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Manchester House Nursing Home

Inspection report

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29 November 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Located near Southport town centre, Manchester House is registered to provide accommodation and nursing care for up to 67 older people and younger adults with a physical disability. Shared areas include two dining rooms and three lounges on the ground floor. A lift is available for access to the upper floor. There is an enclosed garden to the front and rear of the building. A call system operates throughout the home. The home is situated opposite Hesketh Park and is within easy reach of Southport promenade.

This was an unannounced inspection which took place over four days on 24 to 25 October and 28 and 29 November 2016. The service was last inspected in April 2016 when we found four breaches of regulations. The service was rated as 'Requires Improvement'.

During the inspection we found breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment, person centred care, consent to care and treatment and good governance. Two of these, person centred care and consent to treatment, where continued breaches of regulations from the last inspection in April 2016.

Following the first two days of the inspection we found the seriousness of the breaches of regulations to pose a 'high' risk to people living at Manchester House. We used our enforcement procedures and served an urgent notice telling the provider to take action to put things right. The notice also told the provider to not admit any more people to the home until the areas of risk we identified had been addressed. We visited again on 28 and 29 November 2016 to complete a full inspection and check to ensure people were safe.

We found that the provider had made improvements to reduce the risk to people living at the home. This report and outcome is based on the evidence we found over the four days of the inspection.

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.

We found not all medicines were administered safely. We found concerns around the way some medicines such as creams, medicines for pain relief and thickeners added to drinks were administered and recorded which placed people at risk.

We found that some people's risks regarding their health care were not being adequately assessed and monitored. This was in relation to wound care, pressure ulcer monitoring, accident recording and following up on medical recommendations.

We found people's written care plans did not contain accurate, up to date information and had not been reviewed in good time. This had been a breach at our last inspection and was still not met.

We found that when people were unable to consent, the principles of the Mental Capacity Act 2005 were not always followed.

Some of the systems for auditing the quality of the service needed further development and did not provide adequate monitoring of standards in the home.
We found the management structure was not clear and did not support the home with clear lines of accountability and responsibility.

Although these findings were addressed in the short term following the Notice we served and the risk to people reduced, we continue to have concerns regarding the sustainability of standards and will therefore continue to monitor the service closely.
You can see what action we took with the provider at the back of the full version of the report.

We found there was not always enough staff on duty at all times to help ensure people's care needs were consistently met. This was in relation to nurse cover during the evenings. The provider listened to our concerns and allocated nurse cover for this period. When we asked people about the staffing in the home they told us they felt there was generally enough staff to meet their care needs.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people; this had been a breach at the last inspection. We saw checks had been made so that staff employed were 'fit' to work with vulnerable people. This breach had been met.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report any concerns they had.

Prior to the inspection, we were informed of a number of safeguarding matters, where concerns had been raised. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. The overall reviews of these matters had not been concluded at the time of our visit and therefore we are unable to comment on the findings in this report.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed where obvious hazards were identified. Planned development / maintenance was assessed so that people were living in a comfortable environment. We discussed with the acting manager some further improvements for consideration.

We observed staff interacting with the people they supported. We saw how staff communicated and supported people. People we spoke with and their relatives told us staff had the skills and approach needed to ensure people were receiving the right care.

There were two people who were being supported on a Deprivation of Liberty [DoLS] authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The registered manager had also applied for another 26 people to be assessed; we found these were being monitored by the registered manager of the home.

We saw people's dietary needs were managed with reference to individual preferences and choice.

Most people we spoke with said they were happy living at Manchester House. They spoke about the nursing and care staff positively. When we observed staff interacting with people living at the home they showed a caring nature with appropriate interventions to support people.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

Activities were organised in the home. The activities team were motivated to provide meaningful activities.

We discussed the use of advocacy for people. There was some information available in the home regarding local advocacy services if people required these. The activities staff were also responsible for linking in when needed and referring people through the advocacy service if needed.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We saw there were good records of complaints made and the registered manager had provided a response to these.

The registered manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

The rating for the key questions 'Is the service safe?' and 'Is the service well led' are 'inadequate'. This means that the service has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Not all medicines were administered safely. We found concerns around the way some medicines were administered and recorded which placed people at risk.

We found that some people's risks regarding their health care were not being adequately assessed and monitored. This was in relation to wound care, pressure ulcer monitoring, accident recording and following up on medical recommendations.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

There were enough staff on duty to help ensure people's care needs were consistently met.

Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

There was adequate monitoring of the environment to ensure it was safe and well maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

When people were unable to consent, the principles of the Mental Capacity Act 2005 were not always followed in that an assessment of the person's mental capacity was not made.

We found the home did not always support people to provide effective outcomes for their health and wellbeing.

We saw people's dietary needs were managed with reference to individual preferences and choice.
Staff said they were supported through induction, appraisal and the home's training programme.

Is the service caring?

Good

The service was caring.

When interacting with people staff showed a caring nature with appropriate interventions to support people.

People told us their privacy was respected and staff were careful to ensure peoples dignity was maintained.

There were opportunities for people to provide feedback and get involved in their care and the running of the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans had not been revised and updated and did not contain details of some aspects of care; they did not evidence an individual approach to care.

There were some activities planned and agreed for people living in the home.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain. Complaints made had been addressed.

Is the service well-led?

Inadequate

The service was not well led.

There was a registered manager in post who provided a lead for the home.

Some of the systems for auditing the quality of the service needed further development and did not provide adequate monitoring of standards in the home.

We found the management structure was not clear and did not support the home with clear lines of accountability and responsibility.

There were some systems in place to get feedback from people so that the service could be developed with respect to their needs and wishes.

Manchester House Nursing 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 checked 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 was an unannounced inspection which took place over four days. The inspection team consisted of two adult social care inspectors and '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 were able to access and review some provision information we held about the service and this included reviewing the action plan sent to us by the provider following the previous inspection in April 2016.

During the visit we were able to meet and speak with 12 of the people who were staying at the home. We spoke with five visiting family members. As part of the inspection we also spoke with, and received feedback from health care professionals who were visiting the home or who had knowledge of the home and who were able to give us some information regarding how the service supported people.

We spoke with the registered manager and 13 of the staff working at Manchester House including nursing staff, care/support staff, kitchen staff, domestic staff, maintenance staff and senior managers. We also spoke briefly with the providers [owners] of the home. When we returned to the home for our second visit the registered manager was not available and a senior manager was the acting manager for the service.

We looked at the care records for ten of the people staying at the home including medication records, three staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits including feedback from people living at the home and relatives. We undertook general observations and looked round the home, including people's bedrooms, bathrooms and

the dining/lounge areas.

Inadequate

Is the service safe?

Our findings

We reviewed the way medicines were managed and administered. We found some areas of concern that needed to improve to ensure medicines where administered safely.

We found there was poor or inconsistent recording of external preparations such as cream. For one person a relative informed us that staff "regularly forgot to apply cream" to maintain their relatives skin integrity. We were told the person had attended for a hospital check the week before and had been found, on examination, to have skin that was "red and sore".

We saw the chart in the person's bedroom used to record administration of the cream was not completed. A staff member stated cream was applied the morning of inspection but this had not been recorded. When we looked at the person care records we found poor reference to the person's skin care; the care plan did not mention the importance of applying creams for skin integrity. This Issue had been identified on a recent audit carried out but there had been no action to improve the situation.

If creams are not accurately recorded nursing staff cannot accurately ascertain when they have been applied and evaluate their effectiveness. This exposed people to the risk of harm and neglect of their care and treatment needs.

We found there was a lack of recording when people had been given drinks that required 'thickening' following assessed risks due to difficulties with swallowing with associated risks of choking and aspiration. By giving such people fluids which are not thickened there is a risk of choking and / or aspiration. This exposed people to the serious risk of harm – in terms of choking/death and injury.

We saw thickeners made up from communal tins in the kitchen. There were nine people prescribed thickeners and these should be recorded as administered by staff. We looked at the recording for three people and found they did not record thickeners given to fluids at all or were very sporadic. It was not possible to see if these people had received their fluids safely.

For example, we were particularly concerned about one person. We were told by the acting manager at the time of the inspection that the person was refusing to have prescribed thickeners when taking fluids. This was a concern as there was a risk of choking. The acting manager stated it was important that staff recorded on the fluid chart each time fluids were given and whether thickeners were also given. We saw the fluid chart for the person and there was inconsistent recording for this when fluids were given. It was not always clear when thickener had been refused.

Accurate recording is importance so that health care professionals can carry out a more thorough review to help assess the efficacy of the treatment plan.

We found the times when people received pain relief from paracetamol and codeine were not recorded. This is important regarding as these medicines given before these times can increase toxicity and cause liver

damage in elderly people. The medication records (MAR's) seen had a box to record the times but only recorded 'T' and 'B' [tea and breakfast times] which was not accurate enough.

