Mrs M Rai and Dr N S Rai

Manor House Care Home

Inspection report

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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

The inspection took place on 17 August 2018 and was unannounced.

Manor House 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 home is situated near local amenities. It has two floors and both have bedrooms and communal spaces, however at the time of our inspection only the downstairs communal spaces were in use. There was a secure outside area.

The service is registered to provide accommodation for up to 25 people. At the time of our inspection eight people were using the service.

Manor House had not got a registered manager, however, there was a manager in post who had been in post three months. They had commenced the process to become registered. 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.

There were not always sufficient staff to meet people's needs. Complaints were not always addressed in line with the providers policy. The governance systems in place to support the development of quality and improvement were not always robust. Audits had not always been completed to reflect on trends and support changes. People's views had not always been considered.

People had not always been given the opportunity to follow any interests or activities. Care plans did not always reflect all the needs people may have to enable the care they required.

The environment did not always support people's needs or provide clear signage to support people living with dementia to find their way around the home. Safe medicines systems were not in place to support medicine management in line with current guidance. When risk assessments had been completed they did not always reflect how risks could be reduced to maintain people's safety. Measures were not always in place to reduce the risk of infections.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, however the policies and systems in the service did not support this practice. We have made a recommendation in relation to following the guidance in relation to the Mental Capacity Act.

Staff felt supported by the manager. People enjoyed the meals and referrals had been made to health care

professionals to support people's health needs and wellbeing.

People received care from staff who had established positive relationships and staff knew how to protect people from harm. However, systems in place did not always ensure staff had the time to provide people with the level of care they needed. Individuals independence was encouraged, when possible. People's dignity had been considered, however staff time restrictions had an impact on people's choices.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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

There was not always enough staff to support people's needs. Medicines systems were not always in place to manage medicines safely. Measures were not always in place to reduce the risk of infections.

Risk assessments were not always completed to reflect how risks could be reduced. Staff knew how to protect people from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not always effective

People were not always supported with their choices. When people were unable to make decisions the assessments and decision process was not always in place. The environment did not always support people's needs or provide signage for people living with dementia.

People enjoyed the meals and referrals had been made to health care professionals to support people's health needs and wellbeing.

Is the service caring?

Requires Improvement

The service was not always caring

People received care from staff who had established positive relationships.
However, systems in place did not always ensure staff had the time to provide people with the level of care they needed. Individuals independence was encouraged, when possible. People's dignity had been considered, however staff time restrictions had an impact on people's choices.

Is the service responsive?

Requires Improvement

The service was not always responsive

Complaints were not always addressed in line with the providers policy.

People had not been given the opportunity to follow any interests or activities. Care plans did not always reflect all the needs people may have to enable staff to support them with the care they required.

Is the service well-led?

Requires Improvement

The service was not always well led

The governance systems were not always robust to support the development of quality and improvements. Audits had not always been completed to reflect on trends and changes in support needs. People's views had not always been considered.

There was no registered manager, however the new manager had commenced this process. Staff felt supported by the manager.

Manor House Care 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 August 2018 and was unannounced. The inspection was completed by two inspectors. This was the home's first inspection since their registration with us in July 2017.

We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information that we had received from the public. We used this information to formulate our inspection plan.

We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with three people who used the service and two relatives. Some people were unable to tell us their experience of their life in the home, so we observed how the staff interacted with them in communal areas.

We also spoke with two members of care staff, the cook and the manager. The regional manager was present when feedback about the inspection was provided.

We looked at the care records for three people to see if they were accurate and up to date. In addition, we looked at audits completed by the home in relation to falls, incidents and infection control. We also looked at minutes for meetings, feedback events and the providers action plan.

Requires Improvement

Is the service safe?

Our findings

There was not always enough staff to support people's needs. One person told us, "Staff usually answer quickly when I ring for them, but then ask me to wait. Based on this I don't think there is enough staff." There were two staff on duty and we observed that the communal lounge was left unsupervised for large periods of time. For example, during the morning between 10.25am and 10.50am, no staff member entered the lounge. This was due to the staff on duty either supporting other people with their personal care needs or administering medicines. We noted other periods throughout the inspection when the lounge was not supervised. During one of these periods we saw one person walking with their walking aid and asked other people seated in the lounge for directions to the bathroom. There was no staff to guide them and the person became anxious.

