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

Summary of findings

Overall summary

This inspection took place on 6 and 7 April 2016 and was unannounced.

Located near Southport town centre, Manchester House is registered to provide accommodation and nursing care for up to 67 older people and younger adults with a physical disability. Shared areas include two dining rooms and three lounges on the ground floor. A lift is available for access to the upper floors. There is an enclosed garden to the rear of the building. A call system operates throughout the home. The home is situated Hesketh park and is within easy reach of Southport promenade.

During the inspection, there were 65 people living in the home. A contract was in place with the local health service to provide short term intermediate care for up to seven people.

A registered manager was in post. 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.

People told us they felt safe living in Manchester House and staff we spoke with had a good understanding of how to recognise signs of potential abuse and how to report concerns to help ensure people's safety.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. People's emergency evacuation plans did not always provide adequate information to ensure people could be safely evacuated from the home.

We found that medicines were managed safely and staff received training and yearly checks to ensure they remained competent. People told us they received their medines when they needed them.

We looked at how the home was staffed and asked people their views on staffing levels and the feedback we received was mixed. Staff and relatives told us there were usually adequate numbers of staff, and most people living in the home agreed. Some people however, did tell us they did not feel there were always enough staff and they sometimes had to wait short periods of time for support. Our observations showed us that people received support in a timely way during the inspection.

We looked at how staff were recruited within the home and found that checks were made to ensure staff were suitable to work with vulnerable people. These was not always completed fully as risk assessments were not documented when checks identified a potential risk, though the registered manager was aware of the issue and had discussed this with the relevant staff.

We found that consent was not always sought in line with the requirements of the 2005 Mental Capacity Act (MCA). Deprivation of liberty safeguards (DoLS) had been applied for appropriately and people told us they

were asked for their consent to care. When people were unable to provide consent, mental capacity assessments were completed, however this process was not implemented consistently and not all capacity assessments we viewed accurately reflected people's ability to make decisions.

Staff told us they were well supported and were able to raise any issues with the manager when required. Staff received an induction to their role, regular training and supervision to support them to meet people's needs, but annual appraisals were not always completed.

We found that people's nutritional needs were met as the home catered for people's specific dietary requirements and staff provided support to people with nutritional intake when required. Feedback regarding meals was positive; people told us they had choice from a well balanced menu and were able to request alternatives when necessary.

The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained.

People living at the home told us staff were kind and caring and treated them with respect and relatives we spoke with agreed. We observed people's dignity and privacy being respected by staff in a number of ways during the inspection, such as staff knocking on people's door before entering their rooms.

Most care plans we viewed showed that people and their families had been involved in the creation of care plans. Not all of the care files we looked at contained information about the person's life history or preferences and were in the process of being updated to include people's life histories to enable staff to get to know and understand people. Care plans were specific to the individual person and most were detailed and informative. They were written in such a way as to promote people's independence.

Most care plans were reviewed regularly to ensure they were accurate and reflective of people's needs. We found however, some of the plans due to be rewritten had not been reviewed as regularly and did not all contain up to date information regarding people's needs.

When we asked people about the social aspects of the home we received mixed feedback. People told us activities available included singing, games, darts, coffee mornings and trips out to in the mini bus, but other people felt there could be more going on.

There were processes in place to gather feedback from people, such as regular meetings and quality assurance questionnaires. We found that actions were taken based on the feedback received. People also had access to a complaints procedure and this was available within the service user guide in people's bedrooms and people we spoke with told us they knew how to raise any concerns they had.

We asked people their views of how the home was managed and feedback was positive. Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

The provider told us they visited the home most days and records showed that monthly reports were completed by the registered manager and were available to the provider. We found that audits were completed in areas such as medicines, care plans and the general environment. This meant that systems were in place to monitor the quality and safety of the service.

The registered manager had notified CQC of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding

Manchester House.

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.

Recruitment checks were usually made prior to staff being employed, however these were not always consistently completed.

Most people told us there were enough staff to meet people's needs, though some people did tell us they had to wait short periods for support at times.

People's emergency evacuation plans did not always provide adequate information.

People told us they felt safe living in Manchester House.

Staff had a good understanding of how to recognise signs of potential abuse and how to report concerns to help ensure people's safety.

Risk assessments were completed with regards to people's safety, as well as the general environment and equipment.

We found that medicines were managed safely and people told us they received their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not always effective.

We found that consent was not always sought in line with the requirements of the 2005 Mental Capacity Act (MCA).

