Livlife Uk Ltd

The Manor House

Inspection report

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

Summary of findings

Overall summary

This inspection took place on 12, 22 and 30 October 2018. The first day was unannounced, the second day was announced to ensure the nominated individual who represented the limited company was in the home. The final day was spent telephoning people's relatives.

At the last comprehensive inspection in February 2018 the service was rated, 'Requires Improvement.' We found the service was not meeting regulations with regard to good governance. The provider had failed to bring about sufficient, sustainable improvements to improve the quality of the service. We issued a warning notice against the provider.

Following the last inspection, we asked the provider to complete an action plan to tell us what they would do, and by when to improve the service. We agreed the providers date for them to make improvements in the management of the service; and the provider told us they would have completed their actions in relation to the other breach of the regulations by the end of May 2018.

The Manor House is a 'care home'. People in care homes receive accommodation and nursing or 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 Manor House accommodates up to 16 people in one adapted building. At the time of our inspection there were 16 people living at the home.

The care service should be developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. At this inspection we did not see the service provided to people met these values.

There was no registered manager in post. Since the last inspection the registered manager had left the role and cancelled their registration with us. 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. The provider had appointed an acting manager in the service.

Health and safety checks were not regularly completed or evidenced to ensure risks to people's safety were minimised. We identified some health and safety issues to the acting manager on the first day of our inspection visit where we had immediate concerns to people's safety. These had not been followed up by the acting manager and fully reported onto other interested parties.

We found there was an absence of supervision by the provider to check quality monitoring had been carried out effectively. There was no evidence that quality monitoring had been undertaken since July 2018. The areas not covered included care plans and checks on medicines management.

There were no adequate infection control checks in place, staff were unsure which coloured mops and buckets were used consistently by staff in each area of the home. Staff were also unsure what temperature soiled clothing was washed at. These resulted in a heightened potential for cross infection and cross contamination of infection in the home. Improvements are required for the access to policies and procedures which would give staff the information to operate systems effectively and protect people in the home.

The audit systems in place were not reviewed by the previous registered manager to ensure people received a quality service. The nominated individual did not audit any systems in view of no registered manager being employed. Incidents were recorded but information was not always sent to CQC. Improvements are required in assessing risk to people.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. There was no system in place that allowed the acting manager to consistently supervise the staff to ensure people were safe in the home.

Care plans provided limited information for staff that identified some people's support needs, however there was little information about people's associated risks. There was enough staff on duty to respond to people's health and care needs, however, social care and pastimes were not seen as a priority and people were not supported with these because staff did not have enough time. Staff recruitment procedures were adequate which ensured people were cared for by staff who had been assessed as safe to work with them. Staffing levels were adequate to provide basic levels of care. People's health and welfare was placed at risk from a poorly maintained environment.

The environment was in need of decoration, there was no plan of refurbishment of equipment or replacement of items or floor coverings. There were carpeted, corridor and store room areas in need of cleaning or replacement due to malodour.

People were supported in line with the requirements of the Deprivation of Liberty Safeguards (DoLS). People's capacity had been assessed and six people had a DoLS in place for the restriction placed on them. Staff were not knowledgeable about the Mental Capacity Act 2005 (MCA) which could allow staff to unknowingly abuse people's human rights.

People were cared for by a caring and compassionate staff group who. Staff demonstrated some knowledge about how to care for people. However, some staff training courses and training records were out of date. That meant that we could not be assured staff were in receipt of the necessary information.

Care reflected most of people's needs, however care and support plans lacked detail and depth of detail to fully inform staff and protect people from harm. People had not been referred to health professionals to maintain or improve their health; Information about people's dietary and cultural requirements were not updated.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

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.

People were at risk from harm as the provider did not ensure all areas of safety were maintained. Medication administration was not operated safely. Infection control procedures were not detailed or followed, and people were placed at risk from the potential transfer of infection. The environment was poorly maintained. Some areas were not risk assessed to ensure the environment was safe for people. Most staff were recruited safely however staffing numbers did not allow for activities other than basic care.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was not kept up to date to ensure all staff were in receipt of the latest guidance and best practice. Staff were aware of people's capacity to make decisions and had some understanding of Deprivation of Liberty Safeguards though little understanding of the Mental Capacity Act 2005. People were not supported to maintain a healthy diet, nor one which fully met their cultural preferences. There was no evidence of people's health being monitored.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and compassionate, respected people's individuality. However, people's dignity was compromised by the restricted access to their en-suite showers and the systems in place for the prevention of the spread of infection.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care was not personalised. People and their families were not involved in planning and reviewing how people were cared for and supported. There was no planned activity programme that

met people's support needs. Staff understood people's preferences, likes and dislikes. People knew how to raise a complaint; however, the process was not clear for those with communication needs.

