

Park Lane Healthcare (The Manor House) Limited

The Manor House

Inspection report

White Gap Road
Little Weighton
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Date of inspection visit:
01 June 2016

Date of publication:
05 August 2016

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	Requires Improvement 
Is the service effective?	Good 
Is the service caring?	Good 
Is the service responsive?	Good 
Is the service well-led?	Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 1 June 2016 and was unannounced. We previously visited the service on 31 March 2014 and we found that the registered provider met the regulations we assessed.

The Manor House is registered to provide accommodation and personal care for up to 38 older people and people who may be living with dementia. On the day of this inspection there were 29 people using the service. The service is located in the village of Little Weighton and it has its own grounds and parking area. There are individual bedrooms and several communal areas within the service.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). 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.

During our inspection we found that the recording and administration of medicines was not being managed appropriately in the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

The registered manager understood the Deprivation of Liberty Safeguards (DoLS) and we found that the Mental Capacity Act 2005 (MCA) guidelines had been followed. However, the registered provider had failed to notify us of the outcome of DoLS notifications for nine people, which was a breach of Regulation 18 of the Registration Regulations 2009 (Part 4).

We found that although people had access to sufficient meals and drinks, the dining experience and how people were supported with their choices in relation to food and drink was not always appropriate and required some improvement. We have made a recommendation on the subject of respecting people's choices at mealtimes.

You can see what action we told the provider to take at the back of the full version of this report.

People told us that they felt safe living at The Manor House and we found that people were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding issues. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following the service's recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people were working at the service.

We saw that staff completed an induction process and had received training in a variety of topics and staff told us that they were happy with the training provided for them. There were systems in place to manage complaints if they were received and people told us they were treated with dignity and respect by staff.

People had their health and social care needs assessed and person centred plans of care were developed to guide staff in how to support people. The plans of care were individualised to include preferences, likes and dislikes. People who used the service received additional care and treatment from health care professionals in the community.

Staff felt they received good support from the management and people who lived at the service and visitors told us that the service was well managed. Quality audits were undertaken of the systems within the service to help make sure people's needs were safely met.

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.

The recording and administration of medicines was not being managed appropriately in the service.

Staff we spoke with understood their roles and responsibilities with regards to safeguarding vulnerable adults.

Risks were identified and proportionate risk assessments were used to guide staff on how to reduce risks and keep people safe.

There were sufficient staff to meet people's needs.

Is the service effective?

Good ●

The service was effective.

People were given sufficient meals and drinks to meet their needs. However, the dining experience and how people were supported with their choices in relation to food and drink could be improved.

Staff undertook training that equipped them with the skills they needed to carry out their roles, including training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People told us they had access to health care professionals when required.

Is the service caring?

Good ●

The service was caring.

People who lived at the service told us that staff were caring and polite.

People were supported with their independence and their privacy and dignity was respected.

Is the service responsive?

Good ●

The service was responsive.

Needs were assessed and person centred care plans developed to guide staff in how best to support people using the service.

People had opportunities to take part in their chosen activities.

There was a complaints procedure in place. Not all of the people we spoke with were able to tell us if they knew how to raise any concerns. However, staff told us they would support people using the service if they had any concerns and they would be happy to speak with the manager on people's behalf.

Is the service well-led?

The service was not always well led.

We found that the service had failed to notify the Care Quality Commission (CQC) that nine people were subject to a Deprivation of Liberty Safeguard (DoLS) at the time of this inspection.

There was a manager in post who was registered with the CQC.

There were sufficient opportunities for people who lived at the service and staff to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe and effective care and support.

Requires Improvement 

The Manor House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider 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 took place on 1 June 2016 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector.

Before this inspection we reviewed the information we held about the service, such as information we had received from the local authorities who commissioned a service from the registered provider and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection and they returned it to CQC within the required timescales. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of the inspection we spoke with four people who lived at the service, two visitors, four members of staff, the registered manager, the assistant manager and a director of the company.

We looked around communal areas of the service and some bedrooms (with people's permission). We also spent time looking at records, which included the care files for three people who lived at the service, the recruitment and training records for two members of staff and other records relating to the management of the service, including quality assurance, staff training, medication and maintenance.

Is the service safe?

