Waverley Care Homes Limited

# Manor House Residential Home

## Inspection report

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10 March 2016

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

This inspection took place on 10 March 2016 and was unannounced. At our previous inspection in August 2015 we found that the service required improvement.
The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Manor House Residential Home provides accommodation and personal care for up to 33 people. People who used the service were over 65 years old and have physical and/or mental health diagnoses. At the time of the inspection there were 19 people using the service. The service had recently been placed into administration.

There was a new manager in post who was in the process of applying for their registration with us. The person named on our register as the manager of the service was not the manager and they were not the manager at the last inspection in August 2015. 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.

People were not always protected from the risks of harm and abuse because incidents of possible abuse were not reported as required and action was not taken to protect people.

Risks to people's health and wellbeing were not always identified and managed by staff safely. We found there were not always enough staff available to deliver people's planned care or keep people safe, particularly at night time.

We found that medicines were not administered, managed and monitored in a safe manner to ensure that people got their medicines as prescribed.

The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that issues with the quality of the care were not identified and rectified.

People, relatives and staff did not feel supported by the manager. Staff reported that the manager was unapproachable and they had little confidence that action was being taken in relation to issues raised with them.

People were not supported to make decisions in line with the Mental Capacity Act 2005 (MCA) which meant that their legal and human rights were not protected.

People were not always treated with kindness and compassion and their dignity was not always respected.

Care was not always provided in line with people's preferences and routines within the home were not flexible to meet people's needs and preferences.

Staff were not supported and trained to deliver effective care to people. People had access to healthcare professionals though this was not always sought in a timely manner and professional advice was not always followed.

People had enough to eat and drink and were offered some choices but risks in relation to people's eating and drinking were not always minimised.

People's care plans were not regularly reviewed to ensure they were up to date and reflected changes in people's needs. Staff told us they did not have enough time to read people's care plans.

There was a complaints procedure in place but concerns raised were not always acted upon.

We identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not consistently safe.

People were not always protected from abuse and avoidable harm. People's risks were not always assessed and planned for to ensure people's safety and wellbeing. Staff were not always aware of people's risks. Medicines were not safety managed, monitored and administered to ensure that people received their medicines as prescribed. There were not always enough staff on duty to keep people safe and meet their needs, particularly at night time.

### Is the service effective?

**Inadequate**

The service was not consistently effective.

People's consent was not always sought in line with MCA 2005 and people's liberty was restricted unlawfully. Staff were not supported and trained to effectively support people. People had enough to eat and drink but risks in relation to eating and drinking were not always minimised. People had access to healthcare professionals though professional guidance was not always sought in a timely manner and followed correctly.

### Is the service caring?

**Inadequate**

The service was not consistently caring.

People were not always treated with kindness and compassion and were sometimes spoken to in an abrupt manner. People were not always offered the opportunity and given the support to make their own choices about their care and treatment. People's dignity and privacy was not always respected.

### Is the service responsive?

**Inadequate**

The service was not consistently responsive.

People did not always receive care that reflected their preferences. People were not always supported to follow their interests and engage in activities they chose. There was a complaints procedure in place but concerns raised were not

always acted upon.

## Is the service well-led?

**Inadequate**

The service was not consistently well led.

Quality monitoring systems were not effective in identifying issues and actions were not always taken to improve the quality of the service when issues were identified. The manager was not visible within the home and staff did not feel the manager was approachable.

# Manor House Residential Home

**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 was 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 10 March 2016 and was unannounced. The inspection team consisted of two inspectors.

We looked at information we held about the service including information from commissioners of the service and members of the public. We received information of concern about the safety of the care provided and the management of the service and this meant that we bought our planned inspection forward.

We spoke with six people who used the service and two relatives. Not everyone who used the service was able to talk to us about their experiences so we spent time observing how care and support was offered to people in communal areas.

