Manor Care Home Limited

Manor Care Home - Middlewich

Inspection report

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20 February 2019
22 February 2019

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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 well-led?	**Inadequate**

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Manor Care Home on 18, 20 and 22 February 2019. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection date inspection had been made. The team inspected the service against three of the five questions we ask about services: is the service well led, safe and effective. This is because the service was not meeting some legal requirements.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Manor care home is a care home with 34 people living at the home at the time of this inspection. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home has two floors with ensuite rooms and a passenger lift. The majority of people living at the home were living with dementia.

There was no registered manager present in the home at the time of our 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. There was a new manager who had taken up their position as manager from October 2018. The new manager had applied for registration with the Care Quality Commission and was going through the registration process at the time of our inspection.

When we completed our previous inspection on 10 and 11 July 2018 we found concerns relating to staffing in the home and also governance. On this inspection we found a continued breach of the regulation in relation to good governance and we made a recommendation regarding staff deployment within the home. We also found the provider was in breach of regulations in relation to consent, safe care and treatment and the premises.

We undertook a tour of the premises and found numerous health and safety concerns not being addressed by the provider such as an uncovered hot water pipe which was 75 degrees Celsius and fire doors not all staff could open in the event of a fire.

The provider was not always following the Mental Capacity Act (MCA) 2005. A best interests process was absent in the records for one person. Staff were administering prescribed medication to manage their behaviours without evidence of lawful consent.

There was no evidence of behaviours which were challenging being analysed for triggers to always show people were being supported in the least restrictive way.

Safeguarding processes were not robust enough. There was no evidence of trends or themes being analysed by the provider.

Care plans were not up to date with accurate information. Person centred care was not being delivered.

People's nutritional needs were not always being met as we observed people struggling to eat and drink or sitting with food in front of them not being supported to eat. We made a recommendation about staff deployment.

The emergency call bell system was not robust. Emergency pull cords were seen tied up and some sensor mats/door alarms were unplugged/switched off.

Quality checks and audits had not identified all of the issues we found on this inspection. The provider had not demonstrated they had taken robust action since the last inspection.

The home had a 5 star rating for food and hygiene. The rating was displayed in the main entrance of the home.

Prescribed medicines were being managed safely.

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.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Manor Care Home - Middlewich

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 prompted in part by anonymous concerns, a serious incident and information we received from the Local Authority.

The information shared with CQC about the incident indicated potential concerns about the management of risk of falls. This inspection examined those risks.

This inspection took place on 18, 20 and 22 February 2019 and was unannounced.

The inspection team consisted of two adult social care inspectors.

We gathered and reviewed all the information we held about the service. We had not requested a provider information return but we reviewed all statutory notifications we held which are alerts/information the provider must send to us about events occurring in the service.

We used various methods during this inspection including talking to people using the service, their relatives, interviewing staff, pathway tracking, short observational framework (SOFI), observation, reviews of records.

We reviewed four care plans via the provider's electronic care planning system Nourish, we spoke with two service users, one relative and nine staff including the manager. We reviewed the information we received from commissioners and the Local Authority.

Requires Improvement

Is the service safe?

Our findings

We checked if people living at The Manor Care Home were safe. Our observations were people were not always safe. One person who was able to converse with us told us they did not feel safe and records confirmed another person living at the home had assaulted them in their own room. Another person living at the home who needed 24 hour care had left the home without the appropriate support thereby placing themselves at risk. Staff became aware the person was missing and supported them to return to the home.

We checked the providers certification to demonstrate the safety of the premises and found the appropriate certification was in place for electrical devices and to manage the risk of legionella however, there was no gas safety certificate available for us to view. A previous gas safety attendance work sheet dated 16 January 2018 confirmed there had been a gas leak from one of the boilers which was made safe but a recommendation was made for it to be replaced. This had not been actioned by the provider. We requested the provider took action immediately which they did and arranged for a gas engineer to inspect all boilers on the premises. The provider sourced their own gas engineer who deemed all boilers to be safe according to the gas certificates we viewed.

We found other hazards such as an exposed hot water pipe which was 75 degrees Celsius. The recommended temperature by the Health and safety Executive is 43 degrees Celsius. There was a staff member working within the room who was at risk of burns if they were to fall against it. We asked the provider to take action which they did and ensured the pipe was covered with insulation.

These issues are a breach of Regulation 15 Premises of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.
We found the provider was not always managing risks for people. For example, one person who had bedrails in place had no person centred risk assessment in place. We asked the manager for a bedrails risk assessment and they provided us with a generic risk assessment which had not identified the specific risks for the individual person.

When we undertook a tour of the premises we found numerous risks. We found a hazardous set of steps in the exterior of the premises with a wooden fence/gate around the steps. This had been placed around the hazardous steps to reduce the risk of someone falling down them. This had been highlighted at the last inspection and the provider took action to mitigate the risk however, this was not robust enough. We asked the provider to take action and they placed a wooden board across the top of the steps to reduce the risk of falls/injury.

