RMH (Manor House) Care LLP

Lincombe Manor

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 11 and 13 August 2015 and was unannounced.

Lincombe Manor is a care home with nursing, registered to provide care for up to 48 people. People living at the service were older people or people with long term health conditions needing nursing care. Some people were living at the home for end of life care or for short term respite care/NHS funded intermediate care with a view to returning to their own home. The home does not provide care for people with dementia as a primary diagnosis.

The home did not have a registered manager in post. A manager had recently been appointed to the home and had made application to the Care Quality Commission to be registered but this process had not yet been completed. The manager was very experienced, and had been previously registered to manage similar services. 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.

Summary of findings

Staff recruitment practices had not always been safe. Since the appointment of the new manager the home had followed a robust recruitment procedure, but this had not always been the case.

People told us they felt safe at Lincombe Manor, and staff understood how to raise any concerns over abuse or abusive practices they saw. Medicines were being managed safely. However we identified some concerns that care plans did not always demonstrate staff acted in accordance with the Mental Capacity Act 2005, in relation to assessing people's capacity to consent to care.

There were enough staff on duty at the home to meet people's needs, both day and night. However we identified concerns staff had not always completed the training they needed for their role and had not received effective supervision and appraisal. Staff were clear about who they could go to for support, and new systems had been introduced to help ensure they were clear about delegated duties each day.

People told us they liked the food and had a good choice available to them. However we identified some concerns that showed where people had been assessed as being at risk of poor nutrition or hydration it was not always clear whether appropriate and consistent actions were being taken to manage this. For example, food and fluid balance charts were not always being completed clearly. The manager took actions to address this at the time of the inspection.

There was a policy in place for dealing with any concerns or complaints and this was made available to people and their families. People said they would speak with the manager or their family if they had any concerns. The manager had made herself accessible to relatives either in person or out of office hours through email to help address any concerns or ideas for improvement of the service. A forum had been set up to share information with relatives and people who lived at the home about changes and improvements being made as well as offer people opportunities to make comments about the service. People and staff told us there had been improvements since the new manager had been in post. One member of staff told us there had been a "truly spectacular" turnaround at the home and that it was a much happier place to work.

The home provided activities for people seven days a week, and staff took time to ensure everyone who wanted to engage with them could do so. This included people who were effectively nursed in bed due to their ill health or approaching the end of their life.

The home is in an attractive position with panoramic sea views from open terraces, lounges and some bedrooms. It is accessed via a steep hill, but transport is available to help people with going out. The home was clean and free from any unpleasant odours. Staff we spoke with understood about infection control practices and we saw staff using gloves and aprons to protect people from potential cross infection.

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 home was safe.

Staff had not always been employed following a robust recruitment process, but recent changes had ensured a safe process was now being followed.

Risks to people were assessed and reviewed and actions taken to keep people safe. The home was clean, and risks from the environment were assessed and reduced where possible.

Staff were knowledgeable about their responsibilities with regard to safeguarding people.

There were enough staff on duty to meet people's needs, and medicine practices were safe.

Good

Is the service effective?
The home was not always effective.

People's rights were not always protected in that issues of capacity and consent to care did not reflect the requirements of the Mental Capacity Act 2005.

People who were at risk of poor nutrition or hydration did not receive consistent action or monitoring to ensure this was addressed.

Staff had not all received or completed the training, appraisal and support they needed to carry out their role.

People had access to good community healthcare services to meet their needs.

Requires improvement

Is the service caring?
The home was caring.

Staff understood and were sensitive to people's needs. They told us they enjoyed working at the home and that it was a happy place to be.

Staff supported and promoted people's well-being, including celebrating events of importance to them.

People's privacy and dignity were respected. End of life care needs were understood and support was given in accordance with people's wishes.

Good

Is the service responsive?
The home was responsive.

Good

Summary of findings

People's needs were assessed prior to their admission and care plans identified how to support people with their care needs. Plans were reviewed regularly.

Visitors were welcomed to the home, and people were encouraged to remain as active as they could and to take part in activities that met their wishes.

Complaints and concerns were being managed well, with clear systems and policies in place.

Is the service well-led?

Requires improvement

The manager was very experienced in managing care homes, but was newly in post at Lincombe Manor and had not yet been registered. People told us that since her appointment there had been significant improvements at the home, and we could see action plans and audits that demonstrated changes planned.