The staff we spoke with felt that at times some people were not always safe as they could not be closely supervised and care was rushed. One staff member said, "There are not enough staff, it takes two for hoisting people." We observed on two occasions the call bell could not be responded to in a timely manner. This was due to the two care staff supporting another person to transfer, from one chair to another using equipment, this meant there was no other staff available. One person had been in their chair since 8.00am and they had not been provided with any pressure relief until they were transferred to a wheelchair to go back to their room at 3.00pm. This person relied on staff to support their toileting needs and pressure relief, this time frame gave concern to the increased risk of possible sore skin. This person also had to wait 30 minutes for their meal as staff were supporting other people.

Within the PIR the provider had told us they used a staffing ratio of one staff member to four people. This method does not take into account people's differing needs and the layout of the building. For example, people who required two staff to support them periodically through the day or people who choose to stay in their room, which was on the first floor of the home. We discussed this with area manager during feedback and they agreed to review how they calculate the staffing and reflect it against people's needs.

This demonstrates a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The home had regular domestic staff, however they were on annual leave for one week at the time of our inspection visit. In addition newly recruited housekeeping staff, had decided not to commence their role and this had an impact on this area. The domestic duties had not been replaced with another staff member, so the care staff had been tasked with cleaning the home in addition to their care duties. We saw that people's slings were left in a pile on the corridor. Slings are used when people require a transfer using equipment. To avoid the risk of infection each person should have their own sling and they should be hung up to avoid cross contamination. Cross contamination is a the process by which bacteria or other microorganisms are unintentionally transferred from one item to another, with possible harmful effect. We observed staff used protective equipment like gloves and aprons when they provided personal care or served food to people.

Medicines were not always managed safely. For example, some people with swallowing difficulties required

their medicines to be crushed and added to a drink. We observed one person did not drink all the contents, this meant we could not be sure the person had received all of their medicines. We asked the manager to seek advice from the pharmacist, this was completed during the inspection and the new advice was recorded. This was to provide the person with a smaller amount of fluid to assist the person in taking all their medicine.

There was no established medicine round, people were given their medicine to suit their routine. However, one person was sitting in the lounge at 10.30am, and did not receive their medicine until 12.15pm. This meant the next member of staff administering medicine would not know what time the previous dose had been given and what potential impact could have for the person. This was a morning dose and the person had received it until midday, this also meant the person was not given their medicines as prescribed.

We saw when people required topical creams they were recorded; however, one cream was directed to be disposed of after seven days. This meant usage after this time could have an impact on the integrity of the cream. We found the cream in the persons room and it had expired in the seven day timeframe. When people required medicine on an as required basis, such as pain relief, they had a protocol in place. However, when the medicine was administered the reason was not fully documented. This meant that any trends could not be identified to reflect on the pain the person maybe experiencing.

Where risk had been identified there was not always an assessment in place to consider how the risk could be reduced or managed. For example, one person had breathing difficulties, there was no risk assessment to consider how to support the person to reduce the impact of their breathlessness or to give information to staff on how to recognise the person's breathing was deteriorating. Other risk assessments were stored together and not linked in to the care plan section which related to the risk. These assessments were all dated February 2017 and we were unable to identify any review of the assessments following any changes of the person care needs. However, we did see detailed risk assessments in relation when people required moving and handling. Staff were knowledgeable about the persons risks and their individual requirements. We observed staff moving and handling people and this was done safely and with respect to the individuals dignity. We discussed the risk assessments with the manager and they confirmed they were being updated along with the care plans as part of the changes being made.

The provider was working to establish a culture of lessons learnt. This was to support staff to feel able to raise concerns and have them acted upon to resolve the issue. To date this had not yet been established to reflect any examples which had been implemented.

