

Four Seasons Health Care (England) Limited Manor Park Care Home

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Inadequate



Is the service caring?

Requires improvement



Is the service responsive?

Requires improvement



Overall summary

We carried out an unannounced comprehensive inspection of this service on 11 June 2015. After that inspection we received concerns in relation to staffing levels and safeguarding. As a result we undertook a focused inspection to look into those concerns on 10 August 2015. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Manor Park Care Home on our website at www.cqc.org.uk.

Manor Park Care Home is registered to provide accommodation and personal care for up to 49 people, including some people who were living with dementia. At the time of our inspection there were 47 people using the service.

No registered manager was in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At the time of our inspection there were five safeguarding incidents currently open and being investigated. We found that it was not always clear to see what action had been taken to investigate safeguarding incidents, such as reviewing documentation and conducting staff interviews. Where investigations had taken place they did not always follow a robust and thorough process.

Summary of findings

We noted that where following safeguarding enquiries, actions were required, there was not always a clear timescale assigned to each action.

As part of our inspection we visited the home at 6am. On arrival not all staff members could tell us the name of the clinical lead in charge, and the nurse in charge was unable to tell us how many people lived at the home and how many required nursing support. The nurse told us that this because they worked for an agency and it was the first time they had worked in the home in over four years.

During the inspection we observed that people were not always spoken to with dignity and respect. We noted that at times when people's behaviour may challenge others staff did not demonstrate patience and their tone or

approach to the person changed. We also observed staff speaking about a person's continence support in a communal environment, which we concluded may cause embarrassment and was not appropriate.

Care records had been reviewed following safeguarding incidents however we saw that a number of care plans had not been reviewed since May 2015. Care plans in relation to night time care did not provide detail in relation to people's individual preferences and their night time routine.

During our inspection we identified a number of breaches of regulation. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Safeguarding incidents were not always clearly recorded whilst investigations were on-going. Timescales were not always determined when action was required.

Staff did not know the names of the full staff team and could not provide us details about the people living at the home and their needs.

Inadequate



Is the service caring?

The service was not always caring.

People were not always treated with dignity and respect. We observed people's continence support being discussed in a communal environment and staff raising their voice when people were not cooperating when support was being offered.

Requires improvement



Is the service responsive?

The service was not always responsive.

We noted that care plans did not always reflect people's individual needs. Although the provider had a plan in place to transfer all care plans to a new format, we saw there was no clear timescales as to when this would be complete by.

Requires improvement



Manor Park Care Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Manor Park Care Home on 10 August 2015. Prior to our visit we received concerns in relation to safeguarding and staffing levels and this inspection was to look into those concerns. The team inspected the service against three of the five questions we ask about services: is the service safe, caring and responsive.

The inspection team consisted of three adult social care inspectors.

Before our inspection, we reviewed information about any incidents we held about the home. We contacted the commissioners of the relevant local authorities before the inspection visit to gain their views of the service provided at this home.

During the inspection we spoke with six people living at the home. We also spoke with the provider's managing director for the North East, the regional operations manager, two peripatetic managers, a care quality facilitator, two nurses and six care staff. We observed care and support in the communal areas and looked around the premises. We viewed a range of records about people's care and how the home was managed. These included the care records of five people, safeguarding records, induction records and quality monitoring reports.

Is the service safe?

Our findings

At the time of our inspection there were five safeguarding incidents currently open and being investigated at Manor Park Care Home. The service had a written safeguarding policy. This required that the 'Service Manager (the referrer) must...produce a written record of any allegation of abuse or concern as soon as possible. This should be clear, factual and relevant...' and that 'all actions, phone calls and discussions pertaining to cases are fully documented'. We asked the peripatetic home manager for sight of the investigations to date for each of the safeguarding incidents. At the end of our inspection this information was produced for only two of the safeguarding incidents.

It was not clear to see in all cases what action had been taken since the safeguarding incident occurred. For example, a safeguarding meeting was taking place during the inspection but there was no evidence that the service had investigated the incident in advance. We saw that where evidence of investigations was available it was not always robust and thorough. For example, we viewed an interview for one staff member relating to a safeguarding incident two weeks previously. We saw they had not been asked any specific questions in relation to the incident that had occurred. The peripatetic manager advised they were going to interview them again and would ask the questions then. We saw that where external professionals were being interviewed as witnesses to events, they had been interviewed in a group rather than individually. We concluded this could not be relied on as it was not guaranteed to get an individual's view point when other people were present.

The provider's management team had collated a log of all the safeguarding incidents and recorded immediate action taken and the current progress. However, we noted this was not always an accurate reflection of what had been done and did not give clear timescales as to when it was expected for actions to be completed. For example, we noted following an incident in July 2015, under 'Immediate action taken', the safeguarding log detailed, 'Manor Park scheduling further whistleblowing and safeguarding training and policies being reissued to all staff.' We saw the peripatetic home manager had re-printed the safeguarding and whistleblowing policies and was providing these to staff and asking them to read them and then sign a register.

At the time of our inspection 26 staff had still not completed this action. It was unclear what communication had been issued to the staff and whether any timescales had been set.

We concluded the provider was not following their own systems and processes to thoroughly investigate safeguarding incidents and put immediate plans in place to prevent abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We started our inspection at 6am. This meant the night shift were providing care for the people living at the home. The night shift consisted of one nurse and five care assistants. Staff we spoke to told us there would normally be a senior carer on shift, who would be responsible for the residential medicines, however as there was no senior carer there was one extra care assistant. The nurse in charge told us the day shift staff had ensured all night time medicines were administered to people who were receiving residential care before they left.