Is the service well-led?

Inadequate

The service was not well led.

There had not been any recent quality assurance that provided oversight or governance by the provider to ensure people's safety was not compromised. Records of some tests were completed by staff, however these were not overseen by the nominated individual to ensure that shortfalls were identified, resolved or improved. The provider did not ensure CQC were informed of events that involved people in a timely way.

The Manor House

Detailed findings

Background to this inspection

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

This inspection took place on 12, 22 and 30 October 2018. The first day was unannounced, the second day was announced to ensure the nominated individual who represented the limited company was in the home. The final day was spent telephoning with people's relatives. On the first day of the inspection the team consisted of one inspector and an assistant inspector whose area of expertise was in the care of people with a learning disability. On the second day the team consisted of two inspectors, and calls were completed by the lead inspector. On the third day we contacted people's relatives for their opinion of the care provided to their relations.

Before our inspection visit, we reviewed the information we held about the home and information from the local authority commissioners. The commissioners for health and social care, responsible for funding some of the people that lived at the home told us they had some concerns about how the home was being managed. We took this into account during our inspection.

We looked at the notifications from the provider; a notification is information about important events which the service is required to send us by law.

We spent time observing the care and support being provided throughout the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with four people who lived in the home and four relatives, the nominated individual. This home is owned by a limited company, the nominated individual is appointed by the director(s) of the company to act on their behalf. We also spoke with the acting manager, the head senior carer, one team leader and one care worker.

We looked at the care records for four of the people who lived in the service. We also looked at records that related to how the service was managed including staffing rotas, recruitment, training and quality assurance.

We asked the nominated individual to send us documents to clarify the use of a temporary member of night staff. This was not sent for 2 weeks after the date requested. We also requested documents from the acting manager which included copies of the training records, the staff rota and minutes of meetings for the people who used the home and staff meetings. These were supplied following the inspection.

Inadequate

Is the service safe?

Our findings

At our last inspection in February 2018 we found improvements were needed as the provider had not ensured people were protected as records identifying and assessing the potential risks for people were incomplete.

The provider sent us a plan of action following the last inspection to state how and when they would address the concerns raised. At this inspection we noted they had not met any of the actions within the agreed timescale meaning people were potentially still at risk.

The system to manage medicines was not always safe. We found errors for two medicines that were sent from the chemist in their original packaging. On the first day of the inspection there was no accurate record kept of how many tablets had been administered and no check that the number remaining matched the administration record. We found there were fewer tablets than there should have been in each person's remaining tablets. That meant the people may have been given extra medicine. On the second day of the inspection a new supply of medicines had been commenced and all the medicines had been administered correctly. We asked the acting manager if they had investigated the missing tablets from the first day, they said they had not and could not explain how the count was now correct. The acting manager had not put any checks in place following the first day of the inspection, which would ensure staff could easily check the remaining stock numbers.

We found the medicine trolley was not appropriately secured to the wall the and the medicines storage room had a musty odour. Staff could not explain what the odour was which was still present on the second day. Temperatures in the storage area were recorded though some records were missing. All the recorded temperatures were within the limits set for medicines storage. However, when we asked a senior carer why they recorded the storage temperatures they did not know. Similarly, they were unaware of the procedure if the recorded temperatures went below or above the recommended levels. There was a policy and procedure for administrating medicines, however temperature records were not covered.

We observed a different member of staff administering medicines on each of the days of the inspection. On the second day staff were administering from the office, whereas on the first day they administered from a corridor. We asked the acting manager why there was a change. They stated they were observing the staff as they had not been administering medicines properly. We asked if the acting manager had a procedure for the staff to follow, they said there was not one in place. However, we found a medicines procedure in place in the first of three medicines administration record charts (MAR charts). This was a clear instruction how staff were to administer medicines; however, staff were not following the procedure. We spoke to the acting manager about this who said they were unaware of the procedure.