Staff received an induction to their role, regular training and supervision to support them to meet people's needs, but annual appraisals were not always completed.

Deprivation of Liberty Safeguards (DoLS) had been applied for appropriately.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing.

We found that people's nutritional needs were met as the home catered for people's specific dietary requirements.

Is the service caring?

Good

The service was caring.

People living at the home told us staff were kind and caring and treated them with respect.

We observed people's dignity and privacy being respected by staff during the inspection.

Most care plans we viewed showed that people and their families had been involved in the creation of care plans.

Most care files we looked at contained information about the person's life history or preferences and others were in the process of being updated to include people's life histories to enable staff to get to know and understand people.

The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not all care plans were reviewed regularly to ensure they were accurate and reflective of people's needs.

We received mixed feedback regarding activities. People told us activities available included singing, games, darts, coffee mornings and trips out to in the mini bus, but other people felt there could be more going on.

There were processes in place to gather feedback from people and we found that actions were taken based on the feedback received.

People had access to a complaints procedure and this was available within the service user guide in people's bedrooms.

Is the service well-led?

Good

The home was well-led.

People told us the home was well managed.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

The provider told us they visited the home most days. We found that audits were completed in areas such as medicines, care plans and the general environment. This meant that systems were in place to monitor the quality and safety of the service.

The registered manager had notified CQC of events and incidents that occurred in the home in accordance with our statutory notifications.

Manchester House Nursing 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 6 and 7 April 2016 and was unannounced. The inspection team included two adult social care inspectors and a specialist advisor (Nurse).

Before our inspection we reviewed the information we held about the home. We looked at the notifications the Care Quality Commission (CQC) had received from the service and we spoke with the commissioners of the service.

During the inspection we spoke with the registered manager, regional manager, provider, 11 people living in the home, two relatives, five members of the care team, one domestic, the housekeeper and the activities co-ordinator.

We looked at the care files of eight people receiving support from the service, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

We looked at how staff were recruited within the home. We looked at four personnel files and evidence of application forms, photographic identification, appropriate references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff.
We found that there was no risk assessment on file for staff who had convictions on their DBS. We discussed this with the manager who told us they were aware of the convictions and risks had been assessed. There was however, no evidence of risk assessments within staff files. The manager agreed to ensure a risk assessment was available within recruitment files for any relevant staff.

This was a breach of Regulation 19 0f The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

A recruitment policy was in place and the registered manager told us the next recruitment interviews would include a person who lived in the home. We viewed records which showed people had been asked if they would like to participate in interviews and a number of people had agreed to this. We found that staff who required registration with a professional body, had their registration checked at regular intervals.

Most people we spoke with told us they felt safe living in Manchester House. Comments we received included, "I feel safe here, the staff are fantastic", "Yes I feel safe" ,"No reason not to feel safe" and "It's secure enough."

We spoke with staff about adult safeguarding, what constitutes abuse and how to report concerns. All staff we spoke with were able to explain different types of abuse, potential signs of abuse and how they would report any concerns. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available within the staff office. This enabled referrals to be made to the relevant organisations. We found that appropriate safeguarding referrals had been made.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for people living in the home. A medicine policy was available for staff and included guidance on areas such as actions to take in the event of a medicine error, self-administration, controlled drugs, safe administration and covert administration of medicines (medicines hidden in food or drink), though this form of administration was not in use at the time of the inspection. Staff told us and records we viewed confirmed staff had completed training in relation to safe medicine administration and had their competency assessed each year.

Most medicines were stored in the locked clinic room, however one trolley was stored on the top floor in a corridor area but was locked to the wall. The temperature of the clinic room was monitored but was very

warm and staff advised us that the air conditioning system had been sent away for repair. If medicines are not stored at the correct temperature it may alter their effectiveness. We discussed this with the manager and they told us it was being repaired and agreed to put a fan in the clinic room as a temporary measure to reduce the temperature. Medicines that had to be refrigerated were kept in a locked fridge and the temperature monitored daily.

Creams were dated when opened to ensure they could be disposed of within the required time spans. MAR charts we viewed were completed fully and any handwritten instructions were signed by two people in line with good practice. We looked at the management of controlled medicines and found they were stored securely and records showed they were administered safely.

We observed staff administering medicines and found this was completed safely and in line with safe administration guidelines.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility and pressure relief. There were also specific risk assessments for individuals, such as smoking. Most of these assessments were reviewed regularly to ensure any change in people's needs were assessed to allow appropriate measures to be put in place, such as regular weight monitoring or pressure relieving equipment.

