Hyde Lea Nursing Homes Limited

The Manor House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Manor House Nursing Home is a residential care home providing personal and nursing care to 80 people aged 65 and over at the time of the inspection. The Manor House Nursing Home can support up to 85 people in two adapted buildings. One building accommodates people with general nursing needs. The other building accommodates people living with dementia and mental health needs across three separate floors, each of which has adapted facilities.

People's experience of using this service and what we found
Audit systems were not always sufficiently robust to check the quality of the service or ensure that documentation was consistently personalised to guide staff regarding each person's individual needs. Accident and incident recording was inconsistent across the units and we could not always see whether trends had been identified so action could be taken to reduce the risk of reoccurrence.

Care planning documentation used did not always promote person centred care and people's diverse needs were not always documented. Care plans were not always detailed enough to ensure people received personalised support to meet their individual needs. Activity co-ordinators undertook activities with people but not all people were consistently provided with opportunities to access activities of their choice.

People were safe. Systems were in place to keep people safe and staff understood how to keep them safe. People's risks were assessed and staff understood how to manage risk to people. Staff were supported by a sufficient number of safely recruited staff. Medicines were stored and administered safely. People lived in a clean environment and staff understood how to prevent the spread of infection. Where things went wrong, lessons were learnt and action was taken immediately to reduce the risk of reoccurrence.

People's needs were assessed and care was delivered in line with their assessments. People were involved in the assessment process. People were supported by knowledgeable and well trained staff who had the skills to meet their needs. People were supported to eat and drink in line with their dietary requirements. People were supported to access healthcare professionals where needed and staff worked together to provide consistent care to people. People's rooms were personalised with their own belongings.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were supported by kind and caring staff who respected them. People were encouraged to express their views and make decisions about their care. People were supported by staff who respected their privacy and dignity. Staff promoted people's independence and supported them to do what they could for themselves.

Staff knew people well and understood how to meet people's communication needs. Complaints were investigated and action was taken to address any concerns. People's end of life wishes and preferences were discussed with them and advanced care plans were in place.

The provider and registered manager were open and honest with people when things went wrong. People, their relatives and staff were encouraged to feedback regarding the service and were given the opportunity to put forward their views. The registered manager was proactive in learning and encouraged staff to improve their learning in order to provide better quality care to people. The provider worked closely with health and social care professionals to improve outcomes for people.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 21 July 2017).

Why we inspected
This was a planned inspection based on the previous rating.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. Details are in our safe findings below.	**Good**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Care Quality Commission

The Manor House Nursing Home

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of one inspector, an assistant inspector, a specialist nurse advisor and an 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.

Service and service type
The Manor House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the

service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and three relatives about their experience of the care provided. We spoke with eight members of staff including the registered manager, two unit managers, a senior nurse and some healthcare assistants. We spoke with two professionals who were on site during the inspection. 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 reviewed a range of records. This included 13 people's care records and multiple medication records. We looked at one staff file in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at team meeting minutes and additional records including medicine records.

Good

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe. One person told us, "I'm safe here."
● Staff had received safeguarding training and understood how to keep people safe. One staff member told us, "I have had safeguarding training. The types of abuse include physical, emotional, verbal abuse. For example, if I saw a colleague hit a resident or something wasn't right, I would report it straight away. I would have to do an incident form if this happened."
● Staff were confident the registered manager would act to promote people's safety, should any concerns be identified.

Assessing risk, safety monitoring and management
● People's risks were assessed and reviewed when needed to keep them safe.
● Staff understood and followed risk assessments.
● Risk assessments were in place to guide staff how to support people to use equipment safely. One person who used a hoist to transfer told us, "Staff lift me carefully." One staff member told us, "[Person's name] is hoisted. We always use two carers, we always make sure it's the right size sling and the sling is tucked in properly."
● Where people displayed behaviour which may result in harm to themselves or others, risk assessments were in place that guided staff on how to manage people's behaviour.

Staffing and recruitment
● People provided mixed feedback regarding whether there were enough staff to support them but evidence did not indicate this was impacting upon people's safety. One person told us, "They are very short of staff and need more. I have a call alarm and have to wait." However, one relative told us, "There's plenty of staff and we rely on them to keep watch. Staff turn [Person's name] in bed two hourly and its recorded in the blue book." Staff confirmed they repositioned people regularly and recorded when they did this,
● We checked people's records and saw that people were being repositioned in line with their care plans and enough staff were available to ensure people's needs were met safely. On the day of inspection, we observed sufficient staff available to keep people safe.
● Where people required 1:1 support to meet their needs, consistent agency staff were used specifically for this role to ensure people always had the individual support they needed.
● Staff were recruited safely which ensured people were supported by suitable staff who were able to meet their needs. Disclosure and Barring Service (DBS) checks were undertaken and gaps in employment history were checked prior to staff commencing employment.

