South West Care Homes Limited

Manor House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Overall summary

We inspected Manor House on the 19 January, the inspection was unannounced.

Manor House is a registered care home for up to 30 older people. At the time of the inspection 27 people were living at Manor House some of whom were living with dementia. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Manor House is an older style property near the centre of Plymouth. Parts of the home had been redecorated and where this had occurred it had been done with regard to people's dementia needs. There were signs to assist people to move around the home independently and bedroom doors were personalised. Some parts of the home were in need of redecoration and we were told

Summary of findings

there were plans in place for this to happen. We found two areas of the home which were unsafe for people. We have made a recommendation about keeping people safe in their environment. We will follow up recommendations at the next inspection.

People told us they felt safe and were happy living at Manor House. One person told us, "I like it here very much. The girls [staff] are wonderful, there's nothing they wouldn't do for me. I'm very happy here, the food is lovely and the activities fun."

Staffing levels were sufficient to meet people's needs. There was a robust recruitment system in place which protected people from the risk of being supported by staff who were unsuitable.

Staff knew the people they supported well and had a good understanding of their needs. We observed staff took account of people's communication preferences and were thoughtful and compassionate in their approach to them. One person told us, "I get on very well with the staff. They couldn't look after me better if I was their own family."

Some people were having their liberty restricted without the proper authorisation as laid down by the Mental Capacity Act (2005) and associated DoLS. The registered manager told us they would address this in the very near future.

People were able to make choices about how and where they spent their time. They told us they went to bed and got up at a time that suited them. People were encouraged to take part in a wide range of activities within the home although there had been no activities outside of the home for some time. There were plans to hire a vehicle which would make this possible in the future.

Care plans held detailed information and guidance for staff on how to support people. However systems to ensure staff were up to date about any changes in people's needs were inconsistent. We saw gaps in night shift notes and the way in which care plans were written and updated meant the most recent information could be difficult to locate.

The registered manager was available for staff, people and relatives if they wanted information or advice. We observed them in the home talking with people and their relatives and noted the conversations were friendly and relaxed.

Staff told us they were well supported and a close team with a mix of skills and experience. Training was thorough and included subject areas specific to the needs of people living at Manor House.

Regular audits took place within the home. These records were reviewed regularly by the provider. This meant any trends were highlighted and could be acted upon.

We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The actions we have asked the provider to take are detailed at the end of the full version of the report.

Summary of findings

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. The environment was not maintained sufficiently to ensure people were always safe.

Risk assessments reflected people's individual needs.

There were sufficient numbers of suitable staff on duty to support people.

Requires Improvement

Is the service effective?

The service was effective. Staff were knowledgeable about people's needs and preferences.

Staff received training which was relevant to the needs of the people they supported.

People had access to a wide range of health care professionals.

Good

Is the service caring?

The service was caring. Staff demonstrated kindness and compassion towards the people living at Manor House.

People's preferred methods of communication were identified and respected.

People's choices about how they spent their time were respected.

Good

Is the service responsive?

The service was not responsive. Systems to ensure staff were aware of people's changing needs were not robust.

People had access to a range of activities in line with their personal interests.

People and relatives told us they were confident any complaints would be acted upon.

Requires Improvement

Is the service well-led?

The service was well-led. The registered manager had a good working knowledge of the day to day running of the service.

People and relatives were asked for their views on the service.

The registered manager ensured they kept up to date with current working practice.

Good

Manor 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 19 January 2015 and was unannounced. The inspection was carried out by one adult social care inspector 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.

We reviewed the Provider Information Return (PIR) and previous inspection reports before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the home including notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we looked at care plans for four people, two staff records and records in relation to the running of the home. We spoke with the registered manager, and three members of staff. We also spoke with nine people who lived at Manor House and five relatives who were visiting. We also contacted three external professionals and obtained their views of the service.

Due to people's health needs we were not able to communicate verbally with everyone to find out their experience of the service. We spent some time observing people in communal areas using the Short Observational Framework Inspection (SOFI) tool. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

On arrival at Manor House we were shown around the home by the registered manager. We saw the home was clean and odour free. There were areas in the building which were in need of updating. For example we saw peeling wallpaper in the downstairs corridor, the decoration in toilets was tired and in need of worn. We saw a domestic cupboard contained a large Belfast sink which was chipped and badly stained. The registered manager told us this was being upgraded to use as a sluice room in the very near future and the maintenance man confirmed they intended to start work on this during the next few days. They explained there was an ongoing programme of maintenance and plans were in place for redecoration throughout the building.