We looked at how the home was staffed. On the first day of inspection there were three registered nurses and 12 care staff on duty; two of which were agency staff, a housekeeper, 3 domestic staff, a chef, two kitchen assistants, 2 laundry staff, a maintenance person and an activities co-ordinator. The registered manager told us there was usually 13 care staff on duty but this was reduced on the day due to sickness. There were some staff vacancies within the home and the registered manager told us they were currently recruiting to fill these.

We asked people their views on the staffing levels within the home and feedback was mixed. Most people we spoke with who lived in the home told us there were enough staff. One person told us, "I only have to stick my head out of my door at night and somebody comes to make sure I am alright." One person however did tell us, "You don't always get immediate attention, but I don't mind waiting sometimes." Another person also told us they sometimes had to wait to get up of a morning as they required support from two staff members and had to wait until they were both available and another person said, "I don't think that there are sufficient staff here." One staff member told us there was, "Enough staff, we manage quite well." Another staff member told us there was enough staff as long as nobody rang in sick. They told us agency staff could not always be arranged at short notice and they did at times feel that they were short staffed.

Relatives we spoke with told us they felt there were always enough staff on duty to meet people's needs. Our observations during the inspection showed us that when staff provided support to people, they did not rush them. For instance, we observed staff supporting people with their meal at lunchtime in a dignified and unhurried way and people had time to enjoy their meal. We also told a staff member that a person had told us they required support to access the toilet and they provided this help immediately.

The registered manager told us staffing levels were based the outcome of a staffing analysis which looked at people's level of dependency. We viewed the results from the most recent staffing analysis that were recorded in a graph. This showed that staffing levels were always on or above the required amount.

We looked at accident and incident reporting within the home and found that accidents were reported appropriately. An audit of incidents was completed by the registered manager to identify any potential

trends, such as times and location of incidents. This enabled the registered manager to implement appropriate measures to reduce the potential of future accidents within the home. A falls audit completed in February 2016 had highlighted to the registered manager that steps could be taken to make the procedure more robust and they implemented a falls protocol which guided staff on what actions to take should a person have a fall. We also found that post fall observation charts had been implemented and completed following the audit.

Arrangements were in place for checking the environment to ensure it was safe. A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire. Most PEEP's provided adequate information to guide staff on how to support the person to evacuate in the event of an emergency. We did find however, that one person's assessment advised staff to support the person into a wheelchair, but did not advise how they would evacuate as their room was on the first floor. There were evacuation chairs available to assist people down the stairs should they be needed. The registered manager agreed to update this assessment immediately to ensure staff had access to the required information.

Internal checks were completed regularly to help ensure the environment and equipment remained safe. This included weekly testing of the fire alarm, checks on portable electrical equipment, window restrictors, nurse call bells, fire doors, wheelchairs and water temperatures.

External safety checks had also been completed to help ensure the safety of the building and equipment. We saw certificates for areas such as gas, electric, emergency lighting, hoists and slings and fire equipment and these were in date.

There were no concerns raised regarding the cleanliness of the home. There were cleaning schedules in place to ensure all areas of the home were regularly cleaned and these were audited by the housekeeper. We observed personal protective equipment being worn appropriately by the staff. There was hand gel available and bathrooms contained liquid soap and paper towels in accordance with infection control guidance.

Requires Improvement

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager told us they had two authorised DoLS applications in place and had made further applications that were awaiting an outcome. The registered manager told us 11 more applications were still required and they were completing a few each week and had completed the more urgent applications first. A system was in place to monitor expiry dates of authorised DoLS and these were clearly reflected in people's care plans to help ensure staff were aware of the authorisation and the conditions agreed.

Staff we spoke with told us they always asked for people's consent before providing care and we observed this during the visit. For instance, before entering a person's bedroom, providing personal care and when providing support at lunch time.

When people were unable to provide consent, mental capacity assessments were completed. We found capacity assessments in care files which looked at decisions in relation to personal care and medicines. We found that consent was not always sought in line with the MCA 2005. For instance, one care file included a capacity assessment that concluded the person lacked capacity regarding decisions relating to personal care and medicines, but the person had signed a service user agreement to consent to risk assessments and personal care plans. They had also signed an agreement to delegate responsibility of medicines to staff. We discussed this with the registered manager who told us the person was able to make decisions regarding their personal care on a daily basis. This meant that the mental capacity assessment was inaccurate and the care file contained conflicting information regarding the person's ability to make specific decisions.

