Hyde Lea Nursing Homes Limited

The Manor House

Inspection report

Burton Manor Road
Hyde Lea
Stafford
ST18 9AT
Tel: 01785 250600
Website: www.manorhousestafford.co.uk

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Ratings

Overall rating for this service	**Good**
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?	**Good**

Overall summary

This inspection took place on 12 November 2014 and was unannounced.

The Manor House Nursing Home is registered to provide accommodation for up to 82 people who require nursing or personal care. At the time of this inspection 78 people lived at the home.

The home had a registered manager. 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.

Staff had received training in protecting people from harm and were clear about the actions they should take if they had suspicions that people were not safe.

Summary of findings

Some people who used the service were unable to make certain decisions about their care. Staff were aware of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty safeguards (DoLS). Referrals were made for people who may have their liberty restricted.

Recruitment processes were in place to ensure only people suitable to work in care were employed. New staff completed a thorough induction programme before they started working on the units. Staff received training that was necessary for them to do their job.

People were involved in the planning of their care whenever possible. Where this is not possible, representatives were involved. Assessments were completed when people were at risk of harm.

Medication was managed safely and people received their medication when they needed it.

People were provided with a well-balanced diet. However, the mealtime experience should be reviewed so that people can enjoy their meal in a more pleasurable way.

People spent periods of time with little or no stimulation, recreational and leisure activities were not readily available. The recruitment for staff to support people with their hobbies and interests was on-going.

People were treated with dignity and respect. Staff were patient, caring and compassionate.

Complaints and concerns regarding the service were dealt with by the manager.

There was a registered manager and staff told us they felt well supported by the manager and the management team. We were informed of significant incidents and the action taken to reduce the risk of recurrence.

Systems were in place to monitor the quality of care being delivered. The manager had plans for improving the quality of the service provided and for the benefit of people living at the home.

Summary of findings

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. Safeguarding procedures were followed when there was a suspicion that people were at risk of harm.

Staffing levels were determined by the support needs of the people who lived at the home.

Medication was administered safely.

Good

Is the service effective?

The service was effective. People were provided with a well-balanced diet. People's risks of dehydration and malnutrition were identified and appropriately managed. This meant people were provided with sufficient food and drink to maintain their health and wellbeing. But improvements were needed with the presentation of the meals and the meal time experience.

Staff were aware of the principles of the Mental Capacity Act 2008 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Good

Is the service caring?

The service was caring. We observed that staff were kind, patient and compassionate. People told us the staff were caring.

People's privacy was respected and their dignity upheld.

Good

Is the service responsive?

The service was not consistently responsive. Limited recreational activities were available. People spent periods of time with little or no stimulation. The manager had plans for improving the opportunity for people to engage in hobbies and interests of their choice.

Whenever possible people were involved with the planning of their care. When this was not possible, where appropriate, people's representatives were involved.

Concerns and complaints were dealt with by the manager.

Requires Improvement

Is the service well-led?

The service was well led. The home had a registered manager. Staff reported that the management team were supportive and helpful.

There were quality monitoring systems in place and action plans for improvement.

Good

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 was 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 November 2014 and was unannounced.

The inspection team consisted of two inspectors, a specialist dementia 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.

Prior to the inspection we looked at the information we held about the service. This included notifications of significant events that the manager had sent us, safeguarding concerns and previous inspection reports. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with the majority of people who used the service. Some were unable to tell us about their experiences, however 10 people told us what life was like at the home. We spoke with 11 visitors and relatives, 14 staff and the registered manager. 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 carried out a lunchtime observation to see how people were supported during meals.

We looked at the care and support records of seven people who used the service. Other records we looked at were the staff training records, rosters, recruitment procedures, medication records and the provider's quality monitoring audits.

Good

Is the service safe?

Our findings

Most people told us they felt safe and secure living at the home. One person told us: "Yes I feel safe the staff are always around and there to help when I need it". One person told us that on occasions they became anxious and apprehensive because of the actions of some of the other people who lived at the home. They said: "Staff come and help me if people come too close to me". Staff told us there were some people who required one to one support to reduce the risk of them or others coming to harm. We saw that staff were available in areas where this level of support was required and were speedy in their responses to meet the needs of people.

A visitor we spoke with told us they felt their relative was safe at the home. They told us: "Whenever I visit there always seem to be someone [staff] around. My [relative] is safe and well looked after". We did not see any delays in people receiving support from the care or the nursing staff during our visit. Call bells were responded to within a reasonable time. The manager told us that when people's needs changed and additional support was required the staffing levels were increased accordingly. The duty rotas recorded the levels of staff needed for each unit and included the additional staff to cover the one to one support requirements. Arrangements were in place to cover any unexpected vacancies, for example short notice sick leave, with either agency or bank staff.

Some people were unable or did not wish to speak with us because of frailty or personal preference. We observed that people looked comfortable; they had been provided with their own wheelchairs and armchairs that were suitable for their individual needs and for their personal safety. Records showed that people had been assessed for equipment that was appropriate to maintain their safety, comfort and well-being.