People were consulted about the operation of the home and how improvements could be made. Quality assurance systems were in place and learning took place from incidents to improve safety and quality.

Records were overall well maintained and kept up to date.

Lincombe Manor

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 registered 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 11 and 13 August 2015 and was unannounced. It was carried out by one adult social care inspector.

On the inspection we spoke with eight of the 21 people who lived at the home, three visitors, and nine members of both day and night staff. We spoke with the staff about their role, the training they received and the people they were supporting, and observed staff supporting people with their care needs. People and their relatives shared with us their experiences of the home and the care they received.

We discussed the service with the local authority commissioning and quality teams prior to the inspection to gather their views about the service. We looked at the care plans, records and daily notes for seven people with a range of needs, and looked at other policies and procedures in relation to the operation of the home. We looked at five staff files to check that the home was operating a full recruitment procedure, and checked training and supervision records.

Good

Is the service safe?

Our findings

People had not always been protected by the home's recruitment practices, but changes in place with the new manager showed improvements had been made.We looked at five staff files, including two that had been completed since the employment of the manager. We found that of the five staff files, only the two most recent showed that the full recruitment process had been followed. For other staff a robust process for gathering references or exploring past work history had not been carried out. This could have left people at risk because the provider had not previously undertaken sufficient assessments and checks to ensure staff were of good character before they were allowed to work unsupervised at the home. The manager told us she would be auditing staff files to identify if there were further concerns where action could be taken.

People told us they felt safe at the home. People told us "I am perfectly happy here – they look after everything for me so I don't have to worry my family. I feel quite safe." and "I am not worried about anything at all. My family visit me every day and if I was worried about anything I would tell them, but I have no reason to".

Risks at the home which might affect people were being managed, and risks from incidents, accidents such as falls and 'near misses' were monitored and action taken to reduce risks where possible. Plans for the management of emergencies were in place. For example people's personal evacuation plans and emergency evacuation equipment were reviewed each week, and there were well stocked first aid kits in the building. Emergency contact numbers and business continuity plans were available for staff in the case of lift breakdown or power failure. Rooms where oxygen was in use were clearly marked.

Risk assessments had been undertaken for people's care needs, such as risks associated with choking, bathing and showering, pressure damage to skin and moving and handling. Where concerns were identified action plans were in place to reduce the risks. Risks to the environment had also been assessed, including for fire and water safety. The manager was reviewing the window restrictors following changes to HSE advice.

Staff told us about how they would recognise and report any concerns over abuse, and told us they would not hesitate to do so. Procedures were in place to ensure that concerns could be reported to the registered manager and local authority safeguarding team and contact details of who to report concerns to were on display in the office. The manager told us about concerns that staff had raised with her regarding a person who visited the home and the actions that had been taken to ensure the person's rights were protected.

Enough staff were on duty to meet people's needs. Prior to the inspection we had received concerns over the staffing levels being low on a particular date. We checked payrole records and staff rotas and could not substantiate the concern. On the first day of the inspection there were two registered nurses, the manager, five care or senior care staff, two activities organisers, a cook and kitchen porter, three domestic staff and a handyman to care for 21 people. Bells were in the main answered quickly. One person we spoke with told us that sometimes staff were slow to respond to them, but five other people told us their needs were met quickly. One told us "I only have to ring the bell for them, even at night. They come quickly, and I never worry about calling them. They always tell me to ring and that they never mind"

Medicines were managed safely. People in the main did not manage their own medicines but where they did this was following an assessment to sure this was safe. Systems were in place that ensured medicines were ordered, stored administered and recorded safely. An audit carried out in June 2015 had identified some actions to be carried out. The home had been re-assessed by the Care Trust Pharmacists the week prior to our inspection and confirmed that actions needed had been implemented. People received their medicines when they needed them, and as prescribed.

A person who lived at the home told us the cleaning at the home was "exemplary". Before the inspection we had received a concern about how the home had managed risks presented by a person with a hospital acquired infection. The concern was not substantiated. We spoke with staff who were aware of how the risks associated with the management of infections were addressed. For example, a cleaner we spoke with was able to tell us about the products and infection control measures used to protect people from cross infection. An infection control audit carried out in June 2015 identified some practice concerns The action plan from this audit showed concerns

Good

Is the service safe?

identified had been addressed. Laundry management and cleaning schedules meant that the home's cleanliness was maintained. A relative told us "One of the first things you notice about this place when you come in the door is that it doesn't smell like lots of other places do. That was one of the things that really attracted us to here".

