Mark Jonathan Gilbert and Luke William Gilbert

Manchester House Nursing Home

Inspection report

83 Albert Road
Southport
Merseyside
PR9 9LN

Tel: 01704534920

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Ratings

Overall rating for this service	Requires Improvement

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

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. Seven of the places beds] at Manchester House were commissioned by the local Clinical Commissioning Group [CCG] to provide short stay enablement and support for people being discharged from hospital.

There were 57 people accommodated at the time of the inspection.
This was an unannounced inspection which took place over three days on 30, 31 May and 1 June 2017. The service was last inspected in October and November 2016 April 2016 when we found five breaches of regulations. The service was rated as 'inadequate' and was placed in 'Special measures' at that time. 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.

At this inspection we found improvements overall to the service. Staffing of the home was more settled and three of the previous five breaches had been met. Because of the improvements the overall quality rating has been raised to 'requires improvement' and the home has been removed from special measures.

During the inspection we found two continued breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment and governance.

We found that some people's risks regarding their health care were still not being adequately assessed and monitored. This was in relation to wound care, pressure ulcer monitoring and following up on medical recommendations. The provider remains in breach of this regulation.

At the last inspection we found the management structure was not clear and did not support the home with clear Ines of accountability and responsibility. The auditing and monitoring systems in place had been fractured, underdeveloped and not consistently applied. On the inspection we found improvements in these areas but the provider had not fully met their action plan to meet all of the outstanding breaches. There had also been four changes to the management of the home since October 2016 and at the time of our inspection there was no registered manager in place. This did not support effective monitoring of standards in the home. The provider remains in breach of this regulation.

Although still in breach of these two regulations, we found the overall risk reduced from our last inspection.

You can see what action we took with the provider at the back of the full version of the report.

At our last inspection in October / November 2016, we had found the home in breach of regulations relating to safe administration of medicines because people were not always protected by the medication administration systems in place. At this inspection we found improvements had been made. People protected against the risks associated with medicines because the provider's arrangements to manage medicines were now consistently followed. The breach had been met.

At Our last inspection we had found that the home was not fully operating in accordance with the principles of the Mental Capacity Act 2005 (MCA). Although there were examples indicating good practice we found some hesitancy and misunderstanding in particular around the use of the 'two stage mental capacity assessment' and when this should be used as part of making 'best interest' decisions for people. On this inspection we found improvements had been made. Staff evidenced a better understanding of the principals involved, including an understanding of the need to assess individual decisions relating to care and treatment. The breach had been met.

At the last inspection the provider had been in breach of regulations because there had been a lack of detail in care plans for people, lack of update and review [evaluation of care] and a lack of people being involved in their care planning. On this inspection we found improvements had been made. Most care plans we saw were clearly written, agreed with people and were being regularly reviewed.

There was no 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. Following the inspection we had confirmation that the acting manager would be applying for registration with us, Care Quality Commission [CQC].

People's dietary needs were managed with reference to providing sufficient food and drinks. We had mixed response regarding individual preferences and choice. We made a recommendation regarding this.

Most people we spoke with said they were satisfied 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. Many of the people we spoke with reported delayed times for staff responding to calls for assistance. We made a recommendation regarding this.

Activities were organised in the home. The activities team were motivated to provide meaningful activities. We made a recommendation regarding the provision of an activities programme so people could see what was planned.

At the time of our inspection we found enough staff were provided to carry out care. Staff numbers were matched to dependency levels of people living in the home.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We saw checks had been made so that staff employed were 'fit' to work with vulnerable people.

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. The home's management had liaised with the safeguarding authorities.

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.

There were six 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 acting manager had also applied for another 19 people to be assessed; we found these were being monitored by the acting manager of the home.

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.

We discussed the use of advocacy for people. There was some information available in the home regarding local advocacy services if people required these; this was collated through the activities organisers. 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 acting manager had provided a response to these.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

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

Medicines were administered safely. Previous concerns around the way some medicines were administered and recorded were improved. This was an improvement from the previous inspection.

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 met.

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

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

Is the service effective?

Requires Improvement

The service was not always effective.

We saw people's dietary needs were managed with reference to individual preferences and choice but this was inconsistent. We made a recommendation regarding this.

When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made. This was an improvement from the previous inspection.

We found the home supported people to access support for their health care needs.

Staff said they were supported through induction, appraisal and the home's training programme.

Is the service caring?