People's relatives said they felt the home was not cleaned to their satisfaction. One relative said, "There are sometimes when it's not very hygienic, there are odours."
People were not protected by the control of infection. We reviewed the laundry area and although arrangements were in place to manage soiled laundry safely, the laundry room was unhygienic. We saw

walls had not been decorated, with one wall with exposed brick and unpainted plaster, the floor also required to have a non-permeable covering as part of the floor was concrete. This increased the potential for cross infection and cross contamination in the home. The nominated individual told us they had arranged for new laundry machines which would require building work in the laundry room, and this would all be improved at the time.

Staff were unsure what temperature soiled clothing was washed at and there was inadequate separation between clean and soiled linen. On the first day of the inspection we spoke with the member of staff who was working in the laundry. They showed us which clothes were washed and waiting to be put in the dryer. These were placed in a basket on the laundry floor next to clothes waiting to be washed. Both baskets had clothes which went over the side and rested on the floor. This again increased the potential for cross infection and cross contamination. When we returned on the second day the laundry area was tidier though none of the improvements and building work had commenced.

Following the inspection, we asked the nominated individual to send us the policy and procedure on infection control. Although these were sent they were not personalised to the home and did not inform staff how to ensure people were safe. Therefore, staff remained without adequate instruction on how to keep people safe and the home clean and hygienic. We also asked the acting manager to send us the latest training records so we could see what infection control training had been undertaken by staff since our last inspection. This document was sent but did not include training details for the nominated individual, current manager or 14 of the 23 care staff. We could not be assured staff had the latest knowledge of best practice to ensure people were protected from the risk of acquired infections.

The mop buckets used when staff cleaned the floors in toilets and public areas were stored inappropriately and posed a clear cross infection and cross contamination issue. The colour coded mops, used to distinguish which area they should be used in, were still stored together on the floor. That meant they was a chance of cross contamination from one mop to another. The way the mops were stored would not allow them to 'air dry'. Staff were unclear which coloured mop was used in high risk areas, as the domestic staff told us the blue mop was used in the kitchen. Where staff told us they used the blue mop in the bedrooms. Similarly, the domestic thought the yellow mop was used in the shower and bathrooms, and care staff the kitchen. All these issues increased the potential for cross infection and cross contamination and the potential for people to contract an acquired infection.

There was no liquid soap in either of the ground floor toilets. This and some other areas of the home did not have pedal operated bins to ensure infection controls were upheld. Where pedal bins were in place no liners were placed in the bin to cut down the potential for cross contamination of the equipment.

Some bedrooms, corridors and a store room had a musty stale odour. We asked the acting manager for the infection control audit. This could not be found, and we asked the acting manager to urgently undertake an infection control audit to ensure people were protected. This was undertaken following the inspection, the manager said it had revealed a number of areas that required to be improved.

The environment of the home was in need of re-decoration and some carpets and flooring replaced. There was bare plaster in the laundry and a bedroom which had bare bricks under a window, which would not allow proper cleaning and disinfection. We were concerned about some bedroom and bathroom doors as they were able to be locked from the outside but were then not openable from the inside, which may have trapped a person in the room. The laundry area was not secured at times and people who lived in the home could access the detergent and softener stored in there. None of these issues had been recorded on a maintenance schedule and repairs arranged. Staff also told us it was difficult to move some equipment on

the carpeted floor. The staff member said, "One room where the person uses a hoist has a carpet that makes it difficult to move the hoist, it's been like it for ages." We asked the acting manager about this who said they were aware of the staff's difficulties. They had passed the information to the nominated individual to arrange the replacement flooring.

Some risks to people posed by the environment had not been risk assessed. These included hot water temperatures in showers being unregulated and so posing a risk that people may be placed at risk of scalding themselves. Some radiators had guards fitted to reduce the risk of scalds and burns. However, there was a radiator in one bedroom which was not guarded properly and allowed a potential danger to the person who slept in the room. The first floor bannister was not at a suitable height to stop anyone falling over accidentally. At least one of the people who lived on the first floor needed to use a mobility aid to allow access to their bedroom. That placed this person at risk of falling over the bannister. We asked for these areas to be risk assessed on the first day of the inspection. We found there was nothing in place by the time we returned 10 days later.