Again, this issue had been identified on a recent audit by staff but practice had not been stopped and times when pain relief had been given were not recorded.

We found these concerns, on the first two days of the inspection, to be 'high' risk and we issued the provider with an urgent notice to make improvements. When we returned on the second two days of the inspection we found there had been improvement s and people were safe. We will continue to monitor the service to ensure safe standards are maintained.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we returned to Manchester House for the second part of our inspection we reviewed the management of medicines. Prior to the second part of our inspection we received copy of the CCGs medicine management controlled drugs audit and care homes medicines management checklist which had been undertaken of the service in November 2016. This provided us with a detailed over view of how medicines were being managed at the home. Recommendations made from both documents had been taken on board by the management team to help assure the safe management of medicines.

A medication policy was in place to support staff practice and we saw medicines were administered safely to people. Staff responsible for administering medicines had attended medicine training and competency checks to assess their practice for administering medicines had been checked. This helped to ensure staff had the knowledge and skills to administer medicine safely to people. The acting manager informed us that a member of the nursing team had protected time for overseeing the ordering and checking in of medicines each month. Staff informed us this protected time was working well and helping to assure the safe management of the medicines in the care home.

Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation. We saw controlled drugs were stored appropriately and records showed they were checked and administered by two staff members. We checked a number of medicines, including a controlled medicine and found the stock balances to be correct.

We found medicines to be stored safely when not in use. Some medicines need to be stored under certain conditions, such as in a medicine fridge, which ensures their quality is maintained. If not stored at the correct temperature they may not work correctly. The temperature of the drug fridge was recorded daily. This helped to ensure the medicines stored in this fridge were safe to use.

People had a plan of care which set out their support needs for their medicines, including 'as required' (PRN) medicines. We checked twelve medicine administration records (MARs) and found staff had signed to say they had administered the medicines. Records were clear to follow and we were able to track whether people had been administered as prescribed. This included the use of topical preparations (creams), thickening agents added to drinks for people who had difficulty swallowing and were at risk of choking and meal replacement drinks. Meal replacement drinks are prescribed for people when they have lost weight and are not eating. With regards to the application of creams, a body map recorded the areas of the body the cream was to be applied to.

We received some concerns prior to inspection regarding the care of two people living at the home. One

followed the admission of a person to hospital. The hospital had raised concerns around the person's care at Manchester House which included attention to weight loss and wound care. For the second person there were concerns around management of pressure ulcers.

We reviewed 30 people in the home with regard to how their weights were monitored. Weights were monitored monthly. We saw one person had 2.6 kg wt. loss over 3 months from Feb-May 2016. This was not fed into the person's nutritional ratings assessment, however, and no assessment had been recorded since June 2016. The person's care plan had been last reviewed in June 2016. Given recorded weight loss over three month period we would have expected this to be reflected in the care plan at the time and on-going. This lack of monitoring exposed the person to the risk of harm and neglect.

We followed up concerns for one person which were raised with us prior to inspection regarding management of pressure ulcers and wound care. We were told that the person had been admitted to Manchester House with pressure sores in March 2016; this was recorded on the care plan. We found poor records regarding wound care which meant it was very difficult to track and review. The wound care chart was inadequate. A wound dressing was identified and staff stated that the wound should be dressed every 2-3 days. There was no frequency of dressings recorded on the wound care chart or measurements of the wounds or the current condition of the wounds.

We saw a daily record (recorded on the wound care chart) indicating the dressing was last changed on 7 October 2016. A nurse told us they had redressed the wound on 19 October 2016 however they had not recorded this. There was no review of the wound recorded. This meant it was not possible to objectively assess the condition of the wound. This exposed the person to the risk of harm or actual harm.

The 'All care chart' for the person dated 20 - 24 October 2016 records positional change every four hours; this was not the same as the care plan dated March 2016 which said two hourly. Change of position was recorded during the day but there was no record of these positional changes at night. Positional changes were recorded under 'fluid and diet intake'. There was no record of the condition of the person's skin during these position changes which would have been best practice in monitoring skin integrity.

Following our feedback the acting manager instigated full wound care chart and updated the care plan. It is of concern to the Commission that if their inspection findings had not drawn this to the acting manager's attention poor practice may have continued, exposing the person to further risk of harm and neglect.

We found similar concerns when we reviewed the care of another person who was in need of wound care. The recording of the wound and treatment for this person was also confusing. The person was placed at risk as management was inconsistent and poorly planned and recorded. It was difficult to ascertain the stage of the wound and the current treatment.