We spoke with three members of care staff, the manager and the unit manager. We looked at seven people's care records to see if they were accurate and up to date. We also looked at records in relation to the management of the service. These included quality checks, two staff recruitment files and other documents to help us to see how care was being delivered, monitored and maintained.

Inadequate

# Is the service safe?

## Our findings

People were not always protected from avoidable harm and abuse. We saw that incidents of potential abuse were not always reported to the local authority in line with local safeguarding adult's procedures. Staff told us about one person who used the service, whose behaviour could be inappropriate towards staff and other people who used the service. They told us about an occasion when the person had touched another person's leg without their consent. This was not recorded or reported to the local authority. Though staff were able to tell us about the different types of abuse that may occur and how they would report concerns, this incident had not been recognised as potential abuse or reported to the local authority for further investigation. No action had been taken to protect the person from abuse and improper treatment. We saw an incident recorded when one person was verbally abusive to another person who used the service. This was not recognised as potential abuse and no action was taken to protect people who used the service.

One person told us they did not always feel safe when staff supported them to move. They said, "I don't always feel safe when they put me in the bath. I've got bad legs, I fell off the bath chair onto the floor and it hurt me." We saw that this incident had been recorded but there had been no investigation into why this incident occurred and no plans to reduce the risks of a similar incident occurring again.

The above evidence demonstrates that people were not consistently protected from potential abuse and improper treatment. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks were not always assessed, planned for and monitored to ensure people's safety and wellbeing. We saw that one person, who was at risk of choking, started to choke on their meal at lunch time. Staff attended and supported the person to transfer to a wheelchair and took them from the dining room. The person was given a bowl and left unattended in the lounge where they were still at significant risk of choking. Staff told us they pat the person on the back when this happens and that they have had no further guidance or training on how to support the person when choking or being sick when eating, though this happened regularly. Records showed that there were no specific plans or guidance for staff to follow when this occurred. This meant that the person's risks were not suitably planned for to keep them safe and staff were not provided with the skills and competence to safely manage their risks.

We found that one person had a urinary catheter in place to help them empty their bladder. Staff told us about this and that they support the person with hygiene and monitoring of their catheter. When we looked at the person's records, we saw that there was no care plan or risk assessment in place in relation to the catheter and no guidance on how staff should support the person with catheter care to ensure their care was safe and appropriate. Staff had not receiving any training in relation to catheter care. This meant that the person was at risk of receiving unsafe care.

Some people who used the service were at high risk of developing pressure sores due to poor skin integrity. One person had a risk assessment and plan in place that said they were at high risk of developing pressure sores and should be sat on a pressure relieving cushion to reduce the risks of damage to their skin. We saw

that they were not seated on this. When we asked staff about this, they told us they were unsure whether the person needed a specialist cushion and they thought that it had possibly been left in another area of the home. This showed that staff were unware of people's risks and plans in place to manage the risks. We saw that the person was still not sat on the appropriate cushion following our discussions with a staff member so actions had not been taken to reduce the person's risk.

We found that one person was at risk of falls. They had a risk assessment and care plan in place though this had not been updated since August 2015, despite the person falling more recently, including one fall in February 2016. The person's care plan stated that their walking stick should be within reach. We did not see the person with their walking stick. Staff did not know they had or needed a walking stick. The person, who was living with dementia, told us they did have a stick but did not know where it was. We saw that there were no additional measures put into place to minimise the person's risk of falls, despite them continuing to fall.

Medicines were not always managed so that people received them safely. We observed staff handling medicines without wearing gloves and putting tablets out on the table for people to take. We saw that there were gaps in medicines administration records which staff were unable to explain so staff were unable to be sure that people were receiving their prescribed medicines. We checked stocks of medicines which did not correspond with records kept by staff. Some medicines were not present and unaccounted for. This meant there was a risk that people were receiving too little or too much of their prescribed medicines. We saw that some medicines checks were completed by the unit manager in January and March 2016 and these checks identified some but not all of the issues. The checks identified that there were gaps in medicines administration records but no action had been taken to improve the safety of the management of medicines.