Our findings

People told us that their medication on a personal level was handled well. Two people we spoke with said they always got their medicines as prescribed, they told us, "Staff give me my medicines and they do that well," "Staff do my medication for me and I take [Name of medicines]. I don't do it myself as I don't have nimble fingers anymore. [Name of staff] gives me my tablets."

Staff provided support where necessary to help people using the service take their prescribed medicine. The registered provider had a medication policy and procedure in place and staff administering medication received training to support them to do this safely.

Medications were securely stored in a locked treatment room, which was clean, tidy and well organised. A daily record was kept of the treatment room temperature; which we noted was recorded consistently and was within recommended parameters.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs and there are strict legal controls to govern how they are prescribed, stored and administered. We found that controlled drugs were securely stored and records showed these were checked on a monthly basis and recorded when given.

Medication was supplied by the pharmacy in blister packs; this is a monitored dosage system where tablets are stored in separate containers for administration at a set time of day. The system was colour coded to identify the time of day the tablets needed to be administered; this reduced the risk of errors occurring.

We saw that people had individual medication records that included a photograph of the person to aid recognition plus their name, date of birth, room number, the name of their GP, and their preferences in taking their medicines and any allergies. For example, one person's records stated, 'I like my medication in my hand and take one at a time.' We found that medication administration records (MARs) were clear, complete and accurate with no gaps in recording.

Some people had been prescribed 'as and when required' (PRN) medication. We saw that people's records included protocols that described when people would require this type of medication. For example, one person had been prescribed an inhaler and their PRN protocol stated, '[Name] becomes breathless when mobilising at times and is able to alert staff.'

When we completed a sample check of one person's medication we found that the amount of tablets did not balance with the amount of tablets that should have been at the service. We saw from the person's MARs it was recorded that 11 tablets had been carried forward and a further 60 tablets had been booked into the service on 19 May 2016. Our checks against the amount administered and what was remaining indicated there were five more tablets in the service than there should have been. This indicated that medicines had been signed for as administered, but had not been given to the person using the service. We discussed this with the registered manager who started an investigation into this discrepancy on the day of the inspection.

We also saw that the service did not complete regular checks of the stock of medicines held for each person. This made it difficult for the staff to audit the medicine stock held in the service.

Topical medicine charts were in use for the application of external use creams, gels and lotions. The service also used them for recording the administration of eye drops. We found that these were not always completed appropriately and the medicines in use were not always dated when opened. For example, one person's chart instructed staff to apply a gel to their knees three times a day. Over a nine day period it was recorded that this had only been applied once each day. Another person's chart instructed staff to apply gel three times each day to their knees and we noted from 23 May 2016 to 30 May 2016 there were significant gaps in the recording and no indication as to why this had not been applied. We saw a third person had been prescribed eye drops; we noted there was no date to specify when these had been opened. We discussed this with the registered manager and director who agreed that more in-depth stock control and monitoring of recording was required.

This was a breach of Regulation 12 (2) (g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the risk of abuse. The provider information return (PIR) we received told us, 'Staff have a robust training program which includes safeguarding and whistleblowing.' We saw training records for staff confirmed they had completed up to date safeguarding training and they understood how to identify and report their concerns. The staff who we spoke with told us that they would report any incidents or concerns to the registered manager. One member of staff described what the term abuse meant to them. They told us, "It could be harm to a person caused by neglect. Not giving people a choice or not using equipment safely. I did training on safeguarding last year." This meant people were supported by staff that were trained on how to support someone should an allegation of this nature be raised.

The information we already held about the service told us there had been one safeguarding adult's incident in the last 12 months. The safeguarding log at the service included the East Riding of Yorkshire Council (ERYC) Safeguarding Adult's Team risk tool for determining if a safeguarding referral needed to be made to them.

People told us that they felt safe living at The Manor House. One person said, "Yes I feel safe" and another told us, "Well yes, I have felt safe. We have the fire alarm and the doors close and we wait and see what happens." A visitor told us, "I have to sign in when I come here and we have to press a bell to access the place."