There were measures in place to support people in case of an emergency such as a fire. Each person had an emergency evacuation plan which was specific to them and the support they required. These were accessible within the care plans and in the emergency information held in the office. Staff had recently carried out a fire drill and understood people's needs. Maintenance on the building was carried out and all required checks were up to date. For example, electrical testing and checks on moving and handling equipment.

Staff were knowledgeable about safeguarding and told us they had received training. They were clear of what constituted abuse and how to report concerns. For example, shouting at or physical abuse towards people who used the service by anyone would be reported to the senior person on duty. The staff we spoke with told us about the process, this was to document their concerns and the managers responsibility to report the incident to the local safeguarding team.

We saw that checks had been carried out to ensure that the staff who worked at the home were suitable to

work with people who used the service. These included obtaining suitable references and the person's identity through the disclosure and barring service (DBS). The DBS is a national agency that keeps records of criminal convictions. One member of staff told us that they had to wait for their DBS check to come through before they started working. This demonstrated that the provider had safe recruitment practices in place.

Requires Improvement

Is the service effective?

Our findings

People's choices were not always supported. For example, staff shortages had an impact on certain choices, such as when a person could have a bath. One staff member told us, "It depended on availability of the staff rather than patient choice as to the time of day we can provide the support." People's likes and dislikes were recorded in relation to food and staff food based on these preferences.

Staff told us they had received training. The recent training had been implemented by the new providers and manager as it had been identified staff had not been kept up to date with their training. Staff told us they thought the training was effective and gave them enough information to carry out their duties safely. Relatives we spoke with said they thought care staff appeared knowledgeable and competent to carry out their role. We reviewed the training matrix and this showed that training was now planned. New staff received an induction and support to shadow experienced staff.

The home was in need of some investment to make the home suitable for people's needs. For example, staff struggled to manoeuvre a person in their wheelchair and had to make several attempts to fit the chair through the bedroom doorway. There was no signage around the home which would support people living with a dementia related illness to orientate themselves and we noted one person asked on several occasions where the bathroom was and on returning, where they should go. The home lighting was extremely poor and this could have an impact on people being able to orientate around the home. There were some improvements being made to the decoration on the first floor and the garden was accessible from the lounge area. Relatives we spoke with, said on occasions staff had taken people outside, but this did not happen on a regular basis. People had been able to personalise their own bedrooms, for example one person told us they had brought their own chair from home.

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and 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 Deprivation of Liberty Safeguards (DoLS).We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met.

We saw that some capacity assessments had been completed when people were unable to make decisions. However, these were generic and had not considered decision specific assessments. For example, some people required bed rails or a wheelchair belt to maintain their safety, however they lacked the capacity to make the decision on this level of support. When decisions had been made on the person's behalf, these were not documented to identify how the decision had been made and who had been consulted. Staff we spoke with had a good understanding of MCA and the importance of promoting people's decision. We observed staff asking people for their consent before they provided support and when appropriate choices

were offered. For example, with their meal.

We recommend that the provider seek advice and guidance in following the correct procedure for people under the Mental Capacity Act and in supporting people with their decisions.

People told us they enjoyed the food. One person said, "The meals are much better and have improved with more variety. The new cook arranges the food lovely and makes cakes and scones." When people required support with their meal this was done at their own pace and identified equipment was provided to maintain people's independence, for example a plate guide. Referrals had been made to health care professionals when people were at risk of choking. The guidance they provided was included in the care plans and shared with the cook. We saw this guidance was followed and people received meals which were of the correct consistency for their needs.

People had been given a choice of meal and the cook had discussed meal options to include them in future menu planning. The cook told us improvements had been made in the communication and they now had a book which detailed people's needs and any guidance. The home had a five-star rating from the food standards agency, which is the highest award given. The food hygiene rating reflects the standards of food hygiene found by the local authority.

People's health care was monitored. One person told us, "If I was at home I don't think my family would be able to help me like the care staff do, like when I am unwell, they care for me." People told us they could see opticians and had been supported to visit the dentist. A relative said, "Staff had been very good at accessing health care support for [name]."

