Bupa Care Homes (BNH) Limited

The Manor House Care Home

Inspection report

Moreton Road
Wirral
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09 May 2017

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Our last inspection of the The Manor House was in September 2015 when we found that the service was good in all areas. This inspection was brought forward due to concerns that CQC had received. The inspection took place on 8 and 9 May 2017 and was unannounced on the first day.

The home is an adapted grade 2 listed building set in its own grounds in a quiet residential area. There were a total of 58 bedrooms, all of which had been refurbished during 2015 and had en-suite toilet, wash basin, and shower.

The service is registered to provide accommodation and nursing or personal care for up to 59 people and 45 people were living there when we visited. The people accommodated were older people who required 24 hour support from staff. The home also provided respite stays for people who lived in their own homes. The home is part of the range of services provided BUPA Care Homes.

The service had a registered manager, however we were informed that they had left their employment shortly before this inspection. 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.

One of the people living at the home told us "Some time ago it was very good. Now it is not." Our findings during this inspection confirmed that the standard of care provided by the home had decreased since our last inspection.

We found breaches of Regulations 11, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the home was not maintained to a safe standard and that regular checks had not been carried out to ensure that maintenance was up to date. For example we noted concerns with most radiator covers in the home and had to request that these were made safe.

The home was not compliant with the Mental Capacity Act (2005). Appropriate arrangements were not in place for people who were unable to safely consent to their care.

There was no manager working at the home and the home had lacked any clear and effective leadership for a period of time which had resulted in a decline in the service being provided.

Most of the day duty shifts were run by agency nurses who had limited knowledge of the people who lived at the home.

Staff were caring and were well thought of by people living in the home and their relatives.

There were regular activities in the home and people were happy with what was on offer and took part in and enjoyed them.

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.

We found concerns with the maintenance of the home and regular checks had not been carried out.

People who lived at the home and visiting professionals raised concerns about the staffing levels in the home.

Medication was managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The home was not working within the Mental Capacity Act (2005) and arrangements were not in place for people who were unable to consent to their care.

Staff training was not up to date.

Is the service caring?

Good

The service was caring.

People who lived at the home and visitors spoke highly of the staff working in the home.

People had been able to personalise their bedrooms and make them homely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were insufficient to safely meet people's needs as they did not always identify and manage risks to people's health and well-being.

Activities were available and people enjoyed them.

Complaints were not always adequately dealt with.

Is the service well-led?

Requires Improvement

The service was not well-led.

The registered manager was no longer working at the home.

We found that a number of records in the home were missing, incomplete or inaccurate and this was impacting on people's care.

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

The inspection was carried out on 08 and 09 May 2017 and the first day was unannounced. Two adult social care (ASC) inspectors carried out the inspection.

Prior to our visit we looked at any information we had received about the home including any contact from people using the service or their relatives and any information sent to us by the home.

During the inspection we looked around the premises and met with many of the people living at the home, eight of whom we spoke with individually. We also spoke with 10 members of staff who held different roles within the home and organisation and with four visiting health care professionals.

We spent time observing the day to day care and support provided to people, looked at a range of records including medication records, care records for four people, recruitment records for three staff and training records for all staff. We also looked at records relating to health and safety and quality assurance.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at the home. One person explained "I get a bit nervous at times. They make sure you are safe."

A safeguarding log, put into place by the provider to log any safeguarding incidents reported by or about the home, had not been kept up to date. We found the log disjointed and incomplete. Records did not show which incidents had been reported to whom and what investigations or action had been taken. A senior manager for the organisation agreed to speak with the local authority to establish how many safeguarding incidents had been reported, log whether they had been concluded and record any actions that remained outstanding.

Information about the provider's safeguarding and whistle blowing policies was freely available to staff via a notice board in the staff room. Whistle blowing protects staff who report something they believe is wrong in the work place that is in the public interest.

On the first day of the inspection we found a number of radiator covers were broken, ill-fitting or had parts missing. This meant that people were at risk of injury. We brought this to the attention of a senior member of staff and workmen attended the home. However on the second day we found that a number of the radiator covers had not been fixed and remained a danger to people. The provider arranged for an audit of radiators to be carried out which found 66 out of 80 radiators checked were in need of repair or replacement. Workmen were again on site to repair those radiators that presented an immediate risk.

One person had issues with their en-suite shower flooding into their bedroom for over two years. They told us that they had raised this on several occasions but the issue had never been resolved. We saw that this had been raised at a meeting in March 2017 but had not been resolved. A senior member of staff undertook to ensure this issue was addressed as soon as possible.

We looked at maintenance records for the home. Weekly checks of fire alarm safety, emergency lighting, fire panel, water softener, laundry equipment, paths and skips had not been recorded since the maintenance person left the service in January 2017. There were also scheduled monthly checks, three monthly checks, and six monthly checks that had not been completed.