The above evidence demonstrates that people did not always receive safe care. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff on duty to keep people safe and meet people's needs, particularly at night time. We spoke with one person who used the service and they were upset because they had been told they could not go to the toilet during the night time because there was not enough staff. They said, "It's not good, I get very upset, I had to go in the bed, it's not nice for me." A staff member said, "We've been so short staffed." Another staff member said, "There have been times when there have only been two care assistants on and no senior staff member." The manager told us they felt that there was adequate staff to meet people's needs though the dependency levels in the home had not been reviewed since January 2016 despite two new people with complex needs being admitted to the home. They told us that they were aware of one occasion when the home had been short staffed at night time. However, staff told us and the roster book showed a number of occasions when only two night staff were on duty. The unit manager told us that there should be three staff at night time to ensure people's safety because some people needed two staff to support with personal care and moving during the night time. A relative told us that their family member had falls at night time as they would often be awake and walking during the night. They told us they had raised concerns with the manager during a relatives meeting but that nothing had been done. We saw records that showed that people had fallen when the home had been short staffed during the night time.

One person had a pressure area to their sacrum that was being treated by the district nurse. The district nurse advised that the person needed support to relieve their pressure areas every two hours. We saw that during one night, staff documented that they were unable to support the person every two hours due to there not being enough staff to meet all of the people's needs. This meant that the person's risk management plan was not being followed and there was a risk of further skin breakdown.

The above evidence demonstrates that there were not always sufficient staff deployed to meet people's needs. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service effective?

## Our findings

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's mental capacity to make their own decisions was not assessed when required. We spoke with one person and saw that they had some difficulties in making their own decisions. Their records showed a blank form entitled, "Capacity to consent to planned care". Their mental capacity had not been assessed in line with the MCA and staff had no guidance on how best to support them to be involved in decision making. We saw that people's consent to care and support was not always recorded in their care plans when they were able to give consent. Some staff we spoke with did not understand their responsibilities under the MCA and one staff member told us they had not completed the online training offered as they had not had time. This meant there was a risk that people's legal and human rights were not respected.

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). The unit manager told us that two people had a DoLS authorisation in place and one other person had a pending application. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that one person had a condition on their authorisation which stated they should be offered the opportunity to spend time in their room as this was something they enjoyed and would lessen the restriction placed upon them. Staff we spoke with, including the manager were unaware of this condition. We saw that the person was not offered the opportunity to spend time in their room which was on the top floor. This meant that the condition of the DoLS authorisation was not being met and the service was not complying with the MCA.

The above evidence demonstrates that consent was not always sought in line with MCA and people's liberty was restricted unlawfully. This was a breach of Regulations 11 and 13(5) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's health needs were not always monitored and referred to relevant health professionals when their needs changed. We saw that one person looked unwell on the day of the inspection and we heard them tell staff they felt unwell. Care staff told us that the person had seen the doctor the previous day, though care staff felt their condition had changed during the morning. They told us they had reported this to the senior staff member but that they had not responded to the person's deteriorating condition. The senior staff member told us that the person had seen the doctor the previous day and was prescribed anti-biotics. However, further medical advice had not been sought after care staff reported that the person's condition had changed and they were continuing to complain of feeling unwell. We heard the senior staff member tell the person that they needed 'to wait for the anti-biotics to start working'. No further medical attention was sought despite the person's condition changing.

We saw in people's records that they had input from professionals including occupational therapists, doctors and district nurses. However, the advice given by professionals was not always followed. We saw that a district nurse had advised that one person required staff to support to help them to move every two hours to relieve their pressures areas and we saw that this was not always carried out as there were not enough staff. We saw that a Speech and Language Therapist (SALT) gave advice on one person's drinks that staff did not follow. This meant that people's care was not always appropriate and did not always meet their assessed needs.