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

There was no evidence of people's assessed needs or re-assessments of their needs in care plans. That meant we could not be assured that people were being cared for safely. The provider has introduced a new system of care planning and recording of people's activities. The electronic system relies on staff inputting information onto a laptop. However, the laptop was broken on day two of our visit, there was no back up equipment available which meant staff were writing out paper records. That relied on the limited number of staff enabled to do this, then inputting all the information at a later date. That did not demonstrate a provider who arranged a safe and secure system of recording information vital for people's care.

We had been made aware of a safeguarding situation that had not been reported to the local authority or Care Quality Commission (CQC) as the law requires. This had not been reported by the registered manager whilst in post. We asked the acting manager to report the incident to ensure it was followed up correctly. We checked following the inspection and a specialist assessment for the person had been requested. However, the acting manager had not referred the incident to the local authority as a safeguarding incident or forwarded the information to the CQC. That meant we could not be assured that all such incidents were reported and acted on to ensure people were safe.

We later found out that the person had a visit from the same type of specialist in 2009. The outcome of the visit was the person required their food prepared without lumps and at a consistency that was easily swallowed. The person choked on a banana as it had not been prepared properly by staff. This resulted in the person not being provided their food at an appropriate consistency and choking on it the staff then had to perform an invasive treatment to dislodge the obstruction. The provider had not fully implemented the recommendations of the report or retained a copy of the advice on the care plan for staff to refer too.

People's safety was not fully supported by the provider's recruitment practices. When the most recent registered manager had been employed the nominated individual told us they had not gone through the full recruitment process and there was no references or police check in place. This placed people at risk of harm from an employee whose employment and background history had not been checked. We found all other staff that had been employed had gone through the necessary recruitment process including police checks.

People who lived in the home told us there was not enough staff to ensure they were cared for safely. One person said, I like to talk to them [staff] but there isn't anyone sometimes." We asked the acting manager

how the staffing hours are compiled. They told us they didn't know, and it was the nominated individual who allocated the staffing hours.

People who we spoke with felt there was not enough staff in the home to support them with activities. One person said, "I would like to go to the pub but there's not enough staff."

There were no systems in place to assess how many staff were needed, based on the needs of people. Staff told us there were not staff to meet the support needs of people. A member of staff said, "We make sure people are safe but it's difficult when we don't have enough staff, we are often short staffed, a lot of good staff have left." We found there were sufficient staff to undertake the basic care for people, however there was no time for staff to undertake activities in or out of the home.
There was no evidence of any analysis of any incidents which was used to inform staff of any lessons learnt.

Three of the people we spoke with said they felt safe in the home. One person said, "Yes, I have always felt safe, the staff help me move from my wheelchair to my bed, I've never had an accident." A second person said, "My room is upstairs, the staff have to watch me when I go up and down, that makes me feel safe. When I go in the shower the staff help me." A third person said, "Yes, there's always someone here so I feel safe." Relatives we spoke with felt their relation was safe in the home.

We spoke with staff about their responsibilities around safeguarding and keeping people safe. One member of staff said, "It is our responsibility to keep people safe and report any concerns to the team leader or manager." Staff we spoke with understood their responsibilities to keep people safe from abuse. Staff we spoke with on the day confirmed they had received training that ensured they recognised the signs when people may have been at risk of harm. Staff said if they suspected or observed anyone being harmed they would share their concerns with the acting manager or the staff in charge at the time. Staff were aware of whistle blowing and one member of staff told us the process they would undertake, if their initial concerns were not acted upon by the management at the service. They also knew which authorities outside the service to report concerns to.

Requires Improvement

Is the service effective?

Our findings

People were not cared for effectively. Staff told us they felt they had not had the training they required to support people properly. One member of staff said, "I have not done any training for ages."

We spoke with the acting manager about the training matrix, they said, "There is a lot of training to be done." They told us they had spoken with the nominated individual about the training certificates and had been informed they were 'somewhere in the home' but had been unable to find them.