We found other areas of assessment of clinical risk for people to be inadequate.

For example, one person told us they had 'deteriorated' over a period of time in the home. This included their mobility. The person told us they used to walk 'a few paces' but now couldn't. We tried to track this through the care records and saw that the person's assessment of moving and handling had not been reviewed since April 2016. It was not clear whether the assessment met current care needs. The registered manager stated that all moving and handling assessments should be completed monthly.

In another example had an entry in the 'relative communication' sheet recording an episode of vomiting with 'acute abdominal pain, blood in vomit, blood in stools – barrier nursing'. The person had been seen by

the GP who requested specimens for investigation; there was no evidence to support if these specimens were obtained. The nurse we spoke with could not tell us. This could expose the person to possible harm as medical investigations ordered by the GP had possibly not been followed through causing delay in any medical treatment which may have been required.

We found an entry, for one person, in the daily evaluation record from night time which evidenced an accident had occurred for the person. Staff could not locate any accident record completed for this. This meant this event could not be evaluated in the context of the overall risk of falls for the person. This exposed the person to the risk of harm and disregard for their care and treatment needs, as it was not clear what observations were carried out, or consideration made for timely medical attention.

We found these concerns, on the first two days of the inspection, to be 'high' risk and we issued the provider with an urgent notice to make improvements. When new returned on the second two days of the inspection we found there had been improvement s and people were safe. We will continue to monitor the service to ensure safe standards are maintained.

These finding were a breach of Regulation 12 (1) (g) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people whether they felt safe in the home. People we spoke with told us they generally felt safe. One person said, "The staff keep you safe, yes." This person was able to describe the security locks on the front door. A further two people commented, "I feel safe on the whole – yes" and "Yes, I've no problem with that."

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the local contact numbers for the local authority safeguarding team were available.

Prior to the inspection, we were informed of some safeguarding matters, where concerns had been raised. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. The overall reviews of these matters had not been concluded at the time of our visit and therefore we are unable to comment fully on the findings in this report.

We checked to see if there was enough staff on duty to carry out care. There were mixed responses from people; "No – because of the people in wheelchairs and in rooms, who never come out. They're [the staff] running to one then to another. I know they can't help it. I'm not sure about at weekends as well", "I don't know any different – it's been all right up to now", "Sometimes I think not" and "Day, yes. Night, no. They're a skeleton crew [at night] and they've still got as much to do – suppers, getting people up to bed, turning people two to four hourly. They need nearly as many at night as in the day and they haven't got them."

From the observations we made we saw that people's personal care needs were attended to. Staff we spoke with said there was generally enough staff to support people's personal care needs on a daily basis if all staff on the rota were present. The acting manager showed us the home's staffing / dependency tool that was used regularly to indicate if there was enough staff; we saw this showed the home was appropriately staffed.

We discussed with the nursing staff the failings around the assessment and updating of nursing care for people. All of the nurses we spoke with said it was difficult to complete on-going assessments of care because of the daily workload and felt more time was needed. A health care professional we spoke with told us the one concern they had was the lack of nursing staff during the evening to monitor nursing care. We discussed these comments with the acting manager and provider. Following the inspection we were advised that nurse staffing arrangements had been reviewed and there was now and minimum of three nurse's on duty 8am – 8 pm.

At the last inspection in April 2016 we found the home in breach of regulations with regards to recruitment of staff. We checked, on this inspection, how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at three staff files and asked the acting manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people. This was an improvement from the previous inspection and the breach had been met.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed where obvious hazards were identified. Any repairs that were discovered were reported for maintenance and the area needing repair made as safe as possible. We conducted a tour of the home and highlighted some examples of environmental hazards. This included damage to the door frame of one person's bedroom door, which may have rendered it not fire compliant, open stairs in one area of the building which may be a risk to some people living at the home and the need for an extractor to be fitted to the residents 'smoking room'. The acting manager discussed all of these and state that improvements were planned.

A 'fire risk assessment' had been carried out and updated at intervals. We saw personal evacuation plans [PEEP's] were available for the people resident in the home to help ensure effective evacuation of the home in case of an emergency. We spot checked other safety certificates for electrical safety, gas safety and kitchen hygiene and these were up to date. We spoke to the maintenance manager who told us the home was well resourced in this area so that any issues could be quickly picked up and dealt with.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in April 2016 we had made a requirement around the use of mental capacity assessments in accordance with the Mental Capacity Act 2005 (MCA) as these had been confusing in terms of their content and evidenced a lack of staff understanding. On this inspection on 24-25 October 2016, we found the same issues. We found staff had good intentions and there were some positive approaches to best interest decisions for those who lacked capacity to consent to the care and treatment decision in question, but these lacked evidence around assessment of mental capacity and subsequent clear care planning explaining interventions based on least restrictive measures.