The laundry room door opened immediately onto steep steps. The door was bolted but could easily be opened. The steps presented a falls risk which could have been minimised by putting a lock on the door. At the rear of the building there was a garden which was used by people who wished to smoke. There was a drop of approximately three feet at the end which was not fenced off. This meant people were at risk from falls.

People told us they felt safe living at Manor House. One person told us, "I have no worries." One person had a history of entering other people's bedrooms during the evening. We saw two people had asked to have safety gates put across their doorways in order to prevent this happening. Both had been assessed by the GP as having capacity to make this decision and accompanying risk assessments had been developed.

The provider had policies and procedures in place in respect of safeguarding and all staff had received relevant, up to date training. Staff told us they had no concerns regarding colleagues working practices and if they had would have no hesitation in reporting it to the registered manager. They were confident any concerns would be dealt with appropriately but if they weren't they would know who to report it to outside the organisation.

Care plans contained risk assessments for a variety of circumstances, for example falls and moving and handling, use of portable heaters and use of one person's own high double bed. The registered manager told us risk assessments were developed to keep people safe whilst helping them maintain independence. They said it was about "getting the balance right." We saw new style risk assessments were being introduced for people who self-medicated. These defined the risk and outlined any control measures to minimise risk. They included sections for recording any accompanying best interest meetings. This showed us there was an ongoing attempt to improve the service.

At the time of the inspection Manor House was fully staffed with the exception of one vacancy for a domestic. The registered manager used a dependency tool to decide how many staff were needed at any time. This takes account of the numbers of people being supported and their individual dependency needs. We looked at rotas for the previous week and saw the minimum staffing levels were consistently met at all times. Staff told us they felt there were enough staff although one commented that someone dedicated to doing the laundry would help and give carers more time to spend with people. People told us there were enough staff to support them. Comments included, "Yes, we never go without anything," and, "Staffing levels are pretty good and gaps filled quickly."

There was a robust system in place to help ensure any new employees were suitable to work in the service. This included carrying out pre-employment checks and taking up two references, one being from the most recent employer. The registered manager told us people were also involved in the recruitment process. In the past this had meant people being involved at interview although this was not always possible due to their health needs. People had also helped devise some of the interview questions. Part of the interview process involved a tour of the home which gave the registered manager an opportunity to observe potential employees interacting with people and assess their ability to empathise and communicate with them. People were given the opportunity following one of these tours, to express any opinion they had formed about the candidate. This showed us the registered manager took steps to help ensure people were supported by staff they liked.

There were systems in place for the administration, storage and disposal of medicines. The registered manager told us about a recent medicines error. Since this had occurred they had implemented a new protocol around the administration and use of the specific medicine. Team leaders had also undergone additional training. This

Requires Improvement

Is the service safe?

demonstrated the registered manager responded to incidents by acting proactively in order to minimise the risk of the problem reoccurring. Medicines were administered by the registered and deputy managers, team leaders and four named night staff members. All of these had undertaken the appropriate training to help ensure they were competent.

One person had some of their medicines administered covertly if they refused to take them. This meant they were given them in food and would not know they were taking them. We saw a mental capacity assessment had been carried out followed by a best interest meeting involving the person's relative, psychiatric consultant, pharmacist and the registered manager. Strict guidelines had been drawn up to guide staff on when they could give the medicine covertly and how that should be recorded. We checked the Medicine Administration Records (MAR) and saw this was done correctly.

We recommend that the service seek advice and guidance from a reputable source, about keeping people safe in their environment.

Good

Is the service effective?

Our findings

People were cared for by staff with the appropriate knowledge and skills to support them effectively. Staff spoke about the people they supported knowledgeably and demonstrated a good understanding of their needs and preferences. For example one staff member told us about one person who resisted support. They commented, "You have to approach them with humour and make her feel comfortable." We saw signs around the home which read '[Person's name] this way' under an arrow. The registered manager told us these had helped a person with dementia navigate independently from their room to the dining room. This demonstrated people's individual needs were identified and strategies found to support them effectively. An external professional told us; "Staff are lovely. They know all their idiosyncrasies, who they can have banter with and who they can't." People said they thought staff understood their needs with one commenting, "Staff recognise when I am not well even if I don't."