We looked at the training matrix which had been updated by the acting manager. This had few entries for the training staff had completed. We asked why there were so many gaps and they told us it was because there were no certificates of attendance for the majority of staff.

We looked at the training matrix and what staff training had been recorded. For example, we noted that only ten out of the twenty long term employed staff had been trained in infection control. Staff on duty on the day were using the colour coded mops and buckets in different areas and there were no cleaning schedules for staff to refer too. This is important as it specifies which utensils should be used in specific areas, to reduce the likelihood of cross infection and cross contamination in the home. That meant we could not be assured the needs of people were met consistently by a staff group who had been trained with the right competencies, knowledge, qualifications, skills, experience, attitudes and behaviours. There were other areas of training that had not been updated, with no evidence of staff having done any Deprivation of Liberty Safeguards (DoLS) or Mental Capacity Act (MCA) training. We spoke with the acting manager about training plans for staff, they said they were trying to arrange further planned staff training.

Staff told us they were not routinely being given the opportunity to attend supervision meetings since the registered manager had left the home. Supervision can be used for staff development and uses an exchange of information to promote change and improvements for people. They told us they were supervised by the previous manager or their deputy, however, this was not consistently undertaken or planned in advance. The acting manager had not set up any supervision sessions by the end of our inspection.

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 can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being

met.

We spoke with staff who confirmed they had undertaken MCA training but could not remember when. We could not be sure all the staff fully understood the principles of the Act, as some were unsure of what they could legally prevent people doing to ensure their safety. Staff were unaware of the principal of capacity. This is where people were presumed to have capacity to make decisions unless an assessment was completed and proved otherwise.

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). At the time of our inspection, six applications had been approved by the local authority to make sure people's freedoms were not unnecessarily restricted.

We saw that six applications had been granted by the local authority which approved restrictions on people in the home. We saw that people that had a DoLS in place were visited by a paid representative. They were appointed by the local authority to visit regularly and ensure that all restrictions were within the boundaries of the court order, and any positive conditions were met. Positive conditions are included in some DoLS to ensure people continued their previous lifestyle. In the case of the people in The Manor House there were no positive conditions in place.

We could not find any consent forms signed by people or their relatives. For example, areas such as sharing information, taking medicines, and taking photographs. We could not find any consent forms signed by people who had the capacity to give consent. For example, areas such as sharing information, taking medicines, and taking photographs. Where people lacked the capacity to make these decisions and give consent, the MCA had not been applied to ensure the decisions were made in people's best interests.

Throughout the inspection staff demonstrated their knowledge about gaining peoples consent. We heard staff explaining to people and seeking their consent before they commenced tasks. For example, knocking on bedroom and toilet doors before entering the rooms.

There was no evidence people's needs were assessed prior to them moving into the home. The nominated individual told us that assessments had been completed prior to people moving to the home but these were not evidenced in care plans. Assessments of people's needs are essential to ensure the staff could and meet people's individual needs.

Since the acting manager commenced recently people's changing needs were discussed at handover between the changes of each shift. Information was recorded in people's daily records. This information could be used to inform and update people's care plans. However, the majority of staff were unable to use the electronic recording system used for people's daily records, and information was relayed to the senior staff to input the information. That meant information was not being recorded effectively and ran the risk of vital information being forgotten or recorded incorrectly.

People had mixed opinions about the quality and choice of food and dining experience. One person said, "There's not much choice you get what you are given, what I don't like I don't eat, sometimes you may get something else instead." A second person said, "We always get a choice from a menu." A third person told us it could be quite noisy at meal times, and said, "We sit in another room where is quieter."

The menu did not reflect people's cultural choices, though people we spoke with could not tell us if they would prefer choices that reflected their heritage as the people lacked capacity. There was a menu which

was displayed in the dining room. However, this did not reflect the meals that were being offered on the days of the inspection. We asked staff why this was, and they replied they could only offer what they had in stock. This did not demonstrate an effective service for people.

People were not supported to have a nutritionally balanced diet based on their individual needs. Staff were aware of people's dietary needs however they were concerned that the meals purchased by the provider did not meet people's needs. All main meals are purchased ready cooked and frozen from a specialist provider. These are then heated in a special oven. The staff were aware the meals were nutritionally balanced for people that required a high calorie diet. Therefore, this meant that people who did not require a high calorie were not having their dietary needs met. On both days of the inspection we looked at the food store. We did not see any vegetables or potatoes on either of the days, however we did see some avocados on day two. We asked the acting manager and staff if they were for a specific meal they replied they did not know.

