always available to discuss any issues and provide advice.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People told us staff asked their permission before delivering care. We saw several examples of mental capacity assessments being completed when there were concerns that people lacked the capacity to make certain decisions. However, when people had been assessed as lacking the capacity, a record of the best interest decision had not always been completed.
● Several people living at the home required a DoLS in place. We found examples of delays in resubmitting applications that had expired. One person had conditions on their DoLS that related with specific mental capacity assessments being completed, and this was not in place. We did not find evidence of this person having additional restrictions in place.

We recommend the provider reviews their application of the principles of the MCA and applies relevant best practice guidance.

Adapting service, design, decoration to meet people's needs
● Some areas of the home required improvement and redecoration. The provider had an improvement plan in place.
● People and relatives did not raise concerns about the decoration of the home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The delivery of care did not follow best practice guidance. For example, two people living at the service were known to display behaviours considered challenging to others. Their care plans had not been designed using a positive behaviour approach where aspects such as the function of the behaviour and triggers of incidents are understood and recorded. Staff were able to describe to us some of the de-escalation techniques they used to support people. We found examples of professional advice not being followed. For example, one person required additional seating equipment to support their posture; this equipment had been requested but, in the meantime, staff needed to support this person with additional pillows. We observed this was not in place. We raised this with staff and the registered manager.
● People's needs were assessed prior to people coming to live at the home.
● Care plans were not always detailed around how to manage risks to people's care to ensure care was always delivered effectively and consistently.

Supporting people to eat and drink enough to maintain a balanced diet
● People's particular needs and preferences around their nutritional and hydration requirements were assessed and known by staff. People's weight was being monitored when required, to manage any risks to their health.
● People told us they enjoyed their meals. We observed examples in the morning of people wanting to have a drink or breakfast and staff not being around to support them with this. We discussed this with the registered manager, and they acknowledged people should be able to access drinks and meals at a time of their choosing. The registered manager said they were going to rearrange how often this was offered to people to increase frequency and access.
● Relatives shared positive feedback about meals. Comments included, "The food is all home-made, brilliant" and "Food options are really good."

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

● The provider kept in contact with relevant healthcare professionals involved in people's care.
● Visiting healthcare professionals told us staff completed referrals in a timely way, were always available and acted on their feedback.
● One relative shared positive feedback about staff acting quickly when their loved one's health deteriorated; "They [staff] were so proactive towards [person], phoned me, phoned emergency services and stayed with [person], they were exemplary, I stayed the full 2 weeks at the home, I slept in the chair in [their] room, they [staff] brought me blankets, I ate with them, nothing was too much trouble."

Requires Improvement

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
● On our inspection visits, we saw personal and confidential information about people being left unattended and accessible to others who might not have the right or permission to access it. We shared these concerns with the registered manager and asked them to take action.
● Most interactions we observed between people and staff were positive and staff demonstrated a genuine interest in people's needs and interests. For example, we observed people who lived with dementia initiating physical contact with staff, such as holding their hand or hugging a staff member, and staff responding appropriately and professionally to people's emotional need. However, we also observed instances where staff made comments either verbally or in records of care not centred on people's needs.
● Several relatives raised concerns about people's clothes going missing or people not wearing their own clothes. Comments included, "[Person's] clothes get mixed up and lost, 9 or 10 times [person[is wearing other peoples' clothes, underwear and socks;" "I have seen other residents wearing [person's] cardigan, new trousers have gone missing" and "Couple of times seen [person] not in [their] own clothes." We discussed this feedback with the registered manager; they told us they were aware of concerns raised in this area and they were in the process of implementing a new labelling system to make sure people's clothes were properly identified and inventoried.
● People told us they felt staff respected their privacy and dignity. Comments included, "[Staff] always knock, they always do. I say don't bother its only me but they always do" and "They [staff] knock and cover me over, they don't make me feel awkward."

Supporting people to express their views and be involved in making decisions about their care
● We reviewed people's care plans and reviews of care where there was no evidence of people and relatives being involved.
● Relatives told us they were involved in people's care however had not been invited for any reviews of care. Their comments included, "I am not aware of [care plan], we are involved in the health with the phone calls, they [staff] know us and ask us, talk to us, we have a good relationship" and "Had one meeting with the manager and social services, but only one."

Ensuring people are well treated and supported; respecting equality and diversity
● People and relatives told us staff were kind and responded well to people's needs and preferences. People's comments included, "[Staff are] very pleasant;" "If I look sad, they come check on you. You can joke with them" and "Staff are very nice, always help."
● Relatives also shared positive comments about staff; "Staff are absolutely brilliant, very caring," "The

home has got a lovely atmosphere, staff are really nice and caring" and "[Person[has a laugh with them [staff[, I find the staff very nice, really caring."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