On starting work at the service new staff underwent an induction period during which they had training in areas identified as necessary by the provider. For example, food hygiene, moving and handling, infection control and fire safety. In addition training specific to the needs of people living at Manor House was provided. This included dementia awareness and end of life care. When asked about the training one member of staff commented, "We get loads and loads!" There was a system of monitoring staff training in place which highlighted when it required updating. Staff were supported by a regular programme of supervisions and yearly appraisals. This gave them an opportunity to discuss working practice issues and identify any training needs with their manager. People and relatives told us they thought staff were competent and well trained. An external professional told us, "The staff that I have worked with appear to be well trained and professional at all times."

We discussed the requirements of the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS) with the registered manager. The MCA provides a legal framework for acting, and making decisions, on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The legislation states it should be assumed that an adult has full capacity to make a decision for themselves unless it can be shown that they have an impairment that affects their decision making. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The registered manager was aware of changes to the legislation following a recent court ruling. This ruling widened the criteria for where someone may be considered to be deprived of their liberty. A DoLS application had been made for one person and a DoLS assessor was organising for an Independent Mental Capacity Advocate (IMCA) to be involved in any decision making on the persons behalf. IMCA's are able to support people who lack the mental capacity to make specific decisions at key points during their lives. Other people living at Manor House were having their liberty restricted without the proper authorisation. For example we saw written in one person's care plan. 'A new gate has been put out the back and a key pad coded door has been put on the front door so that [person's name] is unable to leave the building unattended.' The service was not meeting the requirements of DoLS. We discussed this with the registered manager who assured us they would make applications for most of the people living at the home as soon as they were able.

The registered manager and deputy manager had recently received training around MCA and DoLS. They were booked to have more advanced managers training in this area the month following the inspection.

People told us they could see a doctor when necessary. Other health care professionals such as dentists, chiropodists, opticians, and district nurses visited. A record of appointments was kept in each person's file. The registered manager told us they had good working relationships with external health care professionals and worked with them to improve the service. For example they had worked with the lead nurse at the local surgery to develop a robust system for monitoring people's blood and they had worked with a Parkinson's' nurse to gain a better understanding of the condition.

We looked in the dining room and saw there was a menu on the wall which was for the Christmas and New Year period. The registered manager took this down when we pointed it out. They told us everyone had copies of the menu in their rooms. People were offered a choice of meals and staff helped people to make the choice by showing

Good

Is the service effective?

them the actual meals available. This helped ensure the choice was meaningful to the person. We saw drinks were readily available throughout the day, both in people's bedrooms and in the lounge.

Staff encouraged people to eat healthily. A relative told us, "The staff encourage mum to eat by bringing their own lunch to her room and eating with her." We saw people being supported to eat during the lunch period. Staff sat alongside people who needed encouragement or assistance and engaged with them in a respectful manner.

Good

Is the service caring?

Our findings

People told us they were treated with kindness and compassion. Not everyone was able to verbally communicate with us about their experience of care due to their health needs. Therefore we spent time observing people in a communal are using SOFI. We saw staff were attentive and prompt to respond to people's needs. We saw one person becoming distressed and anxious when their hand started to bleed. A carer quickly and calmly reassured them. Once the person had become less distressed the carer located the person's key worker who treated the cut appropriately and told the person the district nurse was due in to visit so they would ask them to look at it as well. This all took place over a period of five minutes, staff were understated and quiet in their approach whilst ensuring the injury was treated and the person was reassured.

Staff adapted the way they spoke with people according to individual needs. We observed one carer joking with one person and then using signs and simple short sentences to communicate with another. They then chatted to a group and spent a little time reminiscing with them and showing an interest in their memories. This showed they were able to recognise and respond to people's communication needs.

Care records contained information regarding people's emotional and social needs as well as health needs. We saw written in one person's plan, '[Persons name] mood fluctuates throughout the day….staff to monitor mood changes and provide lots of reassurance.' We did not see much detail recorded in respect of people's life histories. These can help staff gain an understanding of what has made people who they are today. We discussed this with the registered manager who told us they had started work on this and were planning to ask relatives to get involved in developing life histories for people. We saw a template for this information had been developed.