The nurse in charge of the night shift was an agency nurse who had not worked at the home in over four years. Out of four care assistants we spoke to, three could not tell us the name of the nurse in charge.

We spoke to the nurse who was unable to tell us how many people were living at the home and how many required nursing support.

During our inspection we observed one area of the home had no staff available for over a 15 minute time period. We spoke to the management team who confirmed they would always expect at least one staff member to be available at all times.

At the time of our inspection the home only employed two permanent nursing staff members. All other nursing shifts were covered by the provider's own bank nurses or by agency nurses. We spoke to the peripatetic manager about what induction was conducted for bank and agency nurses. They showed us their process; however, we noted that a number of staff did not have the induction paperwork in place which meant we could not be sure that they had received the appropriate induction and information to support people in the home in a safe and appropriate way.

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

Is the service safe?

During the early morning part of our visit we noticed that on all three units of the home there was a loud beeping noise and saw that five people's bedroom door guards were making a loud noise. We spoke to three different staff members who were unable to tell us what the noise was from or how they rectified or stopped it. On arrival at the home the peripatetic manager confirmed the noise was from the door guards and that it was either a fault or they needed a replacement battery. By the lunch time we noted

all door guards were fixed. The management team confirmed they would ensure all staff would be reminded as to where the noise was from and what action they could take outside of business hours.

During our time at the home we also saw one toilet door did not have a lock on and another person's bedroom door, the lock had been removed but this left a hole in the door that you could see through. We fed back these issues to the management team who advised they would ensure action was taken.

Is the service caring?

Our findings

During the early morning part of our visit we saw that not all people living in the home were treated with dignity and respect at all times, and care was not always delivered in line with people's individual care plans. For example, on arrival at 6am we saw that four people who were asleep in bed had their bedroom doors propped open and their bedroom lights and television were on. We noted the TV volume was loud and could be heard down the corridor.

We reviewed the care plans for the four people and saw there was nothing to indicate this as normal practice or required, for example, for their safety. We asked a staff member why the lights and televisions were on. They said as they had supported the person earlier with personal care they had put them on in case they woke up so that they "weren't alone".

As part of our inspection we did not observe personal care however we did overhear two staff members supporting a person to get ready. We noted one staff member's voice appeared to demonstrate frustration as the person was not allowing them to assist. We overheard their voice get louder as they said, "You're playing that game are you." We observed two staff members return 20 minutes later to try and support the person. We heard them say, "The bosses are here and you're going to get us into trouble if you don't stand up", "You need to stand up as I need to go", and, "Right, lay back down then".

Although we observed good practice and good relationships these were not always consistent. For example, we saw one staff member shout across to a person in the lounge area, "[name] are you going to come with the nurse and change your pad." As the person was walking down the corridor with the staff member, the staff member continued to say, "He's okay, he will just let you pull his pants down and change his pad."

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During the day on our visit we did observe a number of good relationships between staff and people living at the home. Staff we spoke to were knowledgeable of people's individual care requirements and had a good rapport with people.

We took part in the handover walk around on both floors. The peripatetic manager had started the 'walk around' process so all staff starting shift were present for an update on each person. We noted during the walk around that staff were greeting each person, saying hello or good morning and checking they were well. All staff were seen to be attentive during the walk around and asked questions where needed to clarify individual care requirements.

Is the service responsive?

Our findings

Due to our concerns in relation to the night time staffing arrangements and some aspects of care delivery we reviewed a number of care plans to see if they reflected the care being delivered and the needs of the people living at the service.

As part of one safeguarding investigation we noted that one care plan had required updating. We reviewed this care document and it was up to date and reflected the needs of the person. However, we reviewed a number of other care documents for the same person and saw they had not been reviewed since May 2015.

We noted all the care plans we reviewed had limited information in terms of night time preferences, particularly that of sleeping habits and person preferences, i.e. one pillow, side light on or time they normally went to bed or woke up. Staff told us and we observed during our early morning visit that one person now preferred to sleep in a chair. We reviewed the person's care plan and noted the main care plan referred to the person as having a sound bed time routine and sleeping in their own bed. Over a 12

month period we noted the monthly reviews of the care plans did indicate the person's needs were changing, however no new care plan was documented to include their current preferences and what needed to be done to ensure they were comfortable and maintained posture and skin integrity over night.

The home was in the process of reviewing all care documentation and transferring this on to a new format. The management team told us that as part of this process each person's care documentation was being reviewed and re-written. We saw the transition plan included the staff member who was responsible for the completion; however, there was no clear timescales as to when this work needed to be completed or whether certain people needed prioritising.

We concluded that although a lot of the care plans were detailed and reflected the care being delivered, some lacked information in relation to people's individual routines or preferences, and in most cases the details behind these decisions or preferences.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Care plan documentation did not always reflect people's individual needs and were not always reviewed in a timely manner.

Regulation 9(3)(a) and (b)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

People did not always receive care and treatment with dignity and respect.

Regulation 10(1)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Systems for protecting people from abuse were not always in place and investigation of safeguarding incidents were not timely or documented appropriately.

Regulation 13(1),(2) and (3)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Sufficient skilled and experienced staff were not always deployed in the home.

Regulation 18(1)