Some people had complex needs relating to their eating and drinking. We saw that one person was at risk of choking and had input and advice from a SALT. Records showed that the SALT advised, "thickened fluids, thin syrup." We saw the person's drinks looked very thick and asked staff how they knew what consistency the person's drinks should be. The staff member said, "We just give what we think until its thick enough, we don't measure it, we don't get enough time to read the care plans." This meant that staff were not following the risk management plan in relation to the person's eating and drinking and not providing appropriate care to meet their needs.

The above evidence demonstrates that care was not always appropriate and did not always meet people's needs. This contributed to a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people were offered some choices of food and drinks. At breakfast time we saw that people were offered choices of drinks, porridge and toast and were asked if they had had enough or would like any more to eat. One person said, "I enjoy it, everyone does." However, staff told us that the quality of the food for people was not always good. One staff member said, "The meals are disgusting some days, they're greasy or overcooked, the vegetables are like mush." Meals were prepared in the kitchen at the neighbouring service and the majority of food and drinks were kept there. This meant that people's choices of food were sometimes restricted because a variety of food and drink was not readily available at the service. We saw that jam sponge and custard was offered for the lunch time desert and when one person did not want this, they were offered an alternative of "just custard" which they reluctantly accepted. However, another staff member then offered to go to the neighbouring service and collect some yogurts so that people could have a choice. A choice of food and drink was not bought over from the neighbouring service as standard.

People did not always receive effective care from staff who had the knowledge and support to carry out their roles. Staff told us that they received online training but some staff said they had not had time to complete their refresher training which meant there were gaps in their knowledge. Some people who used the service had learning disabilities. Staff told us they had not received any training or guidance on how best to support people who have learning disabilities. We saw that some people displayed behaviours which may challenge staff and they had not received training in how to best manage these behaviours.

Staff told us they had supervision with the unit manager; however they did not feel this was useful or effective. One staff member said, "There's no point, there is no support available." Another staff member said, "The unit manager is nice enough but nothing is kept confidential and nothing gets done." We looked at supervision records that showed that staff supervision records were not up to date and staff had not received the regular supervision they required. Staff did not receive effective support and supervision.

Inadequate

# Is the service caring?

## Our findings

We saw that people were not always treated with kindness and compassion in their day to day care and they were not always spoken to with respect. We saw that one person was using a sauce sachet to pick meat from their teeth at lunch time. A member of staff took it from them stating, "You can't have that." When the person tried to get up to go and find something else to use, the member of staff responded, "Where are you going? Sit down." The person said, "But I've still got meat in my teeth." The member of staff said, "Well sit down and wait for your pudding."

We observed that people who used the service were not always spoken to with dignity and respect. For example, when supporting one person to take their medicines, we heard the staff member say, "Open your mouth, let me do it." This was said in an abrupt manner in front of other people who used the service and staff members, resulting in the person not being treated with dignity and respect.

People's privacy and dignity was not always respected and promoted. One relative said, "I think a lack of training may affect dignity, jokes made by staff can sometimes feel a bit inappropriate." One person was very upset because they were told to urinate in their continence pad during the night time when there were not enough staff to support to them to the toilet. They told us, "It's not good, I get very upset and I had to go in the bed, it's not nice for me. I was told to do it in my pad but I don't want to, it's horrible and it's not right." The person's dignity, privacy and independence were not respected.

The above evidence demonstrates that people were not treated with dignity and respect. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to be actively involved in making choices about their care. We saw that people were being offered choices of their lunch and tea time food during the morning. However, we discovered that the choices offered to them were for the next day's lunch and tea time. At lunch time, people's choice from the day before was placed in front of them with no reminder of what they had chosen. Many of the people who used the service had some memory difficulty and this process did not enable them to make a valid choice as they had to order in advance. We saw that one person said they did not fancy their lunch and asked for a sandwich. The staff member responded with, "Jam, that's all I've got" and we saw the person was given a jam sandwich.