We still found hesitancy in terms of staff's competency and comprehension, around fully understanding the use of the 'two stage mental capacity assessment' and when this should be used in relation to the MCA and associated Codes of Practice. Admission assessments for people we reviewed varied in their recording of capacity and decision making. In other, more specific examples, where a mental capacity assessment would have been evidence of good practice, for example the use of bedrails for one person, we did not find any evidence of consent or use of an individual mental capacity test for this specific decision for people who were said to lack capacity by staff. The use of bedrails can be interpreted as a restrictive practice and consent for their use needs to include an assessment activity which would follow the MCA Code of Practice.

Nursing staff we spoke with struggled with the concept of mental capacity and consent. They stated that they had received training but when we looked at their knowledge in more detail they struggled to explain some of the decision making processes. For example, one person had a mental capacity assessment recorded but the decision to be made was not identified. The nurse we spoke with was unclear as to the decision being tested. Both nurses on duty stated they felt uncertain regarding the concepts and would benefit from more training.

The action plan from the provider sent to us prior to our inspection specified; 'New consent forms have been introduced for all service users, those who have capacity are signing their own consent forms'. We found these were not completed for all people with capacity to consent.

The acting manager was able to give examples of good practice verbally but when we tracked the decisions making processes through the service users care records we found lack of follow thorough and monitoring. For example, the acting manager had a good understanding of the complexities around consent and assessment for one person regarding refusing thickeners I their drinks. Staff had involved the person's GP and a referral to the Community Mental Health Team had been made but the assessments requiring to be undertaken in the home were incomplete including a lack of assessment of the person's mental capacity and no care plan for monitoring of on-going consent regarding the use of fluid thickeners.

We found these concerns, on the first two days of the inspection and we issued the provider with an urgent notice to make improvements. When new returned on the second two days of the inspection we found there had been improvements. Managers had completed a full audit of all people in the home and updated care files regarding issues around consent and the requirements under the MCA. We will continue to monitor the

service to ensure safe standards are maintained.

This was a breach of Regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had applied for 26 people to be supported on a Deprivation of Liberty (DoLS) authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found the standard authorisations from the local authority for two people were in place and was being monitored by the registered manager of the home.

We observed staff provide support at key times and the interactions we saw showed how staff communicated and supported people. When we spoke with staff they were able to explain each person's care needs and how they communicated these needs.

We spoke with a health care professional during our inspection who was visiting the home. We also spoke with a senior manager from the local Clinical Commissioning Group (CCG) who had had recent input into the home and were able to provide some feedback. The health care professional told us the staff supported people quite well. They expressed some concern about the nurse staff cover at the home during the evenings for 5pm till 8pm when only two nurses were on shift; we fed this back to the acting manager. The CCG had carried out a series of visits and audits following our concerns from the first two days of the inspection. We were told the audits and reviews, including medication and clinical care audits, had revealed no concerns; people were now getting health care support when needed.

When we returned to Manchester House for the second part of our inspection and followed up the concerns we had previously we found people had received up to date reviews and these included their health care needs. We looked at the health care for ten of the people living in the home. Each person's care file included evidence of input by a full range of health care professionals. If people had specific medical needs we saw these were documented and followed through.

Following the inspection in April 2016 we had found the service in breach of regulations as staff had not been supported through supervision and appraisals. We found this had improved and the breach was now met.

People we spoke with, relatives and health care professionals told us that staff had the skills and approach needed to ensure people were receiving the right care with respect to maintaining their health. We looked at the training and support in place for staff. The acting manager supplied a copy of a staff training statistics in the action plan and we saw training had been carried out for staff in 'statutory' subjects such as health and safety, moving and handling, safeguarding, infection control and fire awareness.

The acting manager told us that many staff had a qualification in care such as QCF (Qualifications and Certificates Framework) and this was confirmed by records we saw, where nearly 70% of staff had attained a qualification and others were currently undergoing such a qualification.

Staff we spoke with said they felt supported by the registered manager and the training provided. They told us that they had had appraisals and there were support systems in place such as supervision sessions. We asked about staff meetings and we were shown notes form meetings undertaken with senior care staff, night staff and domestic staff. A full staff meeting open to all staff had been held in June 2016 which had been well attended. These forums helped staff to have their say in the running of the home.