We asked staff how they kept people safe and their comments included, "We do risk assessments for people. We have one person who is always asking to leave and a risk assessment was done to help us keep [Name] safe inside," "If the fire alarm goes off we meet at the front entrance and check the fire zone. The senior care staff will appoint someone to check the zone. The fire doors close and there are 45 minutes protection from these" and, "If anyone visits I always ask who they are and who they have come to see."

The PIR told us, 'The care plan includes risk assessments for mobility, nutrition, health and well-being and medication, personal support, activity and community support.' Risk assessments had been completed for any areas that were considered to be of concern that included, falls, mobility, moving and handling and pressure care. We saw that people's care records included information on any risks to them. For example, one person's records said, 'I sometimes forget I have had my meals' and 'Weigh me on a monthly basis.' We checked the person's records and saw they had been weighed every month. This showed that any identified risks had been considered and that measures had been put in place to manage these.

Various risk assessments had been completed including nationally recognised risk assessment tools, for example, Waterlow scores and malnutrition universal screening tools (MUST) were used to assess people's needs. The Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sore in a given person and MUST is a five-step screening tool to identify adults who are at risk of malnutrition or obesity. It also includes management guidelines which can be used to develop a care plan. We saw these risk assessments were reviewed regularly and that they helped to identify people's needs and risks.

The registered provider monitored the maintenance of the building. They had in place a current fire safety policy and procedure, which clearly outlined action that should be taken in the event of a fire. We looked at the maintenance log held at the service and saw fire fighting equipment, emergency lighting and the fire alarm system were checked regularly. There were also personal emergency evacuation plans (PEEPs) in place which recorded the support each person would need to evacuate the premises in an emergency.

We saw that visual and health and safety checks were carried out on moving and handling equipment such as moving belts, hoists, swings and slide sheets. Records showed that all necessary checks were carried out on equipment and installations such as gas, electricity, portable appliances, mobile hoists and the passenger lift. This ensured they were safe and in good working order.

We saw that any accidents or incidents involving people who lived at the service were recorded. These were analysed each month to identify the type of accident, the number, what time of the day/night the accident had occurred and whether any patterns were emerging and if any areas that required improvement had been identified. This system ensured that steps were taken in response to incidents to reduce the risk of reoccurrences.

We checked the recruitment records for two members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. These checks meant that only people who were considered safe to work with vulnerable adults had been employed at The Manor House.

When we asked people who used the service, staff and visitors if there were enough staff on duty we received a mixed response. Some felt there were enough on duty but others said there were some times when they were short staffed. Comments included, "I think there is enough staff. When I have been here [Name of person] has not had to wait a long time for staff to come to them," "Sometimes if you are with one person another person may have to wait a little while," "Sometimes they have been short staffed," "As an observer when people ask to go to the toilet I have to go and find staff and they don't always come straight away" and, "I do think there is enough staff, we get cover if people are off sick."

The registered manager told us that the standard staffing levels at the time of this inspection were three care staff from 7:00am until 1:00pm reducing to two care staff until 7:00pm. In addition to this there was one senior care staff on each shift throughout the day. At night there were two care staff on duty. The registered manager was supernumerary to the staff team. Supernumerary is in excess of the normal or required number. In addition to care staff, there was an activities coordinator and domestic assistants on duty. We checked the staff rotas and saw that these staffing levels were being consistently maintained. This meant that care staff were able to concentrate on supporting people who lived at the service.

Is the service effective?

Our findings

Care plans documented what people's preferences were, including their food likes and dislikes. For example, we saw one person's 'Reach out to me' document' which recorded their preferences including food and drink, which said, 'My usual warm drink is tea with milk,' 'Foods I like are, biscuits and cereals,' 'Foods I don't like are spicy' and 'When I eat I need you to cut up my food.' We saw people were supported to eat and drink sufficient amounts to meet their needs.

We received a positive response from people when we asked them about the quality of their meals. Comments included, "In a morning I have toast and marmalade and two cups of tea. I always enjoy my breakfast," "They [Staff] bring me a drink. I can ask for a drink anytime," "The food that I have had is very nice and I generally enjoy what I eat" and, "Yes, they [Staff] come and see me and ask me what I want to eat and the food is okay."