Relatives we spoke with confirmed people had been taken for GP and dental appointments, however, we were unable to evidence if people had annual health checks and had access to a GP and other health specialist when required such as a dentist or optician due to a lack of records. We saw where one person had been referred to a specialist health worker, however this was in 2009. The advice provided at that time had not been retained and used in the person's current care plan nor had a re-assessment of the persons needs been asked for.

Requires Improvement

Is the service caring?

Our findings

We were told and we observed that staff were very caring and compassionate towards people's needs and wishes. People had established positive relationships with the staff. People were treated respectfully by staff and the staff we spoke with were committed to treating people with respect and dignity.

However, the systems in place for the prevention of the spread of infection had an impact on people's dignity. People were left at risk of living in a service which was not hygienic due to the lack of systems in place to ensure the service was cleaned effectively and minimise the risk of the spread of infection. Furthermore, people's dignity was compromised as staff were unable to use people's private en-suite shower rooms. Due to people's individual needs staff had to transport them from their bedroom to the shower room; in what they expressed to us was in an undignified state of dress. The people we spoke with were clear they were unhappy with this and had requested the showers be repaired to enable their choice over their dignity.

Additionally, there was a lack of systems in place to support people to be involved in making decisions about their care, support and treatment due to the lack of applying the principles of the MCA.

We observed staff interactions with people throughout the inspection, which showed they were caring, helpful and respectful. Staff demonstrated patience when they supported people to allow them to maintain a pace that was comfortable for them.

We saw staff understood and respected people's privacy and dignity. One member of staff said, "I always close the door and the curtains when I am supporting people with their personal care." A second member of staff said, "I always knock before I go in to someone's room." We witnessed these practices throughout both days of the inspection.

When we asked people if they felt the staff were kind and caring, one person said, "The staff are lovely, I love living here." A second person said, "Yes, they [staff] are very caring to me."

People were able to express their views and be involved in making decisions about their care. One person told us, "I choose my clothes." Relatives told us they had been involved in care plan reviews with a social worker from the local authority. However, for some relatives these had taken place some time ago and some relatives could not remember being invited to care plan reviews.

Some people in the home could not communicate by word of mouth. Staff told us they were able to understand what people required by some using Makaton. Makaton is a language programme using signs and symbols to help people to communicate. Makaton was designed to support spoken language and the signs and symbols can be used with speech, in spoken word order. The provider had not put any communication tools in place to assist people communicate with staff and staff with people in the service.

There was no information regarding independent advocates available to visit the service, though we were

aware that some people received visits from paid representatives to ensure the DoLS restrictions were being observed legally. An advocate can assist people who have difficulty in making their own, informed, independent choices about decisions that affect their lives.

Throughout our inspection we observed staff knocked on people's bedroom doors before entering which meant staff recognised and respected people's privacy and dignity. We observed people were spoken with respectfully throughout our visit.

Staff we spoke with told us they encouraged as many people as possible to maintain their independence as long as they were safe to do so. Throughout our inspection, we saw staff encouraged people to make their own decisions and prompted them to move around independently.

Staff mostly respected people's dignity. For example, we saw a person being prompted by a member of staff before going to their bedroom. Staff encouraged the person, and we heard staff give clear instructions to the person and allowed them to proceed at their own pace, and successfully reached their bedroom. We observed care staff interacted well with people and read their body language and responded positively to the prompts assisting people when necessary.

Requires Improvement

Is the service responsive?

Our findings

Care was not person centred. Staff were not given direction on how to meet people needs and wishes in a person-centred manner.

Care plans were very basic and none of the care plans we looked at contained any personal information on the people. Care plans did not contain basic details such as the date of admission or how to contact people's next of kin. We asked the provider and the acting manager where this information was kept. They were unable to direct us to any further information on people, some of whom had lived in The Manor House since 2008. This meant staff had no way of promoting people's physical mental and emotional needs. Without this information the provider cannot be sure they meet people rights under the Equality Act.