We asked people what the food was like in the home and observed people having their meals. We had mixed responses but most of these were positive if not over enthusiastic. All were aware of being given a choice from the daily menu, which was on display on tables in the dining room (in very small print); staff also asked people about their choices each morning.

Comments included; "The food's okay but I miss the food at home. My daughter brings me things I like sometimes, so I don't forget", "It was fine, yes [about the lunch just finished]. I don't need so much now but it's generally okay, yes" and "You can ask for something else [if you don't like the menu] and they'll make it for you".

We saw several people were seated at tables in the dining room during the late morning, finishing drinks. The acting manager reported that meals and drinks were served flexibly, to meet people's preferred meal times. The food served at lunch looked well-balanced and adequate in amount. Tables were set attractively and were well-spaced so that people could move about freely and choose where they sat.

People told us that staff were available to help with eating/drinking if you needed. One person said "I have someone to help me with anything I need, like cutting up my food." This person also had their drinks served in a lidded cup, to support them in drinking independently. Another person said, "I need help with everything like that, and I do get it – yes." People reported a range of drinks available to choose from and described having their own choices in their rooms in addition if they wished.

Good

Is the service caring?

Our findings

The people we spoke with said they were happy living at Manchester House. They spoke about the nursing and care staff positively. We did not receive any particularly adverse comments from people during the inspection regarding staff approach when they were delivering care. When we observed staff interacting with people living at the home there was a natural warmth and empathy with a shared rapport. Staff showed a caring nature with appropriate interventions to support people. These interactions showed good interpersonal skills and understanding. Staff had limited time to spend with people and engage with them in a positive manner due the business of the home.

We asked people are the staff caring? Do they [staff] listen to you and have the time to listen? We heard staff speaking in kind and friendly tones at all times. They appeared to be busy moving from person to person but not overly rushed. One person commented, "On the whole, yes, but there's so many people needing help, there's no time for me. There aren't always enough staff. others commented, "Mostly – some are very kind. Some have time to listen. They know me quite well, yes and what I like or don't like", "Some are more caring than others, though", "It's like all places, some staff are very good and others less so."

We asked whether staff showed respect and whether choices are offered and respected. At the start of the lunch period, we observed two people with apparent cognitive/memory difficulties beginning to argue about with each other where they were sitting. A member of staff supporting someone else intervened quickly and appropriately and resolved the issue by providing some reassurance.

People told us that staff encouraged them to be as independent as possible. We saw walking frames in rooms and next to people sitting in day areas. Several people in wheelchairs were able to operate these independently. Corridors and all day areas were very spacious, with hard flooring, supporting free movement by more than one wheelchair user at a time.

We received the comments from four people we spoke with which indicated a culture where staff were trying to encourage people to be as independent as possible.. Comments included, "I just like doing something – I can't sit still – so sometimes they ask me to lay the tables and empty things, you know. I'm bored because I've not got enough to do, so it's good they let me do that", "Within my limits, yes, but I am very limited really", "I can use that [pointing to walking frame] to get about. I get told off when I don't!" and "They're trying, but its early days yet."

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained. People told us that on the whole staff knocked on their bedroom door and waited before entering bedrooms. People said the staff were patient and careful when delivering personal care. A relative told us the staff were polite and helpful at all times.

We asked how the home involved people in its running and provided information to people. The acting manager told us about resident meetings that had been arranged so people could provide feedback. These were not frequent [we saw notes form a meeting held in March 2016 when ten people attended]. We also

saw some surveys given to people such as a recent food survey. The activities team informed us that there were more regular feedback meetings with people as part of the organised activities in the home.

There was some information available in the home for people via the 'service user guide'. We discussed the use of advocacy for people. There was some information available in the home regarding local advocacy services if people required these. The activities team were also responsible for linking in when needed and referring people through the advocacy service if needed.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in April 2016 we found the service in breach of regulations because people's care planning did not always contain accurate or sufficient information regarding people's care needs. We told the provider take action.

The action plan sent to us by the provider stated: 'All care plans are being reviewed on a monthly basis or more regularly as indicated due to change in level of need. Personal care booklets and care preferences are being completed'. We found on this inspection there were still concerns with people's care plans and the service was still in breach of regulations.

We found that the care plans for people were difficult to follow and did not provide staff with sufficient guidance to enable them to safely meet people's needs. We found care plans lacked sufficient detail to give a clear formulation of the care needed. There was also a lack of review. This exposed people to the risk of harm, by way of the risk of them not getting appropriate care to meet their needs for care and treatment.