Relatives and external professionals were positive about the service provided at Manor House. One professional told us; "They are excellent. I can only give positive comments." Another said, "I consider this to be a safe and caring service." A relative told us; "My [relative] was due to be discharged from hospital at midnight and the hospital staff said they doubted if the home would accept her back at that time. But when I phoned they said they would and sure enough they were waiting on the doorstep to welcome her back to her home here."

People told us staff maintained and promoted their privacy and dignity. For example we were told staff always knocked on bedroom doors before entering and provided care in an unrushed manner. Staff told us they always made sure people consented to any personal care before giving it. We heard staff explain to people what they were going to do and making sure the person was comfortable with it. Everyone had lockable cabinets in their rooms.

People were able to make choices about how and where they spent their time. One person sometimes liked to stay up late and this was recorded in their care records, 'Bed time can be 21:00 or not until after 1:00am.' One person told us, "If I wake up at 3am and can't get back to sleep at 4pm I will ring the bell and ask for a cup of tea which is then brought to me." Another person liked to be involved in basic day to day household chores. The care plan stated, 'Keep involved with the day to day set up of the home, for example setting tables and folding napkins.'

People were given time to make decisions. We heard a member of staff asking if someone wanted to eat in the dining room or their room. They stated, "Have a think and I'll come back in a couple of minutes."

Rooms were decorated to reflect people's personal tastes. People were encouraged to bring personal belongings and furnishings for use in their rooms. Everyone had an option to have a telephone installed in their room to allow them to speak with callers in privacy. There were photographs on the wall showing people taking part in various activities.

The registered manager had started to make improvements to the environment which took into account people's dementia related needs. There were reminiscence pictures on the walls in some areas, for example the dining room and downstairs corridors. People had been encouraged to help choose the colours of their bedroom doors thereby making them more easily recognisable. Reminiscence objects were available for people to pick up and look at. For example an old style telephone and radio. The improvements had not been completed throughout the building.

Relatives told us they were always welcomed in the home. There was a quiet lounge area where people could have

Good

Is the service caring?

privacy with their visitors if they wished. This room was also used by people who wanted to listen to music or read quietly. A selection of books was available. The home also circulated a copy of a daily magazine entitled Daily Chat. This was a reminiscence magazine specifically aimed at people with dementia related conditions.

Requires Improvement

Is the service responsive?

Our findings

In the team leaders room there was a white board with a chart on it which listed every resident and had columns to record information such as whether people needed repositioning during the night and how often, whether food and/or fluid charts were in place, any allergies and whether there were Do Not Resuscitate (DNR) orders in place. However the information on this chart was not up to date and the registered manager confirmed it was not being used. They told us staff were made aware of people's needs and any changes during verbal handovers at the beginning and end of each shift. Information was also recorded in people's notes. One member of staff told us that verbal handovers did not always occur. They said, "They're supposed to but if you come on shift and are waiting around for someone to come and tell you what's happened….well sometimes you just have to get on with your work." They added, "Once the chef told me when someone had died."

We looked at night shift notes in people's care files. These were not consistently recorded. For example in one person's care records we saw between 8 and 30 December daily notes had been made on the 8, 11, 15, 17, 20, 23, 24, 26 and 30 December. This meant that over a period of 23 days there had been 14 days when no notes were taken. Notes had been recorded for another person on 6 December and not again until 26 December. The registered manager told us for people who were on bedroom charts, i.e. closely monitored because of their health care needs, daily notes would be recorded in the records in their rooms. However this only applied to 13 residents.

Care plans were handwritten and reviewed regularly. Any changes to planned care were added to the end of the plan. The handwriting on plans we looked at was small and difficult to decipher in places. There was also a lot of information which had become irrelevant within the main body of the plan. However this was sometimes difficult to identify and meant the reader was required to read through a lot of information before being able to establish which was the most up to date. For example staff had told us one person was having their fluids monitored for a period of time but their condition had improved and this was no longer necessary. The care plan still referred to the need to monitor fluids. We looked through the amendments and additions at the end but could not see any reference to this. Another person's file did not have a plan of care and the registered manager was unable to locate it. One member of staff we spoke with told us they did not "have much to do with care plans." We concluded the systems in place to ensure staff were kept up to date with people's changing care needs were not robust and people were at risk of receiving care that did not meet their needs.