The registered manager told us the food was delivered into the service once a week from a catering company and people were offered a choice of two main courses and two desserts at lunchtime. The entrance to the dining room had a menu board with pictures of the meals available on the day of the inspection which were; roast beef in gravy or lamb and mint pie served with roast/boiled potatoes and vegetables and lemon sponge with custard or cooked summer fruits. The food we observed looked appetising and hot when it was served.

From our observations of the dining room experience we saw that some staff practices around offering people choice and promoting their independence could be improved. For example, we saw at the start of the meal there were no cutlery or condiments on any of the dining room tables and two people had to ask for condiments during their meal; which were provided. Two people were given a cold drink of lemon juice without being given any choice. When we asked if there was a choice of drinks the staff immediately began to ask people their preference.

The registered manager told us some people were shown picture cards to support them in choosing their meals. However, we saw 17 people in the dining room at lunchtime and no-one was supported with the use of picture cards to choose their meals. One person was asked which meal they would like and gave no response and we noted a staff member said, "Would you like a bit of both." Despite this, the person was given roast beef. Another person had not been given their lunch after approximately 25 minutes sat at the table. When we pointed this out to staff the person was given a roast beef dinner. We checked the sheet for people's preferences and saw the person had requested the lamb and mint pie.

We observed that some people had to wait for a long period before being given their meal. This resulted in them getting up and down from the table. Once given their meal they became more settled. We recommend that the registered provider seeks advice and guidance from a reputable source on how to improve people's dining experience.

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 MCA 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 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 authorisations to deprive a person of their liberty were in good order. The registered manager told us that nine people who used the service had a DoLS in place around restricting their freedom of movement and we saw documentation was completed appropriately.

Staff had completed training on MCA and were aware of how the DoLS and MCA legislation applied to people who used the service. They told us, "It is people's decisions and you ask them" and, "[Name] is on a soft diet and tomorrow we are holding a best interest meeting to discuss their food as they are asking for other foods."

We saw in care files that staff had taken appropriate steps to ensure people's capacity was assessed and to record their ability to make decisions. We saw seven people's care plans included information about a relative who acted as Power of Attorney (POA) for their family member. A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf. We also saw that there were consent forms in place to ask people to consent to having their photograph taken.

We asked the registered manager about best practice in regards to dementia care. The registered manager confirmed there were no current dementia care models or practices being followed and that best practice input was gained from the dementia care training given to staff and the input the service received from a local GP who visited the service every week. The registered manager told us the GP had talked to them about the 'Butterfly scheme coding system,' which we saw had been implemented on people's bedroom doors within the service. This consisted of an at-a-glance discreet identification via a butterfly symbol on the bedroom doors of the people who had dementia-related memory impairment for staff to be aware of this. We also saw that staff had received training on dementia in the last 18 months.

We asked staff about how they used the training they received around dementia care in their everyday working practices, and received some good feedback. The staff talked about speaking with people, getting to know them and giving them chance to make choices. One member of staff said "We always ask people and they will tell you if they can. If they can't for example, I would hold clothes up so people can choose themselves" and, "[Name] can have a conversation some days and you have to be aware of how they are that day."

We saw that there was signage to help people orientate themselves around the service and the registered provider was implementing a programme of refurbishment. We saw the upstairs corridors had been decorated in neutral colours, new handrails had been installed and people's bedroom doors were in the process of being painted in block colours to aid recognition. One person told us, "The doors have been altered and they are lovely."

People and their relatives reported that the home provided effective care overall. People said they felt the staff were supportive, well trained and gave them good support. They said, "Yes, they are very good" and, "I'm sure they have had good training. [Name of staff] is very efficient." The staff monitored people's health

and wellbeing and when we asked people about the support they received with their health needs they told us, "Yes, if I really wanted to see my GP the staff would ring them for me" and, "I saw my GP a few weeks ago as I needed some antibiotics."

We saw evidence that individuals had input from their GP's, district nurses, chiropodist, opticians and dentists. All visits or meetings were recorded in the person's care plan with the outcome for the person and any action taken (as required). Staff were able to demonstrate their knowledge of people's health needs and support they provided. They told us, "Every Thursday a GP comes and sees the residents and district nurses come for [Names] who have catheter care" and, "[Name] likes to take cod liver oil and we contacted the GP to make sure this was okay." This helped to make sure people received the correct support with meeting their health needs.