At the inspection the acting manager, stated about 50% of the care plans had been reviewed and updated since our last inspection. In total we reviewed 10 people's plan of care; we found five of these lacked information and had not been updated.

For example, one person's care plan had last been reviewed in April 2016. The acting manager could not explain why this was the case. We spoke with the person concerned who told us about their specific concerns around how their condition had deteriorated and their perceived need for further physiotherapy treatment. When we looked at the last review none these concerns were acknowledged. The acting manager was fully aware of the person's concerns and there had been discussion about this but there was no acknowledgment in the care records or care plan about the need to support the person. The care plan was not centred on this person's specific concerns and support needs and was not being reviewed. This exposed them to the risk of harm, by way of neglecting their specific needs for care and attention.

Further, when we looked at the care record we found a reference to the person having a catheter in situ. This was not on their care plan. We asked the two senior managers present whether the catheter was still in situ. Both managers were not sure. We asked the person and they confirmed the catheter was still in situ and was long term. There were no clear records in the care file we looked at regarding the on-going management of the catheter; this had also not been reviewed. This exposed the person to the risk of harm as mismanagement of catheter care can cause unnecessary risk of infection or blockage due to lack of hygiene, routine changes and maintenance and monitoring of fluid intake and output.

We reviewed the care of another person who had a specific medical condition. We found no detail about the management of this in the person's care plans, including a recent evaluation on October 2016. We found this to be inadequate regarding the overall planning and management of the medical condition. There was a risk that the person medical condition may not have been adequately reviewed.

Another person had been the subject of a safeguarding referral prior to our inspection. We reviewed the person's care plan. We saw a handwritten, undated, note identifying the need to update the file and plan of care listing what needed to be assessed. The care plan was a 'respite' care plan for period in March 2016 and had not been updated since. This exposed the person to the risk of harm and or neglect, by way of not having current care plans that set out the current needs for care and attention.

We found these concerns, on the first two days of the inspection and we issued the provider with an urgent notice to make improvements. When new returned on the second two days of the inspection we found there had been improvements. Managers had completed a full audit of all people in the home and had reviewed people's care needs and updated care plans. Only one of the four people we asked in the second part of the inspection were aware of a care plan or felt that they had seen or signed one. We spoke with one person who had been in residence only recently and was actively involved in their care plan and its on-going developments. They expressed very clear preferences and knew how to share these, and who else would advocate for him if necessary.

We will continue to monitor the service to ensure safe standards are maintained.

This was a breach of Regulation 9 (1) (b) 3 (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people about the sorts of social activity they were engaged in. All of the people we spoke with were aware of activities being on offer. None of them took up the activities within the home but two reported being taken out on visits to the local area or further, using the company minibus. One person said, "Sometimes staff take me out – two ladies take us. There's a man here that takes us to Southport shopping or for a look round, once a week." Other people told us, "I'm aware of them but I'm not very well a lot of the time so I don't take part. I think I've seen some of the men playing dominoes. I haven't been out in the minibus because I'm not well", "I know about the activities and I go on the minibus sometimes if there's a trip. They do shows in the main halls. I watch TV and sleep a lot - the older you get, you don't feel like doing so much" and "There are [activities] but they're not my choice. It's the level of intelligence – learning colours and that – which hopefully I don't need! I prefer to be out of the way [in room upstairs]. I can go out [on minibus]." One person explained that the home had agreed for a family member to be included on a recent trip.

We spoke with the activities leader, one of a team of three. Their role included planning and delivering activities, arranging visits out, distributing newspapers and post daily to people and managing the budget, including people's 'pocket money'.

The activities leader reported a wide range of available activities within and outside the home which took place throughout the week apart from Sundays including: Cake decorating; card making; games sessions (dominoes, bingo etc.); reminiscence sessions; monthly movie days (in two lounges, with popcorn); and weekly coffee mornings at which people were invited to discuss their wishes and choices; these were minuted with action points. Church visitors to give Communion (CE and RC) were made welcome at the home. We were told about a prior resident in the home who was Buddhist and was supported in taking regular retreats.

The visits out occur at least weekly and ranged from taking small groups shopping to taking a larger group further afield, such as Knowsley Safari Park or Blackpool.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of

how they could complain. We saw there were good records of complaints made. There had been two complaints received since April 2016. We looked at both of these and they had been responded to appropriately. We saw they had been investigated and addressed in terms of a response by the registered manager.