We found there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and relatives told us they would be confident to make a complaint if they needed to do so. They believed any concerns would be taken seriously by the registered manager and acted upon. The home had not received any formal complaints. We discussed with the registered manager some informal complaints we were made aware of during the inspection regarding the day to day running of a specific aspect of the home. They told us the action they had taken in respect of this. We found this to be appropriate and proportionate. The registered manager gave us assurances that the situation was being monitored. People had information folders in their rooms, these contained copies of the complaints policy. Contact details for the provider's quality manager and the Care Quality Commission were included.

The registered manager told us they organised activities on a monthly basis and the whole staff team got involved using their own interests to help facilitate activities. Copies of the activity programme were given to all residents. In addition students from a local college visited the home and supported people with activities. There were weekly and monthly exercise groups, a monthly relaxation class. The home had established links with a local primary school and people from the home attended their fetes and concerts. The children also visited the home. We saw the programme of activities for January which included manicures, bingo, board games, communion, movie matinee and food tasting sessions. The registered manager told us trips out for people had stopped approximately a year ago due to the lack of a mini bus with a tailgate lift. However they had now identified a vehicle for hire and were planning to reintroduce trips out in the coming months. One person told us, "The activities are fun."

Good

Is the service well-led?

Our findings

The home was managed on a day to day basis by the registered manager and deputy manager. People, relatives and staff told us the registered manager was approachable and friendly. One external professional commented, "She's very hands on." Another stated, "Manager is approachable and willing to co-operate." A member of staff told us, "You couldn't fault her." We saw the office door was open for most of the day except when we were discussing matters of a confidential nature.

There was a sister home nearby and the two services had set up a buddy manager system. This included peer support for both registered managers and phone support for staff teams when one registered manager was off work. Administration support was also available form head office.

The registered manager received regular updates about developments in working practices from head office plus information on any available training. They had only had formal supervision once in four years. However they told us they felt well supported and that the operations manager and deputy and the director were all available and accessible. They added, "It's a happy balance. They leave you to manage."

The PIR stated the service had achieved the Dementia Quality Mark. They were regular attendees of the dignity in care homes forum and had participated in Social Care Institution of Excellence (SCIE) pilot scheme for Dementia Care Audit. This demonstrated they were keen to develop and keep up dated with, good working practices.

Staff told us they had a strong staff team with a good mix of skills and experience. One commented, "You've got the young and enthusiastic mixed with experience. There's no tension between the groups." The service ran an employee of the month award scheme. People, relatives and staff voted. Staff meetings were held regularly and staff told us they valued these. As well as giving an opportunity to discuss any individual issues they were used to give feedback from relatives.

The registered manager had introduced a system whereby a team leader and care worker focussed on a specific area including end of life, dignity, continence and pressure ulcers. They attended any conferences or meetings to keep abreast of best working practice and feedback to the rest of the staff team. This was usually done through staff meetings but other creative ways had been used such as developing a poster which contained relevant information and circulating it through the team.

Residents and relatives meetings were held on a monthly basis. The registered manager told us these were opportunities for people to be involved in the running of the home and decision making, for example in respect of any redecoration. They told us they aimed for a "home from home" feel and believed that involving people went some way to achieving this. Not everyone we spoke with said they felt involved with the running of the home with one person commenting, "They do it so well here we don't need to get involved." However one person told us, "The residents and relatives meetings are really useful." Relatives told us they felt they were consulted on any developments and kept fully informed of their family members' health and well-being.

There were clear lines of accountability and responsibility. The registered manager was supported by an assistant manager. There were three team leaders who oversaw care workers and had responsibility for groups of residents. People were also assigned key workers.

Audits were carried out for a variety of areas. For example a Harmful Care Audit was done on a monthly basis. This looked at falls, accidents and incidents, skin integrity, pressure ulcers, weight charts, UTI's, constipation and anyone taking five or more medicines. Data sheets were completed and sent to the operations manager for analysis. Any trends were highlighted and where necessary action plans initiated.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People who use services and others were not protected against the risks associated with receiving treatment that is inappropriate or unsafe because care was not planned in such a way as to meet the service user's individual needs. Regulation 9(1)(b)(i)