We looked at induction and training records for two members of staff to check whether they had undertaken training on topics that would give them the knowledge and skills they needed to care for people who lived at the service. We saw that the training record identified staff had completed training in topics that included; fire safety, infection control, moving and handling, dementia awareness, safeguarding adults from abuse, health and safety at work and first aid. We saw staff had completed additional training which consisted of safe handling of medicines, dignity and respect, MCA and working at heights and seven of the 20 staff had achieved the National Vocational Qualification (NVQ) training at Levels 2, 3 and 5, now known as the Qualification Credit Framework (QCF).

Records we looked at evidenced that new staff carried out induction training over two week period and also shadowed experienced staff as part of their induction training. This was confirmed by the staff who we spoke with. They told us, "I started in December 2015. I completed some training on the computer, did four shifts shadowing another staff, met the residents and was shown the fire exits," "I have done moving and handling, health and safety, fire and safeguarding," "Yes to be fair we do get a lot of training," "My induction included walking around the home, fire points, introduced to staff and residents and told the dress code which is black shoes, trousers and a tunic" and, "Yes I get enough training. After my induction I felt like I knew what I was doing."

The staff told us they had supervision meetings with their manager. This was confirmed by the records we looked at. Staff told us that they found the supervision sessions beneficial and they felt supported. Comments included, "Yes I have regular supervision. We talk about what's going wrong or right and if we are working short then the managers will always bring someone in" and, "My last supervision was in February 2016. [Name of manager] is always talking to me and there is always support which is really good."

Is the service caring?

Our findings

We asked people who used the service if staff were caring; comments included, "I think so, I have never heard anyone being rude to anybody," "The staff are lovely" and, "Yes, they do all sorts for me." Although the feedback we received was largely positive, one visitor we spoke with told us, "Staff will come in when I am with people and that happens quite often. We will have seen people for years and if people pass away they don't always tell us. There has been a big changeover in staff and there are a couple that I think are quite cold although I have never heard anyone being unkind to people." We discussed this with the registered manager who told us they would speak to the person about their concerns.

Another visitor of someone using the service said, "I think the ambience of the place is nice and it feels like a home. The staff are polite and kind." One member of staff said, "Yes I do think people care. We take time out to spend with people" and other members of staff told us, "Yes staff care. They always speak to people with respect" and, "At the moment we don't have a lot of time to spend with people but interviews have gone ahead for more staff. There are one or two people who are maybe more caring than others but staff who work here are good and really try hard."

The provider information return (PIR) we received told us, 'Good communication is paramount and people are treated with dignity and respect at all times.' People using the service told us that staff were kind and caring and maintained their privacy and dignity. Personal care was provided in people's rooms and bathrooms and we saw that staff knocked before entering people's rooms to maintain their privacy. During our inspection we observed that staff spoke in an appropriate manner and tone to people using the service and in this way treated people using the service with respect. One person using the service told us, "Yes they always keep me covered and close the curtains."

We observed that medication was administered in a communal area during the lunchtime meal, meaning it may be difficult for people who use the service to have any discussion with staff regarding any medications or concerns they had in confidence and it was noted that staff asked one person if they required pain relief whilst stood at the medication trolley and the person was seated at the dining table. This practice did not maintain people's dignity and did not follow the registered providers medication policy and procedure.

We asked staff how they supported people to maintain their privacy and dignity. They told us, "We always close the doors and it's about using your common sense" and, "People have their own private rooms and we make sure people get to the bathroom when they need to. We always close doors and if helping with personal care I would pop a towel over the person to protect their dignity."

Staff also told us that they supported people to make decisions about their day to day lives. Comments included, "Some people can walk to the bathrooms themselves and [Name and Name] can look after themselves" and, "I promote people's independence by encouraging people to wash themselves, choose their own clothing and putting on their own face cream for example." This helped people to maintain as much independence and control over their lives as possible.

We did not identify anyone using the service that had any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation and we saw no evidence to suggest that anyone that used the service was discriminated against.