We saw that some staff knew people well and staff told us that this is something they developed over time with getting to know the person because they did not have time to read their care plans. However, we saw that people were often not offered choice because staff assumed they knew what they liked. For example, we saw that one person was only given carrots to accompany their main meal and was not given other vegetables that other people were given. Staff told us this was because they only ever ate the carrots. We saw that staff asked the kitchen assistant to make a sandwich for a person, one staff member asked for white bread and the other staff member asked for brown bread because they both thought they knew the person's preference, yet no-one actually asked the person what they would like.

We observed some kind and caring interactions between staff and people who used the service. We saw that one person was upset because they had an accident during the night time. We saw that three care staff and the unit manager all responded to the person separately, all offering reassurance and putting the person at ease. We saw that some staff put their arm around the person which made them smile.

Inadequate

# Is the service responsive?

## Our findings

People did not always receive personalised care that was responsive to their needs. We saw that one person asked to be supported to go to their bedroom and lie down. A member of staff told them they were unable to do that because there were workmen upstairs. We saw that workmen were present in the upstairs lounge but not in people's bedrooms and this should not have restricted people's access to their bedrooms. The person was prevented from accessing their bedroom to lie down at their request. Staff told us that people are often all brought downstairs to the ground floor lounge because it was easier for staff to supervise people on one floor. A person who used the service said, "I normally go in the lounge, I go where I am put." This meant that people were not supported to spend their time how and where they would like.

We found that routines within the home were not flexible to meet people's individual needs and preferences. We saw one person, who was sat at the dining table with other people who were eating lunch, ask a staff member if they could have their lunch next. The staff member told them, "We have to go down the list so you'll have to wait a bit." The person had to wait for their lunch which was being served at the convenience of the staff and not by the preference or needs of the people who used the service. We saw another person ask staff if they could be supported to move from the dining room to the lounge. The person was told by a staff member that they had to wait in the dining room until they had been given their medication. The person had to wait for 15 minutes before they were supported to move as requested because the medication administration system was prioritised over the needs and preferences of the person.

We saw there was a 'bath rota' on the wall in the office. We asked staff how this worked. A senior staff member told us that people were allocated a specific day once per week when they could have a bath, this helped staff to manage their workload and ensure that each person had a weekly bath. The senior staff member confirmed the bath rota did not take into account people's preferences, or whether they would prefer to have more than one bath or shower per week. The senior staff member told us that people would be offered an additional bath if they had continence needs but they could not always accommodate people's preferences. We saw that people who were down on the rota to receive a bath on the day of the inspection, were offered a bath.

People's care records were not up to date and reflective of their current care needs. Care plans were not being regularly reviewed to ensure they were still relevant. Staff told us that they did not have time to read the care plans but relied on talking to people and other staff for information to be passed onto them about any changing needs. This put people at risk of receiving care that was not appropriate.

The above evidence demonstrates that care was not person centred and did not reflect people's preferences. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to follow their interests and take part in activities they chose. Some people and a relative told us that the activities coordinator was "good". However, we observed the activity

co-ordinator spent only one hour in the home during day. This hour was during the time that people were eating their breakfast so they spent time talking to one group of people whilst they ate. The activities coordinator told us that they also worked at the neighbouring service and this was where the majority of their time was spent. They told us there was another activities coordinator who was not working on the day of the inspection. We saw that one person was offered the opportunity to go to the neighbouring service and participate in activities. Other people remained in the lounge where the television was on. We asked one person what they were watching and they told us, "I haven't a clue, it's just someone talking." Some people fell asleep in their chairs and others looked around. People were not engaged in any activity and the lounge was often unsupervised.