The information contained in the care plan was task led. For example, under personal history, 'willing to discuss past likes to discuss personal history' we were unable to find any further information, or records of engagement with this person who was keen to talk about their past. This was a missed opportunity to ensure this person had personalised care.

People were not offered the opportunity to express their interests or hobbies and this information was missing from care plans. Therefore, staff had no reliable information about what was important to people and how to assist them to have a fulfilled life while living at The Manor House.

One person said, "There's no freedom here, I like to go out, but we don't, I am stranded." We asked the acting manager about this who said that they were trying to organise outings for people who required to be accompanied out of the building.

We did not observe any activities on the either day of our inspection. People were left without stimulation and this could lead to people being bored. When we spoke to people about what they did during the day, one person said, "I have a key worker she goes out to buy me things, I go with her sometimes for clothes." A second person said, "I go to college to do drama, I get a taxi." A third person said, "I go out to college to do cooking but there are no activities at home."

Relatives we spoke with were also concerned about the lack of stimulation for people. One relative said, "They used to go to the pub every Friday, I don't think they've gone for a long time." We spoke with the acting manager about the activity programme, they said they were trying to organise some, and were in the process of organising a trip to the pub.

Staff said they would come in to work in their own time, so people could go out. One member of staff said, "The people like to get out, but it is difficult with the staffing levels, some people have one-to-one with other care agencies, so they go out."

Where someone had an identified condition such as living with a learning disability this was not explored or the impact on their personal care addressed. This left staff without direction on how to meet someone's

care needs in a person-centred manner.

For example, some people using the service could not communicate verbally, their communication needs had not been assessed to ensure communication with them was consistent. A referral was also required to ensure a person was provided a diet which did not place them at risk of choking. Neither had been considered by the provider

This left people at risk of isolation and meant the provider did not meet the characteristics of the Accessible Information Standard (AIS). The acting manager was unaware of the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given.

The provider did not understand their responsibility to comply with the AIS. There was no information available in formats that people could understand. For example, there were no communication passports none held on people's files. That meant for instance where people were admitted to hospital there was no information to indicate how the person made their choices known or communicated those choices. The menu in the dining room was not produced in a pictorial form and there was no activities programme.

Without personalised care or a record of the person's past the provider and staff had no way of ensuring they were acting in the person's best interests and ensuring care was delivered in a manner that did not cause harm.

We observed staff did encourage some people's independence. One person who was visually impaired could self-propel themselves in their wheelchair and was encouraged to do so along the corridor to their room. However, staff said that the home was not always fit for purpose and that made their job difficult. One member of staff said, "One person who has an upstairs bedroom doesn't have a working shower so [named] has to come downstairs, this isn't ideal because [named] is cold after their shower, it's been broken for ages." We asked the manager about this who said they were aware of the person's shower being broken along with a number of others. They said there was no plan in place to repair or replace any of the showers. That meant people's care was not responsive to their individual needs and did not encourage people's self-help skills.

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

Some relatives confirmed they were involved in care plan reviews. One relative said, "Yes we have one every year."

Staff did know people's individual communication styles, abilities and preferences. We saw staff listened to what people had to say and gave them time to respond to questions, where there were any issues another person who lived in the home interpreted for people.

We asked people what they would do if they were unhappy or had a problem. One person said, "Sometimes I get upset with the others [people who live in the home], the acting manager has said if you are upset come and talk it through with me."

There was a complaints process in place, however the complaints information was not available in a manner that most people using the service could understand. People's relatives that we spoke with had

raised concerns with the previous manager but there were no records of any complaints ever being made. This meant the systems to support people to make a complaint and be assured the concerns would be acted on was not effective.

There was no end of life care planning. This meant the provider could not be sure people how people wanted to spend the end of their life, how they would know if the person could communicate if they were in pain and what staff should do about this. While no one at the service was currently end of life the service had no way of responding to an emergency end of life situation. This meant people may not have the end of life they wanted such as avoiding a hospital admission.
The severe lack of information on people's needs, health care and wishes means they could not safely move between services without putting them at risk or poor care.

Inadequate

Is the service well-led?

Our findings

During our last inspection in February 2018 we found the service had not ensured that people's health and welfare needs were protected or promoted. This was because good governance systems were not comprehensively in place and those that were had failed to identify shortfalls in the service.