We identified that not all sensor equipment was plugged in or was working at the time of our inspection. For example, we observed a person who had previously displayed behaviours which were challenging leaving their room and walking towards a staff member without their door sensor activating. We found the sensors had been unplugged/turned off. We found another room where a sensor was unplugged. Staff we spoke with told us they were turning sensors off when people were supported to be downstairs in the communal lounge/dining room. However, we found one person who had behaviours which were challenging was in

their room with the sensors turned off. This meant staff would not be alerted to them placing themselves at risk or others at risk. Furthermore, we found the person had no behaviour analysis with detailed information about what was triggering their behaviours which were challenging to help staff determine how they could best support the person.

We also found emergency pull cords were tied up which meant if a person had fallen on the floor in their room they may not have been able to reach the emergency pull cord to raise the alarm they had fallen. The manager sent a memorandum to staff informing them to always ensure emergency pull cords were not tied up.

The call bell system was not always safe. We observed people were frequently spending time in the dining room without staff present. We tested the emergency alarm in the dining room but struggled to locate the alarm which was out of sight behind a music speaker and a second alarm was located close to the fireplace. After pressing the alarm next to the fire place, staff including the manager walked into the dining room but had not noticed there was an alarm sounding. This meant if a person had felt unwell and had pressed the emergency pad on the wall staff would not recognise the emergency alarm sounding placing people at risk. The provider was asked to take action which they did and requested a new call bell system including emergency keypads in areas where they were clearly visible.

These issues are a Breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

We reviewed the system in place of safeguarding people from abuse. We found an entry on the handover on the first day of our inspection which highlighted one person living in the home had an unexplained bruise found by night staff. When we returned to the home on the second day of inspection this had not been highlighted to the manager for them to follow the safeguarding policy and procedures. The manager was able to confirm how they were intending to deal with the safeguarding concern upon them becoming aware of this however, the safeguarding system had not been followed in a robust manner. We viewed the incident form dated 17 February 2019 which stated "unwitnessed" but it did not state what was unwitnessed or any detail regarding an unexplained bruise. We also found there was no safeguarding analysis to identify trends or themes by the provider.

These issues are a breach of Regulation 13 Safeguarding People from Abuse of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We undertook a short observational framework (SOFI) during a lunch time which is a method we use to assess care delivery for people who have difficulty conversing with us. During the SOFI we observed there were up to seven staff in the dining area for a short period of time. Despite there being a high number of staff we found some people were not receiving enough support to eat/drink. Staff were observed working hard rushing from one person to the next. Staffing was reported to us to be an on-going issue by different people we spoke with during the inspection. The rotas we viewed confirmed the home had regular staff however, the provider confirmed 40 percent of staff were newly recruited. The Clinical Lead confirmed they had begun to address the issue of staff deployment within the home and showed us their staff deployment plan they had begun to use. As we found a high number of incidents occurring in the lounge and dining room where staff were not being deployed, we discussed this with the manager and provider.

We made a recommendation the manager and provider continue to review staff deployment within the home.

Staff we spoke with were aware of their responsibilities regarding safeguarding people from abuse and described the actions they would take to always keep people safe from abuse. Staff told us they were not afraid to raise a concern or to whistleblow if they needed to.

We reviewed the recruitment practices within the home and checked two staff files. Both staff files had the appropriate checks in place.

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 as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

There were DoLS applications seen within care plans we checked and the manager had a DoLS tracker in place. We found the provider had not ensured all DoLS which had expired were renewed prior to the expiry date. The manager and deputy manager had reviewed the DoLS since they came into post in October 2018 and applied for renewals where appropriate.

We checked the system of recording consent and found improvements were needed to ensure people's consent was being recorded and best interests' meetings recorded when a decision has been made on behalf of a person. For example, we found lawful consent was not always being recorded for bedrails to be put in place. One person had no best interests' documentation in place for their prescribed medication to reduce their behaviours which were challenging. The provider was unable to demonstrate they were following a best interests process by staff administering prescribed sedatives. We could not see evidence in the records of the least restrictive methods being exhausted prior to using prescribed medicines which can be viewed as chemical restraint. The manager confirmed they requested a best interests' meeting during our inspection.

These issues are a breach of Regulation 11 Consent of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff we spoke with were aware of the Mental Capacity Act 2005 and were encompassing asking for consent during their delivery of care and interactions with people. We overheard staff asking people for their consent for decisions such as whether they were ready to receive their care and consent to walk into their room. Staff were aware of restraint and what constituted restraint.

We checked people's nutrition and weights and found there were monthly or weekly weight recordings being taken for people who were at risk of weight loss or malnutrition. However, it was not clear why people had lost weight from the records. For example, we found three people who had lost approximately 1 stone in weight within 1 month with no explanation in the records why this may have occurred or if a dietician

referral had been made. We asked the manager to follow this up during our inspection and to report the significant weight loss to the appropriate professionals.

We looked at whether people's care needs were assessed including their nutritional needs. Our observations were people were not always being encouraged to eat and drink to have the maximum opportunity of maintaining their weight and having nutrition/drinks. We viewed one person's nutrition care plan and found it stipulated they found finger foods easier and had difficulty using a knife and fork. Despite this we observed they had been presented with a plate of food and a knife and fork. They had not attempted to pick up the fork or knife and hence had not eaten their lunch. Staff later removed the cutlery and placed finger foods in front of the person. This meant staff were not always able to sit with people and provide them with the support and encouragement they needed to deliver person centred care.