Using medicines safely

● People's medicines were stored and administered safely. One person told us, "I get my tablets at the same time every day."
● Medicine Administration Records (MARs) were completed by staff when medicines were administered and body maps were in place for the administration of topical creams.
● Protocols were in place to guide staff when to administer 'as required' medicines and staff understood when these medicines should be administered.
● Where medicine errors were identified, these were investigated, and action taken to reduce the risk of reoccurrence.

Preventing and controlling infection

● People were supported by staff who understood how to prevent infection. One relative told us, "Staff always wear gloves and aprons when taking [Person's name] to the toilet and changing their pads."
● Communal areas were cleaned throughout the day during the inspection and people told us their rooms were kept clean. One person told us, "The room is kept clean. My washbowl and toilet are kept clean."

Learning lessons when things go wrong

● When medicine errors had been made, action was taken, and staff were spoken with to reduce the risk of this happening again.
● One social care professional told us where there had been safeguarding concerns raised previously, the registered manager had immediately acted to reduce the risk of reoccurrence.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed, and care was delivered in line with their assessments.
- People and their relatives were involved in assessments. One relative told us, "Currently, [Person's name] is being assessed. We were asked questions and we also asked the manager questions."
- Staff consulted other health and social care professionals and acted on their advice, so people's changing needs continued to be met.

Staff support: induction, training, skills and experience

- People were supported by knowledgeable staff who had the skills to meet people's needs. One person told us, "I think they are trained. The young ones learn quickly."
- Staff were provided with an induction when they started the job to ensure they had the skills to meet people's needs. One staff member told us, "The induction was good, this is my first care job. The person who did the induction was really good and taught me everything."
- Where staff had not completed mandatory training, the registered manager had identified this, and training dates had been arranged to ensure all staff were compliant.

Supporting people to eat and drink enough to maintain a balanced diet

- People consistently told us they were satisfied with the food. One person told us, "The food is alright. I can eat what I want. Staff bring me drinks".
- People were supported to eat and drink in line with their dietary requirements. One relative told us, "[Person's name] has pureed food due to a swallowing difficulty. They are fed but do refuse sometimes. The staff record their intake. They drink from a straw in a beaker."
- Where people had dietary needs, their food was presented in a way that was dignified. One relative told us, "Staff do enquire and encourage [Person's name] to eat. They get a mashed diet as they are a choking risk. The parts of their meal are kept separate. The meal is quite well presented."
- People's weights were monitored and action was taken where concerns arose regarding any unexplained weight loss or weight gain.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff worked closely with agency staff to provide consistent support to people.
- People were supported to access healthcare professionals when needed. One relative told us, "The GP

visited this Tuesday and the social worker has been. [Person's name] has diabetes and the home has a visiting podiatrist."
● People were supported by staff to meet their oral healthcare needs. One person told us, "Staff help me to brush my teeth."
● Staff worked closely with visiting health and social care professionals. One professional told us there was very good communication between them and the staff.

Adapting service, design, decoration to meet people's needs
● People's rooms were personalised with their own ornaments and photographs. One person told us, "I've got my own things in my room."
● Pictorial signs were used to identify toilets and lounge areas to support people living with dementia and mental health needs to orientate around the building.

Ensuring consent to care and treatment in line with law and guidance
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 when this is in their best interests and legally authorised under the MCA. 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.

● Staff understood the principles of the MCA and knew how this applied to supporting people. One staff member gave us an example of how they would try to maximise someone's capacity. The staff member told us, "I would show them two different outfits so they could pick what to wear. If they couldn't make a decision, I would choose in their best interests."
● Decision specific mental capacity assessments were completed where required. For example, where people's liberty was being restricted through the use of bed sensors and crash mats.
● Where people were unable to make decisions for themselves, best interests' decisions had been made in the least restrictive way possible.
● Staff asked people for their consent before supporting them. One person told us, "They don't just do things with me. They do ask."
● Where people were deprived of their liberty, appropriate DoLS applications had been made.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
● People were supported by kind and caring staff. One person told us, "The staff are caring."
● People were spoken to in a respectful way. One person told us, "Staff speak politely to me."
● People were supported by staff who built a positive rapport with them. One person told us, "I get on well with the staff here."

Supporting people to express their views and be involved in making decisions about their care
● People were supported to make decisions regarding their care. One person told us, "I usually say what clothes I want. They (carers) get them out of the wardrobe for me."
● People were given choices of food and drinks at meal times.

Respecting and promoting people's privacy, dignity and independence
● People were supported by staff who respected their dignity. One staff member told us, "If I'm supporting someone with personal care, I draw the curtains and shut the door. If I'm washing them, I keep them covered with a towel."
● Staff treated people with dignity when they were supporting them to use equipment. One staff member told us, "I make sure people's legs are closed if they're wearing a skirt and will put a blanket over them."
● Staff understood and respected people's wish for privacy. One person told us, "Staff respect me because of my age. I insist they knock on my door"
● People were supported to do what they could for themselves. Where people walked independently with walking aids, these aids were within reach to ensure people could maintain their independence.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People's diverse needs were not always documented which posed a risk that care was not always provided consistently in line with their needs and preferences. For example, one relative told us the provider was supporting them to arrange a visit by a religious figure, but other people told us about religious needs that were not documented in their care plans.