Staff told us they had received training in safeguarding awareness and protecting people. They were able to tell us about recognising potential abuse. They were clear about their responsibility to act on any concerns and to report these to senior staff or the manager. The training record showed that nearly every member of staff had received safeguarding training. As part of the planning for the inspection we saw that the manager had notified us when they had referred safeguarding concerns to the local authority.

Staff told us that some people required additional support to help them reduce the risk of developing pressure ulcers due to frailty and immobility. We saw a person who was in bed due to deterioration of their health. They were unable to fully comment but told us they were 'okay'. Risk assessments and care plans had been completed to support staff with information for the care that was to be provided. We saw staff completed monitoring records each time people received support with repositioning and pressure area care throughout the day. This meant that risks to people of developing further skin damage were kept to a minimum.

The manager told us that the recruitment for staff was on-going. We looked at the recruitment files for four members of staff. We saw that the necessary checks to assess people's suitability to work at the home had been made. Staff we spoke with confirmed that references and police checks had been completed before they were offered employment. This meant the provider had safe recruitment procedures in place.

We looked at the way the service managed people's medication. Medication was stored in a locked cupboard and transported to people within the units in locked trolleys. Each person had a medication administration record (MAR) which included a photograph for identity purposes and a list of prescribed medication. Arrangements were in place for the administration of medication that was needed occasionally. Staff asked people if they were in pain and offered pain relief. The nurses told us how people preferred to have their medication and this was recorded in their care plan. Records of the types and frequency of medicines administered were maintained. This showed that systems were in place to ensure people received their medication safely.

Good

Is the service effective?

Our findings

People told us that the staff were good and they were satisfied with the care and support that was provided. Staff told us the training provided was good and there was plenty of opportunity for additional training if they felt they needed it. One member of staff told us how dementia care training had helped them to understand and have a greater awareness of the condition. Some people at the home were living with dementia; we saw staff were patient, kind and compassionate when providing support to people. Records detailed the courses available for staff and the date they received the training. Specialist training for example tissue viability and specific illness and conditions were available and arranged for staff. Staff were supported to gain the knowledge and skills they required to provide the care and support to people.

We spoke with a group of five new employees who were working through an induction programme. They told us that the induction programme lasted for four days and that it was informative and thorough. Following this formal induction period new staff worked alongside more experienced workers. This meant that new staff were provided with the basic training and knowledge to provide people with appropriate support.

The manager told us that some people who lived on the mental health units needed constant supervision and were not free to leave the building. This was for the safety of the person and to reduce the risk of them coming to harm. The manager told us that meetings had been held with various health care professionals and Deprivation of Liberty Safeguards (DoLS) referrals had been completed and sent to the local authority for authorisation. In a care file we looked at, for a person who needed constant supervision, there was information on the impact this had on them and the action staff needed to take to support the person. We saw that staff supported this person in a calm and non intrusive way; this corresponded with the recorded instructions in the care plan.

Staff told us they had received training in the Mental Capacity Act 2005 (MCA) and that gave them a greater understanding and awareness of how to support people who lacked capacity to make decisions. Staff told us that people's preferences for end of life care had been recorded. In a care plan we saw a 'Do Not Attempt Resuscitation' (DNAR) form was in place. The form was fully completed and included discussion with the person's representative. This person was living with dementia. A capacity assessment in regard to the MCA had been completed which identified that the person had fluctuating capacity but was unable to make this specific decision. This meant the provider followed the principles of the MCA, and decisions were made in people's best interests.

We observed the lunch time period in the three mental health units. A staff member told us: "There is a weekly choice of menu but of course no one can remember what they ordered so long in advance". We did not see any menus in written or pictorial form to remind people what they had previously chosen. One person said: "I can never remember what I have ordered but this is alright as the food is good and I like what is put in front of me". People told us they liked the food and had enough to eat. Some people were served their meal in the dining areas. Some people had their meals in the communal areas or their bedrooms where they were supported by staff. We saw that staff encouraged people to eat and discussed what was on offer. On occasions staff were called away in the middle of supporting people with their meal in order to help other people or answer call bells. Where people had been identified as being at risk, monitoring charts were completed to show what people had to eat and drink over the 24 hour period. However, the mealtime period that we observed was chaotic and disorganised and was not presented in a way to encourage independence or enjoyment. The manager offered an assurance that action would be taken and amendments made to improve the mealtime experience.

Staff told us that they contacted external healthcare professionals for guidance and support when it was needed. For example community mental health nurses, speech and language therapists, occupational therapists and doctors. One visitor told us that recently their relative had been referred to the memory clinic as there had been a marked deterioration in the person's capacity to remember or recall events. We saw that records and care plans were updated and reviewed where any changes were recommended following the input from the health care professionals. For example people's weight, pressure area care and mental health. People were supported with their health care needs to enable them to remain as well as possible.

Good

Is the service caring?