These examples are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have appropriate arrangements to maintain a safe environment.

One of the people living at the home told us "They are often short staffed, they go off sick a lot." They told us that on occasions "I have to shout and get the buzzer, occasionally I wait a long time." A second person said "Sometimes there are a lot of them, other times you cannot find one."

Two visiting health professionals expressed the view that staff were always busy and in their opinion there were insufficient staff.

Rotas showed that there were always two registered nurses on duty over the 24 hour period, however only one full-time and one part-time (one day a week) nurse were employed for day duties plus one who was on maternity leave and all of the other shifts were covered by agency nurses. We were told that the home had enough nurses for night duties and there were no vacancies for care staff.

Rotas were inconsistent in terms of staffing levels with variances from five to eight staff on a shift. It was difficult to determine if staffing levels were adequate.

We looked at the management of people's medicines and found that generally they were satisfactory and medicines were stored and administered safely and in accordance with the home's policies and procedures.

We looked at the recruitment records for three staff members and found that the appropriate checks had been made prior to staff commencing work at the home.

Requires Improvement

Is the service effective?

Our findings

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 be as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met and found that they were not.

We asked several members of staff if they knew which of the people who lived at the home had an agreed DoLS in place and none could tell us. We looked at a DoLS file held in the central office and found that this was not up to date. It was therefore not possible to establish who had an agreed DoLS in place and for whom a DoLS had been applied. A handover file given to agency nurses who could be in charge of the home contained no information regarding who had a DoLS in place. This meant that they did not have access to the information they may need to support people safely and legally.

Records of the support people required to make decisions were incomplete and contradictory. One person's file stated that they did not require an assessment of their capacity. It also stated that they required support to make decisions about their care, that they could give verbal consent to meals, medication, photographs and tests. A section asking if they required a DoLS had not been completed and a capacity assessment completed in April 2017 did not state what decision the person's capacity was being assessed for but stated they had variable capacity. We had concerns about a number of the files we looked at.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have appropriate arrangements in place for people to consent to their care.

We saw that new staff had a four day classroom induction prior to commencing work at the home.

We saw that there was an on-line training programme that staff could do at home if they wished and also practical moving and handling training.

The training matrix was mis-leading as it showed 79% compliance with training and we found anomalies in this, for example it recorded that 13 nurses had completed pressure ulcer training but the home did not employ 13 nurses.

A significant number of staff were not up to date with important basic training such as fire safety and safeguarding. The management team told us that they would take immediate action to rectify this.

Visiting health professionals had differing opinions of the support the home provided to people with their health. One told us that staff had referred people appropriately and followed instructions they had given for the person's health. However a second health professional told us that nurses sometimes had limited knowledge of people and their health care needs and said that follow up care provided by nurses could be fragmented. They described the health care provided on occasions as reactive rather than pro-active and gave an example of a pre-arranged health related appointment for a number of people that staff had not been prepared for. Two other visiting health professionals commented that they found staff cooperative and able to answer any queries they had.

We found that people's health care needs were not always being met. Records relating to supporting people with mental health were incomplete or not in place and records relating to supporting people with food and drink intake were also incomplete with guidance from professionals not always followed.

At our inspection of the home in 2015 we reported that a fire door leading directly from the home to adjoining sheltered accommodation, which was not part of the home, had a glass panel which compromised people's privacy. We were advised that action would be taken to rectify this. At this inspection we observed that both this door and a second door on the upper floor still had glass panels which meant people in the sheltered accommodation could see into the care home. This remains a breach of people's privacy.

Signs had been fitted to some of the doors on Leyland unit to help people living with dementia identify rooms more easily. The unit was nicely decorated however we did not see any evidence that the environment had been adapted overall to make it easier for people to negotiate and recognise. For example carpets and chairs were both pale colours which could provide difficult for people to distinguish. A hat stand with hats and scarves was not secured and had a table placed in front of it so people could not access it. We asked several members of staff if they could explain how the environment had been decorated to be adapted to support people living with dementia however they were unable to supply this information.

We saw that the tables were nicely set for lunch and there was a menu on each table. Menus showed a good choice of meals with a cooked meal at both lunch and evening meal. We also noted that the kitchen had received a five star food hygiene from Environmental Health which was the maximum rating that can be awarded.

Good

Is the service caring?

Our findings

People living at the home described staff as "pleasant", "kind" and "thoughtful." One person told us "They are very attentive when they come" and another person said "Most look on it as a pleasure to look after us."

A relative described staff as "kind and well meaning" adding "If you ask, they are very good."

A visiting health professional told us "The care is good, they look after them." A second visiting health professional told us "The carers provide good care."

Care staff we met spoke affectionately about the people who they provided care for and it was evident that they knew people well and were committed to doing the best job they could for them.

We saw that the area manager was well known to some of the people who lived at the home and that they felt confident speaking with him and expressing their views.