The provider sent us a plan of action following the last inspection to state how and when they would address the concerns raised. At this inspection we noted they had not met any of the actions within the agreed timescale.

We found there was a lack of culture in shaping the service around the needs and preferences of people that used it. There was a lack of appropriate governance and risk management framework and this resulted in us finding breaches in regulation. There were no effective systems in place to develop and improve the service, based on the needs of the people who used it, their families and staff.

There was a lack of effective systems in place to monitor how incidents and complaints were acted on and this had led to people being placed at risk of harm and receiving care and support that was not always safe.

At this inspection the provider was unable to evidence any audits had been undertaken since July 2018. That meant there were still systematic and widespread failings in the oversight and monitoring of the service. Despite the previous inspection identifying shortfalls in governance systems and the overall safety in the home, we found that insufficient progress had been made to the auditing and governance systems of The Manor House.

The provider had not ensured guidance was in place that staff could follow and confirm they had completed auditing tasks. The provider had not completed a recent infection control audit. There were infection control issues, with a lack of soap, towels and liners in the waste bins. There were carpet areas that had not been cleaned or disinfected properly, and laminate flooring which staff were unable to disinfect properly. Staff used the colour coded cleaning products however this was inconsistent and left the potential for cross infection or cross contamination. This could have been revealed and addressed had audits of the environment and infection control been undertaken.

Medicine audits had not been undertaken since we last inspected the service. We found a number of issues with the medicines system which included poor record keeping, missing signatures on medication administration charts and an absence of regular storage temperatures. These issues could have been identified and addressed if an audit of the medicines system had been undertaken.

There were no regular or consistent checks on the environment. There was no available plan of repairs, redecoration or refurbishment of the property. There were areas inside the home which had not been properly risk assessed, which resulted in a significant danger to anyone accessing the outside area if unescorted. For example, the low height of the first-floor stairwell bannister.

The policies and procedures did not provide staff with the guidance and instruction to keep people safe or operate processes in the home. The policies were purchased from a specialist company however, these had not been personalised to the home. The manager told us they could not access the company's website to download updates or make changes.

The staff training records was not up to date to provide the acting manager with a clear picture of the training staff had completed. The acting manager told us there was no staff development plan which they were trying to arrange for future staff training and development.

The acting manager told us they were aware of quality assurance questionnaires that had been sent to people who used the service some of which may have been completed by their relatives. Relatives confirmed they had been sent questionnaires in the past, but none could recall the last time they were sent. This was a required action from the last inspection. There were no processes in place to capture people's view of the service. There was no information available to show people were happy with the service. This included if they were happy with their care. If the food was of their choosing and if they had enough to occupy them. Therefore, the provider had no way of knowing they were providing the service people wanted.

These were serious failures by the provider to use any adequate governance processes which could have revealed these errors and omissions.

This was a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager at the service at the time of our inspection visit. The registered manager had left the service however the provider had arranged a replacement acting manager. The nominated individual told us they were going to commence the registration process with the acting manager the week following the completion of the inspection.

We spoke with the acting manager about the provider's vision and values. They said they were unsure about the vision and values, but there was the statement of purpose in place which provided some information. Staff had a negative view with regards to the services vision and values. One staff member said, "The continuous change of management is difficult, we don't know what's happening, and nothing gets done." A second member of staff said, "The new manger seems nice, I hope things improve."

The acting manager explained there was no evidence of any recent staff meetings. This does not support a culture where there is a clear vision from consistent and effective leadership which achieved good outcomes for people.

We found the provider did not always work with other agencies. For example, referrals were required to ensure a person's communication needs had been assessed to ensure communication with them was consistent. Another referral was required to ensure a person who had been placed at risk of eating a diet that placed them at risk of choking. Neither had been considered by the provider.

People knew who the acting manager was, one person said, "I want a shower in my bedroom, I have been to see the manager and they are going to sort it out."
The provider had displayed a copy of the rating from the last inspection in the home however, this and several other documents including the signing in book had been removed by a person living in the home.

The acting manager is now looking at more secure means to display these documents securely.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and support plans were not detailed or updated. Reviews of care did not include the person or their relative to ensure the care and support offered met people's needs and reflected their preferences.