We inspected the kitchens and they had been awarded a five star rating by the Food and Hygiene Standards Agency. Staff were aware of people's dietary needs such as who required a pureed or soft diet but this was not being recorded. The system was not robust enough and required further improvements.

We observed the dining experience for people. There was background music for people and some people were interacting with one another at times. However, we found further improvements were needed. There were no table cloths, place mats or condiments seen on the tables. This meant the tables appeared bare and clinical.
These issues are a breach of Regulation 14 Meeting nutritional and hydration needs of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

We checked if people were being provided with person centred care and had their needs assessed. We found the care plans we viewed did not have a detailed account of the person's medical history and health related conditions including allergies. This meant staff did not have the current up to date information they needed to be able to deliver person centred care. The manager acted immediately and requested a medical summary from the General Practitioner Practice having input into the home.

The home had not been suitably adapted to meet the needs of people living with dementia. For example, there were no pictured menus for people on the table at meal times, there were few memorabilia seen around the home and the exterior was in need of improvements.

These issues are a breach of Regulation 9 Person Centred Care of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

Staff were receiving an induction and a supervision structure was in place. An appraisal system was in place but staff who had worked in the home for a number of years told us they had not had an appraisal. Training was in place and staff told us they were receiving regular training. There was training overdue but the manager had identified this and was ensuring training sessions were being offered to staff such as a moving and handling training session booked for March 2019. Prescribed medicines competencies were seen completed and competencies were being checked in other areas such as in Safeguarding.

Healthcare professionals were having input into the home and staff we spoke with were aware when to refer on to another professional. People were being supported to access healthcare and their General Practitioner when needed.

Inadequate

Is the service well-led?

Our findings

The provider had not sent us an action plan following the inspection in July 2018. We found on this inspection the provider remained in breach of Regulation 17 Good Governance and had not met their legal requirements.

A new manager had started in post in October 2018. The new manager told us their main focus was staffing the home. The provider confirmed there had been a high staff turnover with newly recruited staff accounting for 40 percent of staff in the home. Despite there being a high staff turnover and staffing issues in the home the provider had not notified the Care Quality Commission of this. The provider is expected by law to notify the Commission of any events which may affect the running of the home.

The new manager told us they had received an induction from the provider and was receiving supervision however, we were not provided with any documentation to confirm this.

We found numerous risks were not being managed with oversight from the provider. For example, we found care plans did not contain medical information such as specific conditions or allergies which is important information for staff to know how to care for people safely. The provider told us they had been aware of the issue with care plans since July 2018 and this was not something new. The provider had not taken enough action to ensure this had been addressed to ensure important information was recorded in people's care plans.

We raised concern regarding the system of recording lawful consent. We found the provider had not followed the MCA 2005 in relation to a best interests' decision for a person who had been prescribed medication to manage their behaviours which were challenging. We also found the provider was not always recording people's wishes or recording people's consent within the records we viewed. The provider had implemented an electronic care planning system called Nourish. We found people's consent had not been sought/recorded to confirm they had been asked for their consent for their details to be passed on to Nourish where they were viewed by a third party. We therefore, were concerned the provider had not demonstrated they were always upholding people's human rights in line with the Human Rights Act 1998.

We viewed the provider's audits and found they were undertaking regular checks of call bells, sensor mats and also regular management of prescribed medicines audits. We viewed an infection control audit and a housekeeping audit. The manager showed us their night check audit however, we found there were no actions seen from this audit. We raised concern there were no audits taking place or quality checks of the safeguarding system, recording and management of incidents with analysis for trends or themes. Therefore, there were issues found on this inspection which the provider had not identified through their own quality checks and audits. The new manager confirmed they had recently begun to send regular updates to the provider but no analyses/audits had been undertaken. The provider took action immediately and provided us with an action plan of actins they confirmed they would take going forwards.

We reviewed the provider's investigation of a serious incident and also looked into concerns which partly

triggered this inspection. We found some of the concerns highlighted prior to the inspection were issues we were able to confirm such as the lack of bedrail risk assessments/DOLS for use of bedrails. We raised concern with the manager that their investigatory report we viewed had not identified learning action points to ensure all that could be done was being actioned to reduce the risk of the same incidents reoccurring.

These issues are a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The rating was displayed at the main entrance for people to see as they walked into the home.

The new manager had implemented positive changes within the home such as a DOLS tracker, a new staffing structure to include a deputy and senior carer positions, supervision and appraisal system, training matrix and safety checks such as fire safety

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provision of care was not always person centred or suitable to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not always working within the principles of the Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to identify and mitigate risks to people's health safety and wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding systems were not always being operated effectively to ensure people were protected from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs

People's nutritional needs were not always being met. People were not always being encouraged to eat and drink to have the maximum opportunity of maintaining their weight and having nutrition/drinks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not always safe or properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not established and operated a system to effectively monitor and improve the quality and safety of services provided.