Requires Improvement

The service was not always caring.

We were told there were long waiting times for staff to respond to people when they asked for help and assistance. This affected some people's wellbeing. We made a recommendation regarding this.

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 people's 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.

People's care plans generally showed good detail and evidenced they had been regularly reviewed. This was an improvement from the last inspection. We found some people's care needs had not been included; we made a recommendation regarding this.

There were some activities planned and agreed for people living in the home. We made a recommendation regarding the provision of an activities programme so people could see what was planned.

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?

Requires Improvement

The service was not always well led.

There was no registered manager in post to provide a lead for the home. There had been changes to the leadership and management of the home which had caused instability for staff and people living there.

The action plan submitted by the provider following the last

inspection had not been fully realised and there remained failings in some areas.

We found the senior management structure was now clearly defined and provided better support for the home. The provider had clear lines of accountability and responsibility. This was an improvement.

The systems for auditing the quality of the service had been improved and were more consistent.

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 three days. The inspection team consisted of two adult social care inspectors, a pharmacy inspector and two people who were '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 provisional information we held about the service and this included reviewing the action plan sent to us by the provider following the previous inspection in November 2016. It also included feedback from health and social care professionals.

During the visit we were able to meet and speak with 21 of the people who were staying at the home. We spoke with nine visiting family members.

We spoke with the acting manager and 17of 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.

We looked at the care records for seven of the people staying at the home as well as medication records, two 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.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found the home in breach of regulations regarding people's safe care and treatment. This was because 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. At the time we assessed these concerns as a 'major' risk.

Prior to our inspection on 30 May – 1 June 2017 we received further concerns regarding the health care of three people living at the home. These had been referred through Sefton's safeguarding processes. The concerns included people who had experienced weight loss; poor nutrition, management of fluid intake and management of pressure ulcers.

On the inspection we found there had been improvements which meant the risk to people's health was lower but we remained concerned there was still not enough consistent assessment and monitoring and further improvements were needed.

We reviewed [tracked] the care of seven people living at Manchester house who were defined as having more acute and dependent care needs. We found three of these were being monitored well and were receiving good ongoing care. Four of the people we reviewed did have some anomalies and gaps in their care that meant they may have been at risk in terms of their ongoing health and wellbeing.

For example, one person had a pressure ulcer [admitted form hospital]. They were [prescribed pain relief. The person informed the inspector they were in pain. They had been given some pain relief but this was clearly inadequate. We were told by the nurse that pain had been managed but this was contradicted by the person's interview. We could find no evidence of monitoring of the person's pain [pain monitoring chart for example]. We discussed the need for further review of the person's pain management by the GP.

In another example we saw a person's care notes mentioned they had a wound / pressure sore. We could find no record of a dressing or evaluation. One nurse we spoke with said they had dressed the wound but had not recorded it anywhere. We asked a nurse to update us regarding the wound and another nurse examined the person and advised us this was a 'moisture lesion'. Again we were not clear how this was being treated / managed. We found the care of this clinical need to be confusing and the lack of a common understanding and approach meant the person's ongoing health may have been at risk.

We found an example of another person who had a moisture lesion and similarly there had been no proper assessment of this and there was no dressing record evident.

Another person had lost weight since April 2017 and the care notes advised to monitor and refer to the dietician. Up to the time of our inspection the person had not been referred to the dietician. Lack of referral and further assessment by a dietician meant the person's safe management of their weight loss may have been compromised.

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.

Other assessments and care plans showed good monitoring. For example, a person with challenging behaviour was being supported and managed well with good liaison with professionals. Detailed assessments for mobility and use of equipment meant risks to the person health and wellbeing had been mitigated effectively. Similarly, the ongoing clinical care needs for two people were being monitored effectively and the risks to their health had been appropriately assessed.

At the last inspection in November 2016 we found the provider in breach of regulations because we found some areas of concern that needed to improve to ensure medicines where administered safely. On this inspection we found the management of medicines had improved and the breach was now met.

We watched people being given their medicines at lunchtime and teatime and saw that nurses administered medicines in a safe and respectful way. One person had missed their morning dose of medicine and this could potentially have caused them harm. However, we found that other people did get their medicines at the right times.