Requires improvement

Is the service effective?

Our findings

The home was not always effective. Staff did not always receive the support and training they needed to do their job, or regular appraisals of their performance. Staff were not carrying out and recording assessments in accordance with the Mental Capacity Act 2005, or effectively monitoring people who were at risk of poor fluids or hydration.

Staff files contained evidence of the training staff received when starting at the home and on a regular basis throughout the year. The home's training matrix demonstrated staff were not all up to date with training or learning plans. For example we saw that only 47% of staff were up to date with moving and positioning theory training, but 72% had completed an observation of their competency in practice. The manager had plans to improve this with the accreditation of a registered nurse to be an in house moving and handling trainer.

Some training was delivered online, and some newer training was being delivered face to face as the manager had acknowledged online learning did not suit all staff. One person told us they felt some staff needed additional training and skills to meet the more complex needs of some of the people being cared for, but four others felt the staff had the skills that were needed. Staff told us they felt they understood people's care needs, and had the skills needed to do their job. One said "I am always happy to learn new things. There are always new people coming in and always something new to learn." Newer staff were completing a 12 week induction in line with the Care Certificate, which is a national standard for safe induction.

Staff files did not demonstrate they had been receiving regular supervision and appraisal. For example, one file we saw showed us that the person had received supervision once in 2012 and then not again until 2014. However, staff we spoke with told us they felt supported in their role and that staff worked well as a team. One told us "we understand what needs to be done and we do it. We work well together, it is more like a family now and I love coming to work here".

The manager was aware of the concerns identified regarding training and supervisions and was developing an action plan to address the shortfalls, including ensuring all staff received formal supervision by the end of September 2015. Other training resources were being put into the home by the provider to ensure staff had up to date skills and training.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Applications had been made for deprivation of liberty safeguards authorisations where people were potentially deprived of their liberty.

However, people's rights were not always being protected, because people's care files did not demonstrate a clear understanding of the Mental Capacity Act 2005 (MCA). This is legislation that helps ensure people who do not have the mental capacity to make decisions for themselves have their legal rights protected. Staff were not correctly assessing people's capacity to make a specific decision before making the decision to act in their best interests. 'Best interest' assessments were generalised and in some instances did not specify the decision the person was having their capacity assessed for. This was not in accordance with the legislation and did not protect people's rights to make decisions where they were able to do so. We saw staff supporting people and offering them choices about their care. Staff could tell us about the people they cared for and how they would communicate their wishes with regards to their care. They understood they could not give care to someone without their consent.

People were assessed to see if they were at risk of malnutrition or poor hydration, however we could not see that appropriate or consistent actions had been taken as a result of any concerns identified.

We looked at the records for one person who had been assessed as being at risk of poor hydration and their food and fluid intake was being recorded as a result. Their care plan indicated they were to be weighed weekly but care records showed this had not happened. The manager told us this may have been due to the scales having been broken for a period. The person's care plan said that 'fluids were to be encouraged'. However we did not see any detail about how that was to happen, or what an acceptable target would have been to maintain the person's health. Their fluid balance charts had not been totalled for any 24

Requires improvement

Is the service effective?

hour period in the last month, and some entries did not show the amount of fluid taken in. For example one day their chart indicated an entry at 3pm for "Coffee and cake served" but there was no indication of the amount of that the person had eaten or drunk. This meant it was not possible to see how much fluid the person had drunk. On another day the recorded fluids intake amounted to only around 700mls. There was no information in the person's daily notes to mention if they had been reluctant to drink that day, how they had been encouraged to drink more or what actions the staff had taken as a result. The manager took steps to implement a system for ensuring charts were balanced each day and poor fluid intake identified while we were at the home.

People told us they ate well at the home. Meals presented were attractive, including those that were pureed or softened for people with swallowing difficulties. New menus had been devised following the appointment of a new chef. People could choose to have a cooked breakfast, and could opt to have wine or sherry provided with their meals. Efforts were made to cater for people's choices or preferences, and we saw evidence of this with some more unusual choices that were respected. Medical, religious or cultural diets could be provided for example Halal or gluten free meals.