We saw that referrals had been made when required to health and social care professionals. Health care professionals told us, "Staff here are nice to people and they are approachable. The new manager has made improvements especially to pressure care as we were having a lot of concerns, these have improved." Pressure care supports people to reduce the risk of possible sore skin. This meant people's health care was supported to support their wellbeing.

Requires Improvement

Is the service caring?

Our findings

We were told and we observed that staff were very caring and compassionate towards people's needs and wishes. People had established positive relationships with the staff. One person said, "Staff, they spoil me, they are very caring." Another person said, "I love the staff." A relative said, "I cannot praise them enough." Staff showed a genuine interest in people's wellbeing. For example, we saw one staff member stroking a person's forehead and hair and speaking gently to them to encourage them to eat. People were treated respectfully by staff and the staff we spoke with were highly committed to provide the best possible care to people who used the service.

However, the systems in place to ensure there were enough staff deployed to meet the needs of people and for the prevention of the spread of infection had an impact on people's dignity. People were left waiting for their needs to be met and left sitting in communal areas for long periods of time. For example, one person who required support to go to the toilet was sitting in the lounge for eight hours and was not offered the use of the toilet. People were also left at risk of living in a service which was not hygienic due to the systems in place for storing equipment to aid their mobility, such as hoist slings and a lack of systems for ensuring the service had been cleaned effectively.

The systems currently in place did not support people to be actively involved in making decisions about their care, support and treatment. A lack of appropriate assessment of decision making for people who lacked the capacity to make certain decisions and a lack of involving people and their significant others in their care planning meant people were not actively involved in making decisions about how they were cared for and supported.

People were supported to be as independent as they were able. For example, one care plan reflected that a person liked to try and wash their own face. Staff were also able to share other examples of when they supported people's independence. We observed some people were supported with their mobility and staff only intervened when they thought the person was struggling to maintain their safety.

Relatives told us they were welcome to visit whenever they wished and were always made welcome. One relative said, "I visit most morning, but I can come anytime it's never a problem."

People's records were stored safely to ensure confidentiality. When discussing personal matters, such as going to the bathroom, we observed staff asked people discreetly to maintain their dignity. Staff knocked on doors before entering rooms and announced themselves, this was to maintain people's privacy.

A new handover process had been introduced. This was so that staff could share information about the care and support people required, and if there were any changes, when they commenced their shift. Staff told us this was working well and had improved communication about people's needs.

Requires Improvement

Is the service responsive?

Our findings

There was a complaints process in place and we reviewed the complaints which had been received. One relative told us they had raised a complaint on two occasions, however we found these had not been recorded. The complaints we did review had not followed the providers own complaints policy in full. For example, a letter to the complainant to acknowledge receipt of their concern and then a copy of the investigation and outcome sent. We discussed this with the regional manager during our feedback session. They told us the unrecorded compliant had been received by the provider and was in the process of being addressed. In addition, the complaints had not been audited and considered as part of the homes improvement plans. This meant people could not be assured complaints were being addressed to respond to their concerns.

This demonstrates a breach in Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
People were not given the opportunity to embrace their hobbies or areas of interest. During the inspection we observed no stimulation was offered to people. In the managers action plan, it stated, 'Staff to play cheerful music, play games and chat to stimulate people.' Throughout our visit the television was on and no alternatives were offered. We spoke with staff who told us, "We can't do activities, there are not enough staff, we can only do essential care and that often leaves the floor unattended." Another staff member said, "We go out of our way, but we are so stretched, and feel rushed. We don't have time to sit and talk."

We reviewed people's care plans. There was no evidence that people and their family had contributed to the assessment and planning of the persons care. However, relatives we spoke with said that staff had shown a genuine interest in hearing their views about their family member. They also told us that the staff kept them informed and updated regularly about any changes which had occurred with their relative.