We saw that people had lots of pictures and personal belongings and all had a wall-mounted TV in their bedrooms. This meant that people had been able to personalise their bedrooms and make them feel like home.

Requires Improvement

Is the service responsive?

Our findings

One of the people living at the home told us that if they had any concerns they would "Go to the main office to complain." A second person said "I would go see the person in charge."

We found that care records did not provide accurate up to date information to guide staff on the support people required. One person had recently seen their GP for support with their mental health, we saw that this person appeared agitated at times and was shouting out. Their care plan contained no reference to this behaviour or guidance on how to support the person.

Another person had dressings applied by the district nurses which the person frequently removed leaving them at risk of infection. No care plan or guidance was in place to inform staff of the action they should take when this occurred.

A third person's care plan stated that they ate independently. However we saw staff supporting the person to eat and they told us that without support the person would leave their food. This meant that staff did not have the correct guidance to follow. A letter from the speech and language therapist recommended in April 2017 that the person should be given fortified milkshakes. This was not recorded on their food and fluid sheet despite a dietician giving advice in April 2017 on how this should be recorded. This person was at risk of malnutrition, however records on charts listed the type of food eg 'porridge', 'tea' they had but not the quantities they had eaten or drunk.

We also found that charts and records were not correctly used for the benefit of the person. One person had a behaviour chart in place. Staff informed us that the person had been settled for some time and when we asked they confirmed that no formal review of the behaviour chart had been undertaken for some time. No care plan was available in the person's records to advise staff on how the person could behave at time and the actions they should take. It was therefore unclear as to the benefits to the person of staff completing a chart that was no longer needed or reviewed.

These examples are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have appropriate care plans in place to provide safe care and treatment for people living in the home.

One person told us "There are very good activities. We get a weekly notice. I enjoy the flower arranging and the fellow from the kitchen doing baking."

A small hairdressing salon was based in the home and we saw that this was well used with people from the home sitting in the salon socialising as well as having their hair done.

On Leyland unit we saw that a small area of the lounge had a variety of activities people could use including puzzles, books and crafts. We saw staff sitting with people on this unit engaging them in a game of 'catch' which everyone taking part appeared to be enjoying. On the second day a number of people told us they

were looking forward to entertainers in the large lounge. We saw that this was well attended with a number of people telling us they had enjoyed the activity.

Photographs on the wall showed that activities in March 2017 had included a birthday party, a concert by a local school and celebrating St Patrick's day. We saw that people had a weekly newsletter in their bedrooms which advertised forthcoming activities.

We asked about complaints and saw that there was a complaints procedure available. A relative told us that they felt confident to approach staff with any concerns or complaints they may have. However they added "You never get the same staff twice. I am not sure the message gets through."

We found that complaints were not always identified, recorded and addressed as such. For example the issue of an en-suite shower flooding a bedroom had been raised several times but never adequately addressed. We saw that other complaints had been responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the manager registered with the Care Quality Commission for the home had left. The clinical services manager (CSM) who acted as deputy manager had also left. This meant that the home had no permanent management in place.

Leyland unit had three senior carers allocated to the unit. Each took charge of their shift when they were working including medication and care plans, however they reported to the nurses in charge of the overall home, many of whom were agency nurses and may lack experience of supporting people with dementia and lack knowledge of the individuals living on the unit.

Two nurses worked during the day and were 'in charge' of the home in the absence of a manager. However staff told us it was not clear who was the identified person in overall charge of the home when a manager was not on duty, particularly if there were two agency nurses working. As only 11 people were currently funded to receive nursing care this meant that the nurses were responsible for giving medication and writing care plans for an additional 26 people on Inman and Stern units who did not need nursing care.

Staff told us that the previous manager had not been a visible presence within the home and one member of staff told us "We need consistent management, staff disputes need sorting." This was reiterated by other staff who we spoke with.

We found that a number of records in the home were missing, incomplete or inaccurate. This included records relating to safeguarding, Deprivation of Liberty Safeguards, care plans and charts to monitor people's health.

These examples are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have appropriate arrangements in place to safely manage the home.

An agency nurse working at the home told us that they received a good handover of information each day and said that if senior managers were not in the home they were always contactable by phone.

The provider had arranged for experienced managers from within the organisation to provide management cover five days a week. Additional support from senior managers would also be provided five days a week with the area manager, regional quality manager and regional support manager each spending a day or two at the home covering five days per week. Plans were in place for the regional support manager to be based at the home full time from 12 June 2017 until a permanent manager was in place. The area manager was able to explain to us the plans the provider had to recruit a suitable permanent manager and CSM as swiftly as possible.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have appropriate arrangements in place for people to consent to their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have appropriate arrangements to maintain a safe environment. The provider did not have appropriate care plans in place to provide safe care and treatment for people living in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have appropriate arrangements in place to safely manage the home.