Our findings

We spent time in the units where people living with dementia were accommodated. Staff took time to sit with people and chatted about past life events, family and friends. A visitor told us: “I have found the staff to be caring, nothing seems to be too much trouble for them”. Staff involved people with making everyday choices about their care. For example what drinks they would like. We saw one person wore a favourite necklace and make up. They told us they liked to wear lipstick. We saw staff were patient and relaxed when supporting people with their care needs.

We spoke with a visitor about the care provided to their relative. They told us: “I have found the staff pleasant, helpful and caring. I have been through my relative’s care plan with staff; it was good to be involved”. Staff told us that ‘family days’ were arranged on the units. This is where people and visitors had the added opportunity to speak informally with staff. Suggestion boxes were positioned at the entrance to the home and on the units to offer people the opportunity to make suggestions and comments anonymously. The manager explained they were available when people needed to speak with him if there were concerns or issues relating to the care provision. This meant that arrangements were in place to support people to express their views about life at the home.

One person told us they previously had an advocate to support them with decision making. They told us that they would like to see the advocate again. An independent advocate is a person who supports and enables people who have difficulty representing their interests, to exercise their rights, express their views, explore and make informed choices. We informed the nurse who said they would make the necessary arrangements.

Most people required some level of support with maintaining their personal care; staff ensured that the privacy and dignity of people was upheld during these interventions. One relative commented: “I visit regularly throughout the week; I am very satisfied with the care provided, my [relative] is always well dressed and groomed. They were always very particular about their appearance and I’m happy to say this has continued with the care and support they now need”. We saw that people’s privacy was respected. For example staff supported one person to move from a communal area to a private area in the home so they could receive treatment from a nurse. We also saw that people’s private information contained in their care records was kept secure. This showed that people’s right to privacy was respected.

Requires Improvement

Is the service responsive?

Our findings

We asked people what they liked to do at the home. One person told us that they liked to go out into the local town. They told us: "Staff take me out shopping when I ask. I like to do arts and crafts and staff help me with that". Another person told us that they liked to watch television and listen to music. We saw a small group of people were supported to go shopping during the morning of this inspection. They told us that they enjoyed going out.

Observations in the mental health units showed that people spent periods of time with little or no stimulation. The television was on; people did not seem to be interested in the programme. We observed that people became restless and agitated at times. Staff were available to support people. They were patient and kind; they either sat with the person or offered them support to move to another area of the unit. The manager told us they had identified that additional staff were needed for arranging and facilitating recreational activities. They went on to say that two new members of staff had been recruited and were due to begin work very shortly.

People had a plan of care that was based on their personal requirements and preferences. Whenever possible they and/or their representative had been involved with the process. A visitor told us they had been involved with the review of their relative's care as they [their relative] was now too frail and unable to be fully involved. We saw staff provided care and support to people throughout the inspection; this corresponded with the information recorded in the care plans.

A member of staff told us that a person's condition had deteriorated and they required additional equipment to help and support them with their comfort. Following referral and visit from an occupational therapist the recommended equipment was provided and in use. The person was unable to fully tell us how they were feeling but smiled and told us they were 'okay'.

We saw staff provided care and support to people throughout the inspection; this corresponded with the information recorded in the care plans.

The manager told us that they had received no formal complaints since the last inspection. They told us that if they were informed that someone had concerns about the service they would make a point of visiting or speaking with the person as soon as practicably possible. Issues could then be addressed straight away. One member of staff told us: "Problems are dealt with very swiftly". There were no complaints for us to review since our last inspection but the manager demonstrated they understood the complaints process.

Good

Is the service well-led?

Our findings

There was a registered manager in post. There were clear lines of accountability, the nursing and mental health units had a unit manager supported by nurses and care staff. Staff we spoke with were clear about who they should report to. Staff told us that the manager and senior staff were supportive and helpful. One staff member told us: "The manager is supportive and we are all included in the team".

Staff told us that unit meetings were held at regular intervals. They found them useful as it gave them the opportunity to meet with staff and to discuss unit related issues. Minutes of the meetings were completed and available for staff to read if they were unable to attend the meetings.

Each provider has a legal responsibility to submit notifications to us. We had been notified of significant events which had occurred at the home. For example accidents and incidents and the action that the provider had taken. This showed that they were open and transparent in the sharing of information.

Systems were in place to check the quality of care the home provided. Each unit manager completed their own audits every month. For example, accidents and incidents, falls, infection control, bedrails and mattresses, care plans and pressure ulcers. These were then checked and analysed by the manager who completed an action plan when risks and issues were identified. This demonstrated the provider had a system to identify risks, make changes and to improve the quality of care provided.

The manager told us of the recent improvements to the service which included a revised recruitment and induction process, changes to the management structure and an in-house staff trainer. Future plans included a revision of the medication procedures, provision of WIFI, a sensory garden and taking part in the pilot scheme to promote higher standards of dementia care, with a staff member becoming a dementia champion. This meant that the management of the home were continually assessing and monitoring the quality of the service to identify and implement improvements for the benefit of all people.