In the PIR the provider told us they were introducing a new care plan. We found the current care plans to be confusing and the new care plans lacked the recognition of some areas of need. For example, the need to consider people's communication methods. One person was registered blind, no information had been recorded to reflect on the best methods of communication for this person. In addition, there was no consideration in how this person's needs could be met in offering them stimulation and engagement. This meant the provider was not meeting the Accessible Information Standards (AIS). The AIS is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

Some people had a 'This is me' document. This is used to reflect on the person's life history, details about people's health and their preferences. However, some areas had not been completed or important information had not been included. For example, people's history relating to their health. This document nor the care plan, reflected people's cultural and diverse needs, including their religious needs. This meant we could not be sure people's individual needs would be fully met.

At the time of this inspection the provider was not supporting people with end of life care, so therefore we

have not reported on this. Those people who were able had been given the opportunity to discuss their wishes and preferences in relation to care at the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

Manor House did not have 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. However, the home had a new manager who had commenced the process to become registered.

The providers processes to support the quality improvements required for the home were not robust. Within the PIR the provider had told us they had introduced an action plan to identify all the areas which required addressing. We found the action plan did not contain clear timeframes or the detail to analysis when progress had been made. For example, some staff required a competency assessment and or supervision. There was no record of the number of staff requiring these and a timeframe to identify when they should be completed. Also, we saw that the falls information we identified had not been added to the action plan, to show what action they had taken to reduce the risk in the future.

We saw that audits had not always been completed consistently. There were no audits in place to reflect when people had fallen or when incidents had occurred. For example, one person had fallen on several occasions. The information relating to the falls identified that they had been unwitnessed and often at a similar time. This shows a trend which could have been supported by a change in how the person was supported or their level of supervision.

Another person had sustained an injury to their lower leg. There was no record of this incident and how it had been sustained. During the inspection a health care professional attended this person to review the sore skin on their leg to find a similar injury on the other leg. This had not been identified by the staff and it was unclear how this had been sustained. This meant we could not be sure incidents were being recorded and the information used to reflect people's needs or the reduction of the risk.

The NHS Clinical Commissioning Group had completed an unannounced infection control audit in July 2018. Advice was provided to consider more robust measures in the prevention and control of infections. Some areas of the home had been reviewed and equipment had been purchased, for example, bins and commodes. However, one recommendation was for curtain cleaning to be added to cleaning schedules and we found that cleaning schedules had not been put in place to ensure that areas of the home were cleaned in a routine and robust way. The home had not considered their own audit to enable them to ensure areas were maintained. This showed that lessons were not always learnt from events which had occurred.

The PIR identified that new care plans were being implemented. We reviewed the new care plans and found that some areas of care were still not reflected. For example, people's equality needs and individual support requirements in relation to their communication methods. We saw that medicine audits had been completed. However, these had not reflected the risk when people's medicine was not administered at the prescribed time or that the time was not recorded to ensure the correct time was left between dosages. In

addition, it had not been identified that the unstructured medicine round had an impact on the staff's availability to support people's needs.

This demonstrates a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Partnerships had been developed with health care professionals, however no links had been made with the local community. This was despite the home being opposite a church and nearby other local amenities. We discussed this area with the manager and they agreed this was an area they needed to develop.

People's views had not always been considered. At the time of our inspection people's views about the quality of care they received had not been sought through a questionnaire or the opportunity to reflect on their care. However, the new manager had planned some meetings with people who used the service and their relatives, this was to discuss the home and future developments.

There was a warm atmosphere at the home and we saw staff showed patience and had a caring approach to people. One person told us, "I am happy living here, it's comfortable and I have a good view from my window." Staff we spoke with enjoyed working in the home.

Staff felt supported by the new manager. One staff member described the new manager as 'Amazing, efficient, has great vision and will implement things.' We saw the manager had commenced team meetings with the staff, these discussed items such as safe moving and handling of people, the importance of reporting any incidents of concerns to the manager and the outcome from the recent external infection control audit. Staff told us they received supervision from the new manager and this was a good opportunity to discuss any concerns they had, or developmental needs.

We checked our records, which showed the provider, had notified us of events in the home. A notification is information about important events, which the provider is required to send us by law, such as serious injuries and allegations of abuse. This helps us to monitor the service.