We visited the Albert, Hesketh and Victoria areas of the home and looked at the medication records [MARs] for 24 of the 53 people living there. We only found one 'gap' in the administration records. This medicine, which came from a different supplier, had not been 'booked in' so we could not tell if it had been given by counting the remaining stock. One handwritten alteration on another MAR was not dated or signed. This meant other nurses could not tell who to ask if they wanted to check the instructions. All other medicines had been checked upon receipt from the pharmacy and other records on MARs were complete. We checked four peoples topical cream chart, where carers recorded the application of moisturising and barrier creams. These were up to date records and showed people's creams were being used frequently, as prescribed.

Some people were prescribed one or more medicines to be taken only 'when required'. With one exception, extra information on how nurses should give these medicines (in the form of a protocol) was kept with the person's MAR. Most protocols described a person's individual needs well but some were written in a more general way. For example, two people were prescribed both a mild and strong painkiller when required. Their protocols did not tell nurses about the cause of pain or help them to decide which painkiller to offer. We fed this back to the manager.

Medicines were stored safely. Most medicines were kept at the right temperature. However, records in one room showed that the maximum recommended room temperature of 25 degrees Celsius and the maximum fridge temperature of eight degrees Celsius had been exceeded on a number of days. If medicines are not kept at the temperature advised by the manufacturer they may become less effective or even harmful. We fed this back to the manager for action as necessary.

Medicines that are controlled drugs (medicines subject to stricter legal requirements as they can be misused) were stored and handled safely. The stock balances of the six controlled drugs we checked were correct.

The home had an up to date medicine policy describing how staff should manage medicines in the home. We saw that regular audits (checks) were carried out to see if staff followed the policy. The manager had taken the necessary action to correct shortfalls found in the May 2017 audit.

Previously 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 found this had improved and people were now monitored safely with up [to date records available]. 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 asked people whether they felt safe in the home. People we spoke with told us they generally felt safe. One person said, "There's always someone on hand. It's also reassuring having someone with me, for example when I go into town; I'm not very safe on my own." A further two people commented, ""I feel safe but I don't know why" and "It's the staff – [they help]."

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 for staff to refer to.

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 fully 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, although most people said they felt there were enough staff on duty, both day and night. From the observations we made on the inspection 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. We spoke with both senior carers who had responsibility for covering the rotas in terms of care staff numbers. Both said they were supported to arrange rotas to cover the care needs and there were only occasional shortages. The duty rotas we saw conformed this. One care staff commented, "I've been here a few years and the staffing [care staff] is very settled presently."

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.

The nursing team were not as settled. Some key staff had left recently and the clinical lead post was also recently vacated. 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 ongoing assessments of care because of the daily workload and felt more time was needed. These were similar discussions to our previous inspection. Following the previous inspection the acting manager had increased nursing staff cover on the afternoon to support nursing staff; we noted this had again been reduced. We spoke with the acting manager who stated that consideration had been given to increasing nursing cover again – it had been reduced because resident numbers had fallen previously. During the inspection nursing numbers were again increased as the resident numbers had risen. We spoke with the acting manager about the importance of maintaining this staff cover.

We checked how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at two 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.

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. 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.

Requires Improvement

Is the service effective?

Our findings

We received mixed comments and opinions regarding the provision of food in the home. Many people were unenthusiastic, with comments indicating that they thought the food was just acceptable rather than enjoyable. 15 people were asked about meals and half were negative in their comments.

One person commented, "It's not brilliant but it's all right. Sometimes it's not enough and sometimes it's just lukewarm when you get it [in own room]. I get a cup of tea about eight or nine at night, then nothing until breakfast about 9.00-9.30am the next day. There's no hot drink during the morning and none at lunch, just cold [drinks]. The drinks trolley comes round at about 3.00pm but not at teatime."

Some comments indicated better care could be taken with offering choice and quality of the meal time experience: "I don't like it, we get the same things, (it tastes the same) it doesn't taste like homemade food, it's not good at all", "Not a lot, it's the same thing most days, (this person said it tasted the same) there's not a lot of variety" and a visitor said, "It was nice before they got Apetito [external contracted provider of meals], and the pudding used to be served separately. [Person] doesn't like eggs, but they gave [Person] an omelette the other day."

We observed lunch, a pureed diet was served with the different food separated on a plate to help with appearance and make the meal look more appetising; the staff member assisting one person mixed it all up. A staff member was observed stood up supporting two people with their lunch. This did not afford either person with a more personalised dining experience.

There were no drinks served with the meal. A staff member told us "Residents prefer not to drink with meals as it fills them up". Two people who ate in the lounge had their plates on their knees; one person didn't mind but the other didn't like it.