There was a complaints procedure though it was not always followed to ensure that concerns were logged, investigated and acted upon. One person told us they would speak to the care staff if they had any complaints. The manager told us they had not received any complaints and there were no complaints currently being investigated. A relative told us that the unit manager would aim to address any issues but that they had raised concern to the manager during a residents' and relatives' meeting and the manager had said they would look in to the issue. The relative was not happy with the response they had received from the manager but the manager had not logged the concern as a complaint. The relative had raised concern about the lack of staff of night time and we saw and staff told us that this continued to be an issue, which meant the concern had not been acted upon.

Inadequate

# Is the service well-led?

## Our findings

Quality monitoring systems were not effective so the manager was unable to identify areas for improvement and act upon these. We asked to see the quality monitoring systems that were in place and the manager told us they were kept in the office at Manor House Residential Home. The manager based themselves at a neighbouring service so they were not present in the service for the majority of the time. The senior staff member showed us audits that were completed at the service and these consisted of weekly medicines audits. We found that no medicines audits had been completed in February 2016. Some had been completed in January and March 2016 which identified some, but not all of the issues we found with medicines during the inspection. Audits completed in January found some issues and the unit manager had recorded that they were awaiting a staff meeting to discuss the documentation of medicines. We saw that one staff meeting had taken place and medicines documentation had not been discussed. We asked the manager why this had not been discussed and they told us they were unaware of the issues with medicines and had not been made aware by the unit manager. The manager had not completed or viewed any audits in relation to Manor House Residential Home so did not have an overview or understanding of the issues.

We found that the care records we viewed were out of date, some were contradictory and some did not reflect the needs of people. We found that where people's needs had changed the records had not been updated. For example, some people had experienced falls recently but their falls care plans and risk assessments had not been updated. One person exhibited behaviour that was inappropriate and they did not have a care plan in place. Another person had a catheter they also did not have a care plan in place. The unit manager told us that care plans were not up to date and this was because new paperwork had been introduced by the manager but staff were not given the time or support to update the records. We saw a file entitled 'care plan audits' but this was empty. There was not an effective system in place to monitor or review the care records to ensure that they were accurate and reflected people's needs.

The manager told us they analysed accident and injury records monthly and we saw they had started to complete some analysis. However, no actions were taken to reduce risks. We saw that one person had been found on the floor three times in February 2016 and no plans were in place to minimise the risks to them despite the manager telling us they completed an analysis of accidents and injuries. The manager was not aware of the incidents we identified that required reporting to the local authority under safeguarding adult's procedures. They told us this was because they had not yet started the analysis for that months incident records. This meant that systems were not effective in assessing monitoring and mitigating risks to people who use the service because these issues were not identified and acted upon in a timely manner.

People were not asked for their feedback about the quality of the care they received. One relative told us they completed a survey some time ago but had never heard any response or follow up on issues raised. The manager told us that feedback from people and relatives had not been requested in the time they had been the manager, which was approximately three months because they had been prioritising other areas which required attention.

People, relatives and staff did not feel supported by the management. Staff reported that the manager was

unapproachable and had failed to act on concerns that had been raised to them. One staff member told us that a person who used the service was often inappropriate towards staff members but they did not always report it because they were not confident that their concerns would be acted upon. They said, "There's no point reporting it, the senior staff just think it is cute and the managers don't do anything about it." We observed this on the day of the inspection.

Staff told us that the manager and unit manager were not visible or effective in their roles. One staff member said, "The managers are never on the floor to help us or see what it's like." Another staff member said, "We don't see the manager much. They say you can tell them anything but they are not approachable, they can be rude to you." We saw that incidents were going unreported because of a lack of staff confidence in the management to listen to them and support them.
The manager did not have an understanding of the issues at Manor House Residential Home and was unaware of many of the issues identified during the inspection. The manager did not spend enough time at the service or complete appropriate audits of care provided and staff stated that they were not listened to. This meant that staff felt unable to report concerns and that issues would go unidentified which impacted upon people's care and wellbeing.

The above evidence demonstrates that systems and process were not established or operated effectively to ensure that people received a good quality and safe service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.