Inadequate

Is the service well-led?

Our findings

We identified concerns regarding governance and leadership by the provider at Manchester House. Whilst the Commission had been provided with action plans which had been developed by the registered manager and the regional manager we found evidence that these had not been actioned. There was a failure to meet regulatory requirements and provide safe care and treatment. The service had met two of the four previous breaches from the previous inspection in April 2016 but has not met another two and has now breached two additional regulations by way of unsafe care and treatment.

Following the first two days of the inspection at the service we concluded that governance arrangements were inadequate. We found multiple serious failings particularly in respect of people's safety and experience of care as well as risk management and care planning. In particular the lack review of service users care planning meant the effectiveness of the key system in place to understand service user's experience of the care they received was failing.

We found managers had identified key issues requiring improvements on audits carried out but then failed to act in good time; such as identifying issues around fluid thickeners for some people residing at the home. Some of the issues identified correlated with our findings but the prescribed actions had not been carried out or given priority given the risk to people. This exposed people to the risk of harm and showed a failure of good governance by the provider.

For example, we saw audits for care planning carried out October 2016. These identified issues we also found regarding lack of reviews and content. Despite previous requirement from April 2016 and audits carried out we still found a lack of adequate care plans for many people.

There have been two managers since the last inspection of Manchester House Nursing Home in April 2016. The last manager resigned just prior to our inspection. The registered manager was available for the first two days of our inspection. When we returned to the service a regional manager was acting as the manager as the registered manager was not available. We found these changes were making progress difficult as there was a lack of consistent leadership. All staff we spoke with commented that a regular management identity and strategy would benefit the home greatly.

Over the inspection there was an acting manager, deputy manager, registered manager and two management consultants on site but issues still persist and inconsistencies remain.

Basic feedback from staff did not appear to have picked up key issues. We spoke with nurses who told us there was not enough time to sit back and evaluate care as daily events made this not possible. This has not been recognised and we found it was managers who were being employed to update care records. We asked the acting manager how newly updated care records would be 'owned' by nurses and carers but there were no definite plans for this which means there is a risk people's care would not get reviewed in future.

We saw some acknowledgment of this culture in the minutes of managers meeting from August 2016 which

stated; 'action plans to be assigned to members of staff and not left solely to [the] manager'. This was not being carried out as managers were seen to be carrying out most auditing.

We found these concerns, on the first two days of the inspection and we issued the provider with an urgent notice to make improvements. When new returned on the second two days of the inspection we found there had been improvements. The provider had reviewed and updated the management structure of the organisation and this was clear in terms of lines of accountability. The service had worked at the requirements in our urgent notice and met the conditions we had made. Overall the service was safer. We have also been made aware that the previous registered manager has returned to lead improvements at Manchester House.

We will continue to monitor the service to ensure safe standards are maintained.

These findings are a breach of Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In order to meet the requirements of the urgent notice we issued the managers at the home had carried out a series of audits and checks and started to implement some key changes to help ensure progress would be maintained. The acting manager contacted us and told us: [We have had] reports from the [external] infection control visit and a visit from the CCG; we have developed actions plans form them. We have also had the medication management people in who have undertaken a full review. We have completed audits within the home covering the following areas: Fluid thickeners, wound care, catheter care and diet & nutrition; following the audits actions identified have been either actioned or are being actioned'.

On the last two days of the inspection we saw that a full list of audits had been identified and responsibility and the times / scheduling for these was identified.

We discussed, at feedback with the provider and senior managers that the overall management structure and monitoring had improved over a month but more work was needed to ensure key areas where being identified and addressed consistently and on-going.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care plans had not been revised and updated and did not contain details of some aspects of care; they did not evidence an individual approach to care.

The enforcement action we took:

We served an urgent Notice of Decision telling the provider to meet regulations

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	When people were unable to consent, the principles of the Mental Capacity Act 2005 were not always followed.

The enforcement action we took:

We served a urgent Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Not all medicines were administered safely. We found concerns around the way some medicines were administered and recorded which placed people at risk. We found that some people's risks regarding their health care were not being adequately assessed and monitored. This was in relation to wound care, pressure sore monitoring, and accident recording and following up on medical recommendations.

The enforcement action we took:

We served an urgent Notice of Decision.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Some of the systems for auditing the quality of the service needed further development and did not provide adequate monitoring of standards in the home. We found the management structure was not clear and did not support the home with clear lines of accountability and responsibility.

The enforcement action we took:

We served an urgent Notice of Decision.