We found that although mental capacity assessments were completed, when a person was assessed as lacking capacity to make a decision, there was not always evidence that decisions were made in the person's best interest. One person's care file contained a care plan regarding their physical health which recorded they lacked capacity and discussions had been held with relevant people such as family members, GP and social worker and agreements made in their best interest. However another person's file recorded that the person lacked capacity regarding all activities of daily living and medicines but there was no evidence that care and treatment was discussed and agreed with relevant people and was provided in the person's best interest. This meant that consent was not always sought in line with the requirements of the MCA 2005 and showed inconsistency of understanding by staff. We discussed this with the registered manager who agreed to review how consent was gained within the service.

This was a breach of Regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at on-going staff training and support. Staff we spoke with told us they felt well supported and were able to raise any issues with the manager when required. The registered manager told us annual appraisals were not up to date and there was no record of when these had last been completed. Records showed that supervisions were completed, but not all staff we spoke with had received a supervision within the last few months. This meant that staff may not be supported adequately within their role to help them meet people's needs effectively. The registered manager told us they planned to complete staff appraisals within the next few weeks.

This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that staff received training in areas such as safeguarding, mental capacity act, moving and handling, end of life care and infection control. Staff we spoke with told us there was sufficient training to enable them to meet people's needs. One staff member told us they completed training specific to people's needs, such as catheter care and the use of specialised feeding tubes. There was a system in place that enabled the registered manager to monitor when training was due to be refreshed. The provider had developed a training academy recently which would provide training for all staff in Manchester House as well as other care homes the provider owns. We viewed a plan for scheduled training which included courses such as person centred care, dignity, common health conditions and dementia care.

We looked at staff personnel files to establish how staff were inducted into their job role. Staff we spoke with and records we viewed, showed that all staff had received an induction when they were employed which covered areas such as health and safety and the policies and procedures of the service. The registered manager had updated the induction to include the requirements of the care certificate and all staff were in the process of completing this. The care certificate is an identified set of standards that health and social care workers should adhere to in their daily working life.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the district nurse, diabetic nurse, dietitian, GP, physiotherapist and the local drug and alcohol service.

Staff at Manchester house also had access to advice and support from the telemedicine system. This enabled staff to speak with health professionals via video link so that they could assess a person and provide clinical advice regarding their treatment. Staff told us they had a good relationship with the community mental health team and professional at the local health centres. This enabled staff to provide care and treatment based on advice from the relevant health professionals.

We looked at how people were supported to maintain a healthy and well balanced diet. People's dietary requirements were assessed as part of the pre admission process to ensure their dietary needs could be met straight away and preferences were recorded within the care files we viewed. Nutritional risk assessments were completed and reviewed regularly and people had their weight monitored at planned intervals to enable staff to identify changes in people's needs. The home catered for people's dietary requirements, such as diabetic diets, soft meals and high calorie meals.

We observed the lunch time meal in the dining room. People had access to a menu, tables were set and

meals were well presented. We observed staff providing support to people to eat their meal when required and this was done in a dignified and unhurried way. There was a relaxed atmosphere in the dining room with people chatting whilst they ate their lunch.

People living in the home told us they had enough food and drinks provided to them. One person told us, "I can have a cup of tea whenever I want one and choose where I eat my meals." When asked about the food, we received comments such as, "Excellent", "Always a lot of it, could not go hungry" and "The food is good on the whole." Relatives we spoke with agreed and one relative told us they had joined their family member for lunch once and the food was, "Very pleasant." People told us they had choice and they were aware that alternatives were available if they did not like either of the meals on the menu that day.

Good

Is the service caring?

Our findings

People living at the home told us staff were kind and caring and treated them with respect. One person told us, "They [staff] are all lovely" and another person told us they were, "Very well looked after." Relatives we spoke with agreed and one relative told us, "They [staff] look after mum very well, they have made it home" and another family member described the staff as, "Very nice." Staff we spoke with enjoyed working at Manchester House and told us what they enjoyed most about working here is that, "Everybody cares."

One relative described a situation when their family member had to be admitted to hospital and staff escorted them and stayed until a family member arrived at the hospital to ensure they did not become anxious.

We observed people's dignity and privacy being respected by staff in a number of ways during the inspection, such as staff knocking on people's door before entering their rooms. One person living in the home told us staff always, "Say hello and knock on my door." Personal care activities were carried out in private and people did not have to wait long if they needed support. Interactions between staff and people living in the home were warm and kind. We observed a number of occasions when staff supported people when they were distressed and this was done in a professional and kind manner.