During our inspection we observed positive interactions where staff and people using the service engaged in meaningful conversations. We saw a number of examples where people using the service responded positively and warmly to staff. For example, we saw two people using the service were singing a song together and when a staff member passed they told them what a beautiful song it was and how lovely they sounded. The two people responded with smiles and laughter. We also saw people were asked if they would like warm drinks and biscuits, the staff member asked people individually in a calm and kind tone of voice and was chatting with people throughout. This showed us that people using the service and staff had developed caring relationships.

The PIR told us, 'Staff have a lot of contact with each resident to help them feel safe and valued. A key worker is assigned to every new resident to ease their transition into the care home environment. The key worker also becomes a point of contact for family/friends and advocates of the new resident.' We reviewed three care files of people using the service and saw that these contained person centred information about each person to enable staff to get to know the people they were supporting. This included information about people's likes, dislikes, and interests.

We saw each person had a named keyworker. A keyworker's role is to take a social interest in the person in conjunction with the management and take part in care file development with the individual. One staff member told us, "I am [Names] keyworker and I keep their records updated and keep [Name] up to date with everything they need." We saw the most recent satisfaction questionnaire results collated in December 2015 from relatives of people using the service, and noted comments included, "The communication I have with my relatives keyworker has improved" and, "I really value the time the staff give to [Name of relative]."

People who used the service told us their friends and relatives came to visit them and we saw visitors at the service on the day of this inspection. People told us, "My nephew lives close by and his daughter and she comes with the baby every week. My nephew looks after everything for me and comes to visit and brings me my sweets and crisps" and, "My sister comes to see me and my daughter always comes."

Is the service responsive?

Our findings

People's care files contained assessments, risk assessments and individual care plans. Assessments were undertaken to identify people's support needs and individualised care and support plans were developed outlining how these needs were to be met. People who lived at the service had care plans in place for care needs which included mobility, sleep, pressure areas, behaviour, dressing, nutrition, personal hygiene, communication and sight/hearing. We saw people had a 'Client profile' with the person's preferred name, date of birth, GP, date of admission and details of any known allergies and of their family relationships.

The care files we looked at were written in a person centred way and identified the person's individual needs and abilities as well as choices, likes and dislikes. Care files included a 'This is me' document which recorded the person's life story so far, their routines and any medical diagnoses. In addition to this we saw a 'Reach out to me' document which included the person's preferences in areas such as food, drink and night time. For example, one person's night time routine said, 'I like to have two pillows.' We saw one person had periods of upset and distress and their care plan for behaviour recorded, 'I can become verbally aggressive and you can help me by letting me walk around and make my own choices. Reassure me during my times of aggression and try to find out the reason for the change.' One staff member told us, "Everything we do depends on the person and we all follow people's care plans."

We saw each of the person's individual care needs and the outcome were appropriately reviewed and updated to ensure a person's current needs were known and met and had been signed by a member of staff and the person concerned (when they were able to do so) or their representative.

Handover meetings and a communication book were completed by staff at the end of one shift and the beginning of the next to share important information about people's changing needs or significant events with new staff coming on duty. We saw that a handover record was completed to record information and any actions needed for staff to look at during the shift and the communication book contained information that included any visits from people's family or health care professionals. This ensured that information was effectively shared so that staff could provide responsive care to meet people's changing needs.

The registered provider employed an activities coordinator and people we spoke with explained that activities provided included entertainers, quizzes on a Monday and a sing along on a Tuesday. Comments included, "On a Tuesday there is [Name of manager] the boss and her mother who run a musical sing song and we sometimes have games. I can join in if I want to" and, "I like listening to music in my room, it's lovely." One visitor told us, "There is activity on offer if you want they have just had a guitarist and an entertainer" and another said, "We come in for an hour once a fortnight to do communion and we say prayers, sing hymns and give out communion wafers." We observed nine people taking part in the communion service on the day of this inspection. When we asked staff about people's activity they told us, "There could be more activity. A quiz man comes in and people love that" and, "Absolutely we spend enough quality time with people. People love the entertainment and the quiz. [Name] loves football and [Name] loves dancing."

One person using the service told us they knew how to raise issues or concerns and they felt that staff and the registered manager were approachable. They told us, "If I was unhappy I would tell [Name of relative]. I could talk to the staff at any time." Staff told us they would listen to people if they raised any concerns with them, they told us, "I would always listen to them and if I couldn't resolve it myself I would report it" and, "I would always ask the person what their problem is and we have a complaints book and I would pass this on to my manager."