People told us and we saw from their files that they had access to healthcare services in the community. This included dentists, podiatrists, speech and language therapists, psychiatric nurses and GPs. People's care files showed evidence of specialist hospital appointments. On the inspection we saw some specialist moving equipment was being provided for one person along with a specialist bed following an assessment. The manager told us that in mid-August a physiotherapist was due to start supporting people with falls prevention exercises.

Accommodation is of a high standard with single rooms and en-suite facilities; many rooms have sea views and communal areas include access to terraces where people can sit out. The building was purpose built as a nursing care centre and is situated within a retirement centre on the cliff top in Torquay. The centre provides privately owned flats for people that are not subject to CQC regulation, and has communal facilities such as a restaurant which people at the home could access if they wished. The care centre is situated at the top of a steep hill but can be accessed via car or golf buggy from the main house. There is also a separate unit of 8 beds within the grounds not currently in use, but previously used for intermediate care.

Good

Is the service caring?

Our findings

The home was caring.

People told us the staff were caring towards them. One person told us "The girls and other staff are all exceptionally caring". Others said "Some are better than others but overall they are a good lot", and the staff went "Above and beyond" what they needed to do".

Staff knew people well. A staff member told us about a person they had got up that morning. They told us about how this person liked their care to be delivered and understood about the person's background and prognosis. A relative told us about how care was delivered discreetly when it was needed. They spent considerable time at the home supporting their relation and told us how much they appreciated how well staff also supported them at what was a very difficult time. People's privacy was respected and all personal care was provided in private. Staff knocked on people's doors before entering and supported people in communal areas in a discreet manner, respecting their dignity.

Staff celebrated successes and events with people, for example it was one person's birthday on the day of the first inspection visit. Staff celebrated with the person with a cake and decorated their wheelchair. Other relatives told us about the support the home had given them to celebrate the birthday of their relation who was very unwell. They told us the home manager had organised a family party for the person on the upper floor terrace with views of the sea, and had 'pulled out all the stops' so that the person could attend, even though this had presented risks and required additional equipment. The person's family had described this as a 'lovely memory' for them all to keep in difficult circumstances.

Staff communicated positively with the people living at the home. We saw humour and affection from staff, but this remained within professional boundaries. Staff used appropriate touch to help support and comfort people. A relative said "Thank goodness for (Staff member's name). She breezes in and makes a joke or light hearted comment and it breaks the tension. We have a great relationship with all the staff here"

People's confidentiality was respected. We saw a visitor ask a member of staff for a person's name and we saw that they staff member discreetly refused to give this in order to respect the person's privacy. Private information about people was stored securely and kept confidential. Written records were respectful and used appropriate language.

Some people were at the home to receive end of life care. People's care plans contained clear information about any end of life care wishes they may have. Where people had made decisions about whether they wished to receive emergency treatment such as cardio-pulmonary resuscitation, or had made advanced directives, these were clearly recorded in their care files. This helped ensure staff understood and could respect people's wishes about their end of life care.

One person's care file contained an entry that showed how staff had accommodated the person's wishes to spend time outside with their family, even though they were nearing the end of their life. Their file notes recorded that "as (person's name) is at the end of their life, Quality is a must to maintain" and "Daughter and family sat with (person's name) on top decking area. (Person's name) expressed how happy she was to be in the sunshine". Another relative told us how staff timed their care being delivered to ensure the person would be most awake and receptive to care.

Good

Is the service responsive?

Our findings

The home was responsive.

Care files showed each person had their needs assessed before they moved into the home. This was to make sure the home could meet their needs and expectations. Assessments included information from previous placements, relatives and the person themselves, as well as information about people's life history where the person was willing to share this. Plans covered all areas of need, from moving and handling, pressure relief to emotional support, and were being reviewed regularly at a rate of one each day throughout the month, which ensured they were an up to date reflection of people's needs.

People were involved where possible about making decisions around their care. For example, people were able to request the gender of carer they wished and we saw this recorded in people's plans. One person told us they would not like a male carer as they would 'be embarrassed'. This had been respected. Another person had requested a male carer. We heard this being discussed in the handover with staff ensuring this happened.

One person told us they were always being asked about how they wanted things done for them. A relative confirmed both they and their relation were involved in making decisions and were consulted about their care They said "If she doesn't want to do something the staff will go away and try again later. She always agrees in the end, but in her own time". Plans included instructions to staff about how people wanted their care to be delivered and information on retaining people's skills and independence. Plans also included instructions for staff on how to manage people's behaviour that might challenge as a result of mental health symptoms or acute ill health.