- We found people did not always receive person centred care.
- Care plans had information about people's needs and preferences,. However, this was not always detailed or accurate. For example, some people living at the home were known to frequently decline support from staff with their personal care; their care plans did not identify this, or the strategies staff should follow to appropriately support these people. Another person required additional and regular support with their oral health; their care plan did not describe this, and other records of care did not evidence this was being regularly provided.
- The service had routines which could create the development of an institutionalised environment for people. People had their meals at the same time in the dining areas or in the lounge, if there were no chairs available in the dining area. We observed people commenting they wanted to eat and have a drink and there were no staff present; breakfast was served at a particular time and there was a drinks trolley that offered people a drink at particular times. We discussed our findings with the registered manager, and they agreed people should be able have access to their meals and drinks at any chosen time and staff should offer this. The registered manager told us the changes they were going to do to embed this in the home's practices.
- People were not offered or provided with regular baths and showers. Their personal hygiene needs were met using other approaches such as strip washes, but there was no indication this was people's choice. We asked staff and they told us bathing equipment was not in working order, but we discussed this with the registered manager, and they confirmed bathing facilities in the building were working. During our visits, we did not observe people's dignity and hygiene not being maintained. However, some relatives raised concerns about this area of people's care. Their comments included, "At times, I would see [person] in the same clothes for 5 or 6 days, that was 2 months ago, but more recently [person] has been washed and hair tidy" and "The only problem is sometimes [person] is unshaven, I ask and they say that [person] has refused."
- We found there was an inconsistent provision of activities. During our inspection visits, we did not observe people being offered activities. Records of people's care did not evidence regular and meaningful activities were offered to people; in particular people living with dementia who at times could display behaviours considered challenging to others. The registered manager told us the service employed an activities coordinator who worked on a part time basis and they were looking to recruit another staff member to focus on this area.

We found care was not always designed or delivered in a way that met people's needs and preferences. This

was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.
● People's communication needs were assessed, and some plans put in place to support people with this area of their care. However, we found one example where there had been a lack of action to enhance one person's communication because the registered manager had not taken timely action to make sure they had the equipment required. We discussed this with the registered manager who told us they would take immediate action.

Improving care quality in response to complaints or concerns
● The service had complaints policies and procedures in place. At the time of our inspection, there were no complaints logged.
● People and relatives told us they were confident that if there had any concerns, they could contact the registered manager and they would act on their concerns. One relative said, "[Person has] been there two years, 99% fine, one instance a carer left [person] in a soiled bed, it happened a couple of times, I spoke to them and that carer is no longer there, they took immediate action."

End of life care and support
● People's care plans included reference to end of life wishes and preferences. The registered manager told us no one living at the home required this level of support but they knew who they could contact for relevant professional advice to meet the needs of people who required palliative care.

Inadequate

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- At this inspection, we found systematic and widespread failings in the management of the service, which meant people did not always receive safe and person-centred care. There was a significant lack of oversight and monitoring of the quality of the service. As a result, the management of the home had not identified the issues found during this inspection relating to people's care, environmental hazards, medication, staff recruitment and training, staffing levels and unnecessary restrictions on people's movements.
- We found the quality assurance processes in place had either not been completed, such as staff files or care plans, or those completed had not been effective, such as medication and health and safety audits.
- The provider had not kept appropriate oversight of staff's training, supervision and staffing levels and deployment; we found this impacted on the quality of care people received.
- Care plans and records of care were not always complete, accurate and contemporaneous.
- The provider and registered manager were not always following their own policies and procedures; for example, in relation to medication, mental capacity and supervision and appraisal of staff.
- The provider was not displaying the ratings of their last inspection on their website, as required by regulations. We are considering our next action in relation to this issue in a process separate to this inspection.

Systems were either not in place or robust enough to demonstrate effective oversight and management of the service. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager collaborated with this inspection, was knowledgeable about people's needs, and receptive to the inspection findings. They acted on the issues found or told us the action they would take to address the issues identified. The nominated individual was also open to this inspection's findings and expressed their intention to continue investing and developing the service.
- We received positive feedback from people, relatives and staff about the management team. People comments included, "People who run [Morley Manor] are very lovely." Relatives told us, "Manager is very good, very busy, got lots on her hands, very friendly and approachable;" "It is the manager, the difference is the manager, she is on the ball, she cares and creates a good atmosphere around her, we are happy with the home" and "Manager is very fun loving and down to earth person, she is [person's] cup of tea, a fun loving

manager not just sitting in her office all day, very hands on with the residents."

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

● There were residents meetings taking place where themes relevant to the running of the service and people's care were discussed; such as choice of menus.

● There were communications with staff, via handovers and meetings.

● Relatives' meetings were not taking place and the provider and registered manager did not have a structured way to gather feedback from relatives, for example through surveys and questionnaires. Relatives confirmed this however, felt they could speak with staff or management at any time. One relative told us, "Communication is good, I feel we have been told things, had phone calls, they [staff] come and chat when we are visiting."

● People and relatives were satisfied with the care provided and shared positive feedback about the impact of the care provided. Their comments included, "I was doubtful when my [relative] said you are going in an old folks home but it's been good;" "Generally they [people] are happy, feedback from them is that everyone there is nice, even down to the man that changes the light bulbs;" "I am happy with everything, got no problems, [person] is settled there" and "[Person has been] there since [date], it has gone really well, we are so happy, staff are always in and out, [person] seems happy there."

Working in partnership with others

● The service worked in partnership and collaboration with a number of key organisations to support care provision. This included working with health care professionals from multidisciplinary teams to make sure people had their health and social care needs met such as district nurses and mental health team.

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 9 HSCA RA Regulations 2014 Person-centred care Information in people's care plans were not always detailed or accurate. People's personal care choices were not recorded. People were not offered meaningful activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medication was not managed safely. Risks to people's care were not fully assessed, planned for or documented. Environmental risks were identified during this inspection, including fire safety concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not working effectively to protect people from abuse and improper treatment. Safeguarding referrals had not always been done timely. There were unnecessary restrictions on people's movement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff had not always been recruited safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels and staff deployment was not effective to ensure people's needs were met in a timely way. Staff did not always have essential training and access to regular supervision and appraisals.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to implement effective processes to assess and monitor the quality of the service and to identify the issues found during our inspection. Records related to people's care were not always complete or contemporaneous.

The enforcement action we took:

We issued a warning notice.