We did receive positive comments regarding the meals as well; "It's plain but good, there's plenty of choice" and "On the whole it's pretty good, there's just one or two things I don't like." it was apparent that meals, although adequate, could be improved.

We spoke to the chef who told us people could have omelettes, jacket potato or cheese on toast if they didn't want the main course off the menu. We saw a menu displayed in the dining room, which offered these kind of choices and more. Most people told us they were offered an omelette as an alternative.

We spoke with the catering manager in respect of feedback about the Apetito meals. Later in the inspection we saw the catering manager undertaking food quality surveys and looking to make changes to the menu in conjunction with Apetito and people's views. We were told by the catering manager that a large print menu board was to be placed in the dining room as the print on the displayed menus was too small. We also found this menu confusing as the catering manager informed us this menu was the wrong menu as this was one used for catering arrangements. We were told a pictorial menu was available and this should be taken round to people each day along with menu for them to choose. The catering manager was to look into this

as it appeared this was not being carried out and people may not be offered the correct choices.

We check whether people were getting enough fluid, particularly those people who required close monitoring. We had received feedback from a visiting health care professional before the inspection who told us they had a concern that fluid monitoring charts were not completed consistently and accurately; they did not ensure that the fluid totals were calculated so it would be difficult to monitor people's fluid intake accurately. We reviewed a number of people who were being monitored. We found charts were kept up to date by staff but the recommendation regarding the totalling of fluids was not being followed. One person we reviewed had less than 1,300mls recorded for the last three days, indicating a risk of dehydration, but this was not easy to see without really scrutinising the charts. Care staff were responsible for reporting poor fluid intake to the nurses for evaluation, but the care staff we spoke with did not have any guidelines for minimum fluid intake for people. When we fed this back, the acting manager instigated improved recording of fluid charts with a total recorded each 24 hour period. The acting manager also introduced a drinks round mid-morning to aid fluid intake.

We would recommend that the quality of the meal time experience and monitoring of fluid intake continue to be monitored in line with best practice.

We looked to see if the service was working within the legal framework of the Mental Capacity Act 2005 (MCA). The 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 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 our last inspection in October / November 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 we found improvements had been made; staff were able to evidence a better understanding of the principles of the MCA. The breach had been met.

For example, we reviewed one person whose capacity to make decisions regarding their care varied due to their medical presentation as they experienced loss of short term memory. We saw that key decisions regarding the person's care had been assessed using a standard assessment tool; these decisions included placement at the home, sharing of information and consent to photos being taken [for example]. We saw the person's partner had been consulted and 'agreed decisions made in the [person's] best interest'.

We had discussion with senior managers regarding continued development and auditing to help ensure principles continued to be embedded. We saw, for example, that the use of bedrails for people, to help ensure their safety, 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; this was not always evident for people lacking capacity.

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.

We saw other care files that contained copies of people who had undergone proceedings through the Court of Protection [to establish accountability and responsibility for key decisions] or had relatives acting on people's behalf through other legal process such as lasting Power of Attorney [LPA].

When we spoke with people we asked whether staff asked routinely for consent to care they were carrying out. Most people gave a qualified 'yes' to this, as an acknowledgement that consent was a 'given', as part of their daily routine. There was no sense that care or support was ever imposed on people against their wishes. We saw entries in care records [although not wholly consistent] where people or advocates had signed to consent for aspects of care.

Staff had applied for 25 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 six people were in place and were being monitored by the acting 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 found that people's health care needs were, overall, being effectively monitored. We found people had received up to date reviews and these included their health care needs. We looked at the health care for seven 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.

People we spoke with and their relatives told us that staff had the skills and approach needed to ensure people were receiving the right care with respect to maintaining their health. People commented: "Oh yes; they're really good", "They seem okay all of the time. I've noticed staff undergoing training in the activity room", "I need someone to help me shower and they do [know what they're doing], yes" and "I've been on the verge of having a lot of trouble with [described issue] and it's now managed well."

We looked at the training and support in place for staff. We spoke with the manager of the 'Academy'. This is a training provision set up by the provider to develop and implement training opportunities for staff in all of the provider services. We were supplied a copy of a staff training statistics and 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 training manager told us the Academy was currently concentrating on developing the induction programme to include standards relating to the Care Certificate; this being the recommended blue print for induction of staff into care settings.

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 52% of staff had attained a qualification and 12 others were currently undergoing such a qualification.