We saw people being supported by staff to eat a meal and also in transferring from wheelchairs to dining chairs ready for lunch. Staff supported people well, and when assisting them with eating this was done sensitively and with respect for the person's dignity. People were given their medicines with an explanation of what the medicines were for.

The manager had extended the activities provided to cover seven days a week. We talked with two of the activities staff who told us about the planned activities on offer at the home and how they made sure that everyone had opportunities to take part. This included people who were being nursed in bed due to their frailty or who did not want to leave their rooms, as well as people who were able to take part in more social activity. They told us for example that one person liked their 'daily poem' time, but that others just liked a cup of tea and a chat sometimes in their rooms. Activities were based on people's needs and wishes. On the first day of the inspection people were being taken out for a 'ladies lunch' in the minibus and on the second day a person who lived at the home had invited two friends over for lunch, while other people were watching a film show. Posters were displayed to inform people of forthcoming events and activities, to which relatives were also invited. Staff told us some people had forged new social groups at mealtimes since being at the home.

The complaints procedure was given to people and their relatives at the point of admission and was on display in the home. The new manager ensured complaints were acted upon promptly and a response sent to the person with an apology or an indication of actions to be taken to prevent a re-occurrence if needed. People told us they would feel free to raise any concerns with the management or would tell their families if they were unhappy about anything.

Requires improvement

Is the service well-led?

Our findings

The manager had been working at Lincombe Manor since the start of June 2015, and had made an application to the Care Quality Commission to be registered but this had not been completed at the time of the inspection. This meant the home did not have a registered manager in post at the time of the inspection, which was a condition of the home's registration.

People and staff told us there had been improvements since the manager had been in post. One member of staff told us there had been a "truly spectacular" turnaround and another said "The manager is very good – we can go to her at any time and she listens to us". We saw minutes of meetings where the manager had introduced herself to families and spoken about changes that were being made. This included statements from her that her door was always open, she was contactable at evenings or weekends via email and that she always wanted to hear if there were areas people felt could be improved. Communication within the home had improved with daily update meetings being held with heads of all departments to review the day's activities. Staff told us they had benefitted from improvements to the way daily duties were delegated, which made it easier to ensure things did not get missed. Office and clinical areas of the home had been tidied and organised, the manager's office had been moved to a more central position within the home and copies of the organisation's vision and values were displayed in the reception and lounges. Managerial responsibilities and other staff roles in the home had been clarified, so that staff both understood their roles and also their accountability.

The manager had plans to encourage best practice by supporting staff to become champions in particular areas of care, for example dementia, continence and end of life care in line with their interests. They told us that previously the home had a more formal culture which was focussed on tasks, and they were working to become a more informal and democratic workplace, with staff able to raise issues of concern to them as well as suggestions on how to make improvements. The manager attended local manager's forums and had links with local healthcare services such as the hospice care team to learn about best practice developments.

People benefitted because the service monitored the quality of the care delivered through quality assurance and quality management systems. Regular visits were carried out by the compliance officer teams from the provider organisation, and action plans compiled as a result. We saw the manager had been working through the action plans and could demonstrate improvements were being made. For example we saw an infection control audit had been carried out in June 2015. The manager had completed the actions required from the action plan, which had included improving access to personal protective equipment, providing additional hand gels and improved cleaning and disinfection schedules. Other audits completed during the preceding month had included the quality of the mattresses and pillows, whether anyone had fallen and medicines. Quality monitoring reports were also in place to assess the service against the standards the CQC uses to assess the home, the last being completed in July 2015. The manager told us she was getting good support from the provider organisation to make the improvements needed at the home.

Questionnaires were sent to relatives, visiting professionals and people who lived at the home to gather their views about the home and any improvements people felt would be of benefit. Following the return of the questionnaires the results were analysed and an action plan drawn up. Where there were issues identified actions were put in place to address them and feedback given to the person concerned. The manager was working on customer service questionnaires for people who had received respite and intermediate care at the home that could be given to them at the end of each stay to gather more effective feedback.

The records we saw were well maintained and up to date. Care plans were available to staff in the home's office, and some information such as policies and procedures was available on computers to which staff had access as well as in paper copy. Policies and procedures were being updated to ensure they all reflected changes in legislation that came into force in April 2015.