● Care plans did not always contain the level of detail required to ensure people received personalised support for individual needs. For example, one person was diabetic, but their care plan did not contain sufficient detail to guide staff what to do if their blood sugars were excessively high or low.

● Care plans were inconsistent in the level of detail they contained to guide staff how to meet people's personalised needs. 'This is Me' documentation was in place for some people which contained personalised information such as people's interests and family but this was not consistent across each person's care file. The registered manager told us 'This is Me' documentation would be completed for each person as soon as possible to ensure personalised care could be delivered consistently.

● Behaviour management plans and protocols to guide staff when to administer 'as required' medicines were not always personalised sufficiently to each person's needs.

● People told us that whilst they felt safe, they did not always think there were enough staff to deliver care in line with their preferences. One person told us, "Everyone wants to go to bed at the same time but there are not enough staff doing it so sometimes we have to wait up to 2 hours." We spoke with the registered manager about this who confirmed she would look at staffing ratios at this time.

● Despite documentation not always reflecting people's needs and preferences, staff knew people well. One social care professional told us, "Staff know people well and do know their likes and dislikes."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were not always provided with consistent opportunities to access activities of their choice.

● Activity co-ordinators were employed specifically to support people to follow their interests and take part in activities. We saw activities included arts and crafts and yoga had been undertaken. One social care professional told us, "They do lots of things with people here, they bring animals in, there's lots of stimulus."

● However, most activities were undertaken on the general nursing unit so people living with mental health needs were not always consistently supported to engage in activities of their choice. One person told us, "There's not a lot to do. The residents entertain each other."

● People's relatives were able to visit them when they wished.

● The registered manager told us they would look at how activities were delivered at the home to ensure all people had the same opportunities.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People had communication care plans in place which guided staff how to meet their communication needs.
- Staff understood how to meet people's communication needs. One staff member told us, "If a person didn't understand what I was saying, I would write it down and turn the television off to allow them to hear me better."

Improving care quality in response to complaints or concerns

- Complaints were investigated, action was taken when needed to address them and responses were given to people or relatives who complained.
- One relative told us, "I haven't complained but I have brought things to people's attention. Staff listened and the home rang me so they take things seriously."

End of life care and support

- People's end of life wishes were discussed with them and their relatives. People had advanced care plans in place that detailed their preferences at that time of their life.
- People had 'Do Not Attempt Resuscitation' orders in place that had been discussed with them and their relatives.
- Relatives were provided with support with understanding people's end of life needs. One relative told us, "The home gave me a form recently about the future when my relative passes away."

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Audit systems were in place to check the quality of the service, but these were not always effective to ensure that all concerns would be identified. For example, medicines audits were undertaken but these were only completed for a sample of people, so errors would only be identified for people whose MARs were audited. Medicine audits also failed to identify where people had surplus stock of medicines.

● Audit systems did not identify where documentation was not consistently personalised to ensure they guided staff how to meet people's individual needs. For example, care plan audits were not effective in identifying where 'about me' documentation had not been completed. Medicine audits also failed to identify where protocols for 'as required' medicines were not personalised.

● Call bell response times were not monitored which meant there was a lack of oversight over how long it was taking staff to respond to people when they needed them.

● Audits did not always identify where documentation had not been completed in full. For example, for one person, we saw their diabetes sugar levels were high. The unit manager told us how this had been addressed but this had not been documented and it hadn't been picked up in any case file audit.

● Documentation used for accidents and incidents was inconsistent across the units and action taken following incidents that occurred wasn't always documented. This meant that trends were not always identified so action could be taken to reduce the risk of reoccurrence. We spoke with the registered manager regarding this who took immediate action and showed us consistent documentation had been reissued to all units for use going forward.

● The registered manager and staff were clear about their roles. The registered manager also told us they were currently recruiting for a nurse liaison manager which would give additional nursing support to the unit managers.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider and registered manager promoted an inclusive culture within the home which achieved good outcomes for people in relation to maintaining their safety and providing effective care.

● However, the documentation used to plan people's care did not always promote person-centred care as it was not always personalised and maintained a focus on people's health rather than their holistic needs.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong

- The provider and registered manager were open and honest and operated in accordance with the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People, relatives and staff were encouraged to be involved in the service and there was an open-door policy in place to enable their views to be heard.
- The registered manager told us that surveys were usually issued to gather feedback from people, relatives and staff although these had not been done over the past year due to a change of management. The registered manager showed us the survey that had been devised and told us this would be issued in January 2020.

Continuous learning and improving care

- The registered manager was proactive in learning to improve the quality of care people received.
- The registered manager told us she had been reading CQC reports for services rated as 'outstanding' in order to improve the service.
- The provider and registered manager encouraged staff to undertake additional qualifications to aid their learning.

Working in partnership with others

- The provider worked closely with health and social care professionals to improve outcomes for people. One social care professional told us, "There is very good communication, they are listening, and things have improved."