Staff we spoke with said they felt supported by the home's training programme. 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 from meetings undertaken with senior care staff, night staff and domestic staff. During our inspection we saw the acting manager had a meeting organised with night staff the same week. These forums helped staff to have their say in the running of the home.

Requires Improvement

Is the service caring?

Our findings

Staff were consistently kind and friendly in their support of people at Manchester House and relationships appeared to be good between staff and people living there.

People responded positivity when we asked about care in general and staff attitude but we received negative comments when we asked specifically about staff responding when people required direct assistance; this was in relation to staff responding to a call bell (which people activated when they needed assistance). Two visitors commented, "On the whole staff respond but it's these intermittent problems caused by staff shortages and lack of stand aids [mobile hoists] and other equipment that I feel are an issue when it comes to giving proper care to people" "Not completely, no. There seem to be a few issues at the moment that need to get sorted out. The one thing they could do better is get [people] to the toilet when they ask for it. There never seem to be any stand aids around, so people have to wait. My [relative] has waited up to an hour and a half before now."

Staff told us they answered calls bells as soon as they could, although at different times of the day the response time could be longer. Many people required two staff to support them to the toilet and this was an issue at key time so of the day such as meal times if people requested the toilet.

During the feedback with the provider we were informed that more stand- aids would be considered along with as review of care routines. Also it was agreed that an audit would be carried out look at staff response time to calls for assistance and part of this audit would include a review of the current staffing levels.

We recommend the provider reviews how staff respond to people's needs taking into account people's dependencies and the current staffing levels.

We did have concerns expressed before our inspection from visitors and relatives regarding the provision of personal care which ensured people were being provided with dignity around their appearance. At the inspection, however, people we spoke with said they were happy living at Manchester House. They spoke about the approach of nursing and care staff positively. Comments made included, "They're nice", "They're very friendly", "mostly pleasant, and sometimes they're a bit forgetful, they forget to come back to me at night. They answer the bell but then don't come back", "Polite, friendly, I feel comfortable with them" and "Generally the staff are very caring".

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.

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 their bedroom. People said the staff were patient and careful when delivering personal care.

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 arranged on a monthly basis by activities staff. We also saw some surveys given to people such as a recent food survey for March 2017. These forums helped people living at Manchester House to have a say in the way 'things' were run.

People we spoke with were not aware of any advocacy service that might be available. We were advised by the acting manager that the activities staff had information available for people. One example was for a person who had had advocacy input from the local service regarding the provision of various benefits and payments and how these could be accessed.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in October / November 2017 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 provider sent us an action plan telling us this had been addressed and improved. On this inspection we found there had been improvements and the breach was now met.

People had a plan of care to address particular care needs and preferences specific to each individual. A care plan provides direction on the type of care an individual may need following their needs assessment. The care plans we saw recorded information which included areas such as, physical health, mental health, personal care, mobility, skin integrity, medication, sleeping and nutrition. People's plan of care also contained information about the individual from a social aspect, including previous interests, work and leisure pursuits. Information was recorded around preferences and choices for daily living and how people wished to be supported. The completion of personal care booklets helped to evidence information about the person as an individual and what was important and mattered to them. We saw detailed information about people's dietary likes and dislikes and preferred routine, for, example. Input regarding the completion of these booklets was sought from relatives if needed.

When reviewing care documents we found not everyone's plan of care had been updated to reflect the current care provision. For example, we found a person who was receiving 'one to one' support did not have a care plan to explain this and, in respect of a treatment plan for a condition that needed close infection control monitoring one person also did not have a care plan. There was a risk therefore that staff did not have the information they needed to provide the care, support and treatment required. From our observations it was evident the people concerned were getting the care needed.

We recommend the service reviews how people are supported to have care plans that reflect their current care, treatment and support.

The lack of information identified in these two examples was brought to the acting manager's attention and the care plans were updated with the required information. Discussion with staff confirmed their knowledge and understanding of the care these people needed and we saw people receiving this during the inspection. In respect of supporting people with other aspects of care, for example mobility, communication and nutrition, there up to date information which was subject to regular review.

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. Activities organisers were employed and there were social activities going on each day. Trips out from the home were also arranged. Social activities were planned at different times of the day and people's enjoyment and participation was recorded.