Most care plans we viewed showed that people and their families had been involved in the creation of care plans. We spoke with the activities coordinator who told us that they were in the process of completing life history books with people to enable them to understand people, their experiences and their preferences better. Not all of the care files we looked at contained information about the person's life history or preferences. The registered manager told us that they were in the process of rewriting all of the care files to be more person centred and the files we viewed which had been rewritten, contained a personal care book. This included information regarding people's preferences in areas such as meals, drinks and activities, their family, previous jobs and what the person enjoyed.

Care plans were written in such a way as to promote people's independence, such as advising staff to offer prompts to people so they could complete as much for themselves as possible.

We found on discussion, that staff knew the people they were caring for well, including their needs and preferences. For instance, one person had specific needs regarding their ability to swallow and staff we spoke with were all aware of how to support the person safely. A staff member told us a few people liked to have a lie in of a morning and was aware of which people had a preference regarding the gender of carer who supported them with personal care. The staff member told us and records showed, these preferences were met and when necessary.

Care files were stored securely in order to maintain people's confidentiality.

The registered manager told us that nobody living in the home at the time of the inspection, had any particular cultural needs that they required support to meet, but dietary requirements could be met if

needed. The registered manager told us they had previously supported a person who ate a kosher diet and the home were able to provide this. A member of the local clergy visited during the inspection to provide holy communion to those people that wanted to attend.

We observed relatives visiting throughout both days of the inspection. The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained. People we spoke with and their relatives agreed, stating they could visit whenever they wanted to.

For people who had no family or friends to represent them, contact details for a local advocacy service were available within the home for people to access and the registered manager told us they would make referrals on people's behalf if required.

Requires Improvement

Is the service responsive?

Our findings

We observed care plans in areas such as personal care, mobility, medicines, communication, nutrition, maintaining a safe environment, sleeping and skin integrity. There were also health specific care plans, such as those for mental health conditions. This helped staff to access relevant information to support people effectively.

Care plans were specific to the individual person and most were detailed and informative. For instance, one care file we viewed clearly described the person's preferred routine when getting ready for bed and care required overnight. Most care plans were reviewed regularly to ensure they were accurate and reflective of people's needs. For instance, one person had recently been reviewed by the speech and language therapist who had recommended changes to the person's diet. The care plan had been updated to reflect these changes to help ensure their nutritional needs could be met safely. The reviews were detailed and described care people received each month.

We found however, that not all care plans contained sufficient detail regarding people's needs. For instance, one person's mobility plan reported that the person required support from one or two staff to transfer but their moving and handling risk assessment reflected that the person now required a hoist. The registered manager confirmed that the person did now use a hoist and agreed to update the care plan that day. Staff we spoke with were aware of the person's needs in relation to their mobility.

We also found that some of the plans due to be rewritten had not been reviewed as regularly. For instance, one person's review indicated pressure relieving equipment had been supplied and was in use, but this had not been updated on the care plan. We discussed this with the registered manager who told us they would ensure all care plans were reviewed and that a clinical lead was being recruited and that would assist in ensuring all care plans were reviewed regularly.

This was a breach of Regulation 9 (3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We looked at how people were involved in their care planning. When able, people had signed a consent form to agree to the care plan in place and family members were consulted when required. Relatives we spoke with were happy with the care being provided to their family members and one relative told us they had reviewed the written care plan and that staff, "Keep me updated."

The registered manager told us they ensured people and their relatives were involved in the care planning process from the beginning and included relatives when completing pre admission assessments. We viewed a number of care files that contained a pre admission assessment; this ensured the service was aware of people's needs and that they could be met effectively from admission.

Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily handovers between staff and through viewing daily evaluation records

and people's care files.

Staff we spoke with demonstrated a good knowledge of people's individual care, their needs, choices and preferences. Most care files we viewed included information on people's preferences. This included how people liked to spend their day, when they liked to go to bed, what meals they particularly enjoyed and any drinks or meals people did not enjoy. One relative agreed and told us, "Staff know [relative] well."

When we asked people about the social aspects of the home we received mixed feedback. People told us activities available included singing, games, darts, coffee mornings and trips out to in the mini bus. One person told us they had enjoyed a trip to the botanical gardens recently and had also been to Blackpool. Another person told us, "[Staff] do try to get people engaged, but some of the activities don't appeal to me." Another person said, "I feel there could be more going on."