The registered provider had a complaints policy and procedure in place. Records showed that there had been two complaints since our last inspection. We reviewed documents relating to these complaints and saw that they had been appropriately investigated where necessary and a response provided to address the concerns raised. This showed us that the registered manager was responsive to concerns and acted appropriately to resolve issues

The registered provider completed two surveys each year in April and October which involved sending quality assurance questionnaires to people using the service and relatives that visited. We saw questionnaires from the previous year's survey (October 2015) and were told that feedback was being collated from this year's survey (April 2016) at the time of our inspection. We saw comments from the previous surveys included, "I enjoy the activities," "[Name of relative] is not one for joining in but the staff do try" and, "I feel the team work very hard." We saw one negative comment had been recorded in relation to people's laundry being placed in the wrong room and this had been followed up in the services' newsletter with a request for relatives to place people's initials on any clothes they brought for them to try and eliminate this occurring. This showed us that the service listened to people's views.

Is the service well-led?

Our findings

We sent the registered provider a 'provider information return' (PIR) that required completion and return to the Care Quality Commission (CQC) before the inspection. This was completed and returned with the given timescales. The information within the PIR told us about changes in the service and improvements being made.

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of this inspection. The registered manager told us that they attended regular local care home manager forums as well as receiving good information from within the organisation, and that this helped them to keep up to date with any changes in legislation and with good practice guidance.

The notice board in the staff room held advice documents for staff, such as the service whistleblowing policy, the NHS 111 service details, the principles of the Mental Capacity Act (MCA) and the services' mission statement. A mission statement is a formal summary of the aims and values of a company, organisation, or individual. This showed that staff had been provided with good practice guidance.

When we reviewed people's files we saw evidence of how the management and staff worked with other professionals to help make sure people's needs were met. This included collaboration at best interest and decision making meetings, and we also saw that GPs and district nurses visited the service regularly.

The registered manager was on duty and along with the assistant manager; they supported us during the inspection and they were knowledgeable about all aspects of the service and able to answer our questions in detail. Overall we found that management knew about their registration requirements under their registration with the CQC and the need to notify CQC of certain events. However, we found that nine people using the service were currently subject to a Deprivation of Liberty Safeguard (DoLS) and during checks of the information we held and our discussions with the registered manager during this inspection we noted that there had been a failure to notify the CQC of these authorisations.

This was a breach of Regulation 18 of the Registration Regulations 2009 (Part 4).

One person who used the service told us, "I am not worried because [Name of manager] is very good and I think they run it very well." We asked visitors to the service what they thought of how well the service was led at The Manor House; feedback included "It's kept very clean and I'm sure it well run" and "I like it. I've been about six times and it's got a welcoming atmosphere and it's warm."

We asked staff if they thought the service was well-led; feedback included, "I am usually well supported. It's hard work but it's fine and I've worked here for 20 years. [Name] and [Name] are my managers and I can just go to them and say it," "Yes it is. The managers would listen to me and I would go to them. It's like one big family," "Yes I do. [Name] is a diamond and [Name] is good. It's very tiring but I love working here. It's a nice little home and I would be happy if my mum lived here" and, "This is a comfortable home for the residents.

Overall it is very family friendly although there is always room for improvements."

We saw the minutes of senior staff meetings, full staff meetings and committee meetings (between service managers). Staff told us that they felt they were listened to. One staff member said, "Last week [Name] took me right through the last staff meeting."

We could see that the registered manager completed an annual audit plan which covered areas of the service such as care plans, medication, infection control, dignity practices, meals and nutrition, health and safety, kitchen and people's bedrooms. For example, in May 2016 we saw 25% of people's medication, five people's bedrooms and five people's care plans had been checked. In addition to the registered manager's audits we saw the maintenance log which was split into months of the year with individual checks on areas such as window restrictors, water temperatures, extractor fans and the nurse call systems. This meant the current systems in place would identify any shortfalls in practice and help to identify where improvements to service delivery may be required.

We asked for a variety of records and documentation throughout our inspection and found that these were stored securely, but readily available on request.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>During our inspection we found that the recording and administration of medicines was not being managed appropriately in the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>