Holmleigh Care Homes Limited

Mantley Chase Residential Care

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Mantley Chase is a care home operated by Holmleigh Care Homes Limited. The service provides support, personal care and accommodation for up to 12 people. It provides care to adults living with a learning disability, autism and behaviours that may challenge. Eight people were living at Mantley Chase at the time of our inspection.

People's experience of using this service and what we found
At the last inspection we told the provider they needed to improve the oversight and governance of the service. Systems had not been effective in identifying and responding to maintenance issues and ensuring the home was clean with infection control measures adhered to. At this inspection we found the provider had made the improvements necessary to meet legal requirements.

During this inspection we found that the provider had made changes to the environment at Mantley Chase. For example, the carpets in people's bedrooms and on the main staircase had been replaced and items that had required fixing had been repaired or replaced.

Changes had been made to the systems in place to assess the quality of the service and plan improvements. The management team were making regular checks of all aspects of the service. This was used to develop a comprehensive service improvement plan, which was regularly reviewed. Further time was needed to ensure that systems in place routinely identified areas for development and encouraged continuous improvement.

Medicines were safely managed. People were supported to take the medicines they had been prescribed. Staff had received training and managers regularly checked to ensure the systems were working well.

Risks people faced had been assessed and there were clear plans setting out the support they needed to stay safe. Staff had a good understanding of the risks and support people needed to stay safe.

More time was needed to fully imbed the quality assurance systems the provider had implemented. This was to ensure they were fully effective in identifying and responding to issues identified through these audits.

Rating at last inspection
The last rating for this service was requires improvement (published 24 April 2019) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected

We carried out an unannounced comprehensive inspection of this service on 20 March 2019. Two breaches of regulations were found and we served a warning notice against the provider in relation to Good Governance. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and governance of the service.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions 'Is the service Safe?' and 'Is the service Well-led?' which contain those requirements.

The ratings from the previous comprehensive inspection for those Key Questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has improved to good. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Mantley Chase on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was not always safe.

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Mantley Chase Residential Care

Detailed findings

Background to this inspection

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

Inspection team
Our inspection was completed by one inspector.

Service and service type
Mantley Chase is a 'care home' that provides accommodation for up to 12 people who require personal care. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who was registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was announced. We gave the service 24 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people at home to speak with us.

What we did before the site visit
We reviewed the information we had received about the service since the last inspection. This included

previous inspection reports and details about incidents the provider must notify us about, such as abuse, serious injuries and deaths. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We visited Mantley Chase on 17 July 2019. We spoke with the registered manager and one care worker. We observed staff interacting with people throughout the day, including supporting people with various activities. We reviewed a range of records. This included one care record, and staff training and supervision records. We undertook a comprehensive tour of the home to review changes made to the environment and we also reviewed records relating to the management and monitoring of the service.

After the inspection
We sought feedback from a local authority commissioner about Mantley Chase.

Good

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has improved to Good.

Good: This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection:
• At the last comprehensive inspection, in March 2019, we assessed that the service was in breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the premises were not kept clean and properly maintained. We told the provider they needed to meet the requirements of the regulation by 13 May 2019. Enough improvement had been made at this inspection and the provider was no longer in breach of the regulation.
• Changes had been made by the provider to ensure people's care environment was safe. For example, carpets throughout the home and been replaced and no longer presented a trip hazard to people. A member of staff told us, "There has been a big change in the environment and cleaning systems used."
• Health and safety audits (such as checks of the environment and systems for keeping the home clean) had been improved and developed to monitor the safety of people's environment. These audits had identified which pieces of equipment were broken and had been listed in priority order to ensure the most urgent issues were addressed first.
• Risk assessments had been completed to ensure people were kept safe until after the maintenance work was completed.
• The home was clean and people were no longer at risk of the spread of infection. Cleaning schedules had been improved and had been used effectively to ensure a clean environment.
•The garden area was well maintained. For example, the patio area had been cleared of weeds and debris that was evident at our last inspection.
• People's risks had been assessed and records were updated when people's risks changed. Staff acted to reduce risks in relation to people accessing the community and supporting people to have safe relationships.
• Behaviour management plans cleared identified individual risk to people and what measures should be taken to keep people from harm.

Systems and processes to safeguard people from the risk of abuse:
• Training records we reviewed demonstrated that staff were trained in safeguarding adults and had access to an up-to-date safeguarding policy.
• The registered manager worked appropriately with the provider and relevant agencies to safeguard people.

Using medicines safely:
• We reviewed the storage and administration records (MAR charts) for three people living at the home and

found these had been effectively completed and that people had received their medicines as prescribed.
• People received their medicines as prescribed and when needed. Some people occasionally needed medicines (as required) when in pain or when exhibiting behaviours that could challenge staff and staff knew how to recognise when they needed this medicine and provided it promptly.
• Training records we reviewed demonstrated that staff were trained and assessed as competent to administer medicines.
• Any medicines errors had been identified and responded to effectively and practices had been improved to prevent further errors occurring. For example, secure storage systems had been set up in each person's bedroom to ensure the right medicines were administered to the right person.
• Staff followed good practice when storing, administering, recording and disposing of people's medicines. Audits were in place for the registered manager to check good practice was followed and we saw prompt action was taken if for example, MAR charts had not been completed when medicines had been administered.

Staffing and recruitment:
• The registered manager had reviewed staffing at the home and ensured there was an even mix of staff with the right skills and experience to support people throughout the day.
• Records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, people worked a probationary period whilst they were new to the service, suitable references were obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question had remained Requires Improvement.
Requires improvement: This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
• At the last inspection, in March 2019, we identified the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to ensure there was sufficient oversight and governance at the service. We served a warning notice and told the provider they needed to meet the requirements of the regulation by 13 May 2019, we also met with representatives with the provider to discuss the actions they planned to take.
• At this inspection we found the provider had taken the action needed to improve the monitoring systems of the service and were no longer in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager was working to ensure there was sufficient oversight and effective governance at the service. Systems and processes to assess, monitor and improve the quality and safety of the service provided had improved. However, time was still needed for a cycle of all audits to be completed. Action plans generated from audits still needed to be completed for us to be able to assess if auditing systems were always effective.
• Staff told us morale was improving. The registered manager was seeking ways to improve staff involvement. Staff meetings however, were still not well-attended. A member of staff we spoke with told us, "Things are getting better."
• The provider had responded to all maintenance issues which had been raised by CQC and following our inspection. The registered manager had liaised with the provider to ensure resources were focused on the work required at Mantley Chase.
• Systems to ensure the home was clean and infection control measures adhered to had improved. Cleaning schedules were followed to ensure the service was clean and free from infection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others:
• Each person had a key-worker who was able to support them through monthly key-worker meetings and promote ways in which they could be involved in the running of the home.
• The registered manager was working on ways to improve engagement of staff in order to improve morale. The registered manager told us staff meetings had been held but staff did not always attend. They told us how handovers were now used to update staff on work practice and upcoming plans. Time was needed to ensure this would facilitate effective communication with staff.

• On the day of our inspection, people were actively involved in various tasks. Some people had chosen to assist staff with clearing the back patio and other people were working with staff in the kitchen area to make their own lunch and maximise their independence.

Continuous learning and improving care:
• Incidents and accidents were recorded and action taken to reduce the risks of incidents reoccurring. There was detailed information about how each incident was followed up and what steps had been taken to keep people safe.