We spoke to the activity coordinator who gave us a long list of activities, including: board games, bingo, quizzes, trips out every Thursday, petting animals, reminiscence, jigsaws, knitting, shopping. However, on

the first two days of the inspection we observed the activity room and there was nothing going on. We did see quiz papers on people's tables in the afternoon, but there were no staff around to help people. There was no defined budget for activities.

Most people we spoke with acknowledged that there were a number of activities available to take part in; most of these said they did not choose to do so most of the time, for reasons of poor health or not wishing to socialise. A people said, "Yes; I stay in my room most of the time, writing, reading and watching TV, but during that hot weather one of the activities people ordered up a load of ice cream, put up the gazebos and we all trooped out into the garden. It was lovely. In general, I can get out if there's someone to push me [in wheelchair]." Another person said, "They don't really have any activities every day. The other day we had a game of Bingo – just a makeshift game – and they stopped after the first one."

On day one the planned activity was recorded as being a 'pet visit' but nobody we spoke with had seen any 'visiting' animals and we saw none in the home during our visit. There seemed to be very little for people to do during the day, other than watch television, read or other solitary activities. At times, people were sitting alone at tables and around the lounge/dining room and not engaging with anybody or any activity.

We fed this back to the acting manager. It was clear that activities were organised but these could be better coordinated and advertised in the home; we did not see anywhere planned activities were displayed or advertised.

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. We reviewed a recent complaint and saw it had been responded to quickly and appropriately. The complaint had been investigated and addressed in terms of a response by the acting manager.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in October / November 2016 we identified concerns regarding governance and leadership by the provider at Manchester House. We found the provider to be in breach of regulations. This was because 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. We told the provider to take action.

The information in the Provider Information Return [PIR] stated; 'There is a Deputy Manager as well as a Clinical Lead in post. Regular audits are carried out within the home covering a wide range of areas including Health & Safety, Infection Control and CQC Regulations as well as
Individual focused audits'. The action plan sent to use following the last inspection also reinforced this.

We found on this inspection that some progress had been made in aspects of the governance of the home and this helped negate some of the risk to people's wellbeing we still identified. However, leadership in the home continues to be inconsistent and fractured causing continued instability at Manchester House.

Leadership of the home in terms of a registered manager continues to be an issue. The home has had four changes of management since the last inspection. The current acting manager was not registered with CQC. All of the staff we spoke with identified the lack of consistent leadership in the home as the main barrier to further progress. One of the providers we spoke with explained the position with the last two managers having left abruptly for personal reasons. The current acting manager was, in fact, a regional manager who had stepped down to manage the home. The 'clinical lead' appointed following our last inspection has also recently left. This echoed the position at our last inspection in October 2016.

We found the senior management and organisational structure was much more clearly defined with clear structure from provider, to regional managers, and supporting quality managers and training managers. There had also been a lot of work completed in developing audit tools used to regularly monitor the service to help negate clinical risk. However, whilst CQC had been provided with action plans which had been developed by the [then] registered manager and the regional manager we found evidence that not all of these had been fully actioned. There was a failure to meet some regulatory requirements and provide safe care and treatment. Audits had not picked up some failings such as the clinical omissions leading to issues around safe care and treatment, monitoring of fluid intake and the poor meal time experience. We found further developments were needed for care planning as some people's care needs had not been included in care planning.

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 had still not been recognised and we found that in the main it was managers who were continuing to update care records. We asked the acting manager how newly updated care records would be 'owned' by nurses and carers but there were still no definite plans for this which meant there was a risk people's care would not get reviewed in the future without senior managers' intervention. The acting

manager and provider explained it was still difficult to employ regular full time nursing staff; citing the homes CQC rating as a barrier to employment.

The service remains in breach although they have met three of the outstanding breaches from the last inspection.

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.

We found the provider and managers open and constructive to work with. Immediate feedback following our inspection was met openly and positively. Immediately post inspection we received an 'action plan' from the provider taking immediate action of feedback given. We were also informed that the acting manager would be applying for registration with CQC; this would provide on-going stability in terms of leadership for the home.

The Care Quality Commission (CQC) had been notified of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding Manchester House.

From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Manchester House was displayed for people to see.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Although improved we found that some people's risks regarding their health care were still not being adequately assessed and monitored. This was in relation to wound care, pressure ulcer monitoring and following up on medical recommendations.

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 There had been changes to the leadership and management of the home which had caused instability for staff and people living there. The action plan submitted by the provider following the last inspection had not been fully realised and there remained failings in some areas.