We found that not all people were aware when activities were planned. We discussed this with one of the three activity coordinators in the home and they told us they were in the process of reviewing activities. They showed us new files that were being compiled which will be provided in each person's room with a schedule of available activities, as well as when the hairdresser would be available and when pamper sessions were being held. The coordinator told us they were in the process of discussing activities with people living in the home to find out what people enjoy most and will ensure those activities are included in the new schedule. We observed a coffee morning being held during the inspection.

We looked at processes in place to gather feedback from people and listen to their views. Quality assurance surveys were given to people and their relatives to complete and had last been issued in January 2016. This provided people with an opportunity to provide feedback regarding the whole service. A survey had also been given to people to share their views regarding the food available in the home. There were some negative comments within the responses and the registered manager arranged for a representative from the contractor who provided the meals, to attend a resident meeting to allow people to discuss their concerns. This resulted in extra options being available on the menu, such as cheese and biscuits. This showed that people's views were sought and actions taken based upon the feedback received.

Resident and relative meetings were also held and relatives we spoke with confirmed that they were aware of the meetings and some had attended. Minutes from the meeting showed that people were asked their views on areas such as care provided and meals available. Actions were taken on the feedback received. For instance, the registered manager recorded a discussion with the cook regarding the temperature of meals to help ensure people received their meals hot.

People had access to call bells in their rooms to enable them to call for staff support when required. One care file we viewed documented that a person required support overnight and guided staff to ensure the call bed was clipped to the person's pillow to enable them to call for support when needed.

People had access to a complaints procedure and this was available within the service user guide in people's bedrooms and people we spoke with told us they knew how to raise any concerns they had. The registered manager told us they encouraged people to speak with them at any time if they had any concerns and had an open door policy. We viewed the complaints log for the home and found that complaints were investigated and responded to appropriately.

Good

Is the service well-led?

Our findings

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. People described the registered manager as, "Approachable", "Great" and "Very supportive." All people we spoke with felt able to go to the manager with any concerns and were confident they would be listened to and have their concerns addressed. Staff told us they were well supported by the registered manager and one staff member told us the, "[Manager's] door is always open and I can go and talk through any issues with[manager]."

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. Having a whistle blowing policy helps to promote an open culture within the home. Staff told us they were encouraged to share their views regarding the service.

We looked at processes in place to gather feedback from people and listen to their views. As well as resident meetings and quality assurance surveys, there were also regular staff meetings held to ensure views were gathered . Records we viewed showed that staff meetings took place every few months and covered areas such as the use of mobile phones, communication and care provision.

During the visit we looked at how the manager and provider ensured the quality and safety of the service provided. The provider told us they visited the home most days and records showed that monthly reports were completed by the registered manager and regional manager and were available to the provider. These reports covered areas such as complaints received, training, any safeguarding referrals, feedback regarding activities and new staff file checks. The report included action plans based on the findings and recorded timescales for actions to be completed as well as identifying who would be responsible for meeting each action.

We viewed completed audits which included areas such as medicines, care files, maintenance, water temperatures, fire safety equipment, window restrictors, wheelchairs and the nurse call system. Audits we viewed identified areas that required action to be taken and when the action was completed. For instance, the care file audit recorded that a risk assessment had not been updated for a number of months and was then signed off as completed. We viewed the identified risk assessment and found it had now been updated. Part of the medicine audit also highlighted that the controlled medicines cabinet was not large enough for the stock and we could see that a new cupboard had been ordered. This meant that systems were in place to monitor the quality and safety of the service.

Most of the concerns identified during the inspection had previously been identified by the registered manager and steps were being taken to address them. For example, the registered manager had identified that care plans required improvements to ensure they were accurate and person centred and care plans were in the process of being rewritten. The registered manager was also aware that staff appraisals were overdue and told us they would be scheduled in within the next few weeks.

The provider and regional manager told us a new electronic audit system was being developed which would

enable the providers to oversee key information which would be updated on a monthly basis. This would help the provider to monitor the quality and safety of the service.

The registered manager had notified CQC of events and incidents that occurred in the home in accordance with statutory requirements, such as any serious injuries or safeguarding referrals made. This meant that CQC were able to monitor information and risks regarding Manchester House.

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 did not take formal enforcement action at this stage. 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 9 HSCA RA Regulations 2014 Person-centred care Care plans did not always contain accurate or sufficient information regarding people's needs.

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 Consent was not always sought in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices were not always followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always supported in their role through supervision and appraisal.