Barchester Healthcare Homes Limited

The Manor

Inspection report

Haydon Close
Bishop's Hull
Taunton
Somerset
TA1 5HF

Tel: 01823336633
Website: www.barchester.com

Date of inspection visit:
23 July 2019
24 July 2019

Date of publication:
09 October 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Manor is a Nursing Home which was providing personal and nursing care to 69 younger adults and people aged 65 and over at the time of the inspection. The service can support up to 86 people.

The service was registered to provide the regulated activity Diagnostic and screening procedures which they were not providing, and we asked the provider to assess whether this was still required.

Care Homes
The Manor operates in a building that is designed to deliver care over two floors in three units.

People's experience of using this service and what we found
People told us they were not happy with aspects of the service. In particular, staffing, being listened to and the quality of the food. They told us the care was delivered by staff who were caring, but the high use of agency staff and changes in management had not ensured they felt the service was as good as it could be. Staff and families shared similar concerns.

We found the service not meeting the standards to be safe, effective, caring, responsive and well-led. People's records did not meet requirements of the legislation and people were at higher risk of unsafe, inappropriate and inconsistent care and of not having their preferences and needs met.

People had not been fully protected from the risk of abuse as some important information had not been shared with the local authority and CQC as required. This meant the safeguarding authority had not had the opportunity to review and oversee concerns as they arose.

People were not always protected from the risk of falling, skin damage, cross infection and, ensuring medicines practice was now always safe. The service was not always evidencing how essential equipment needed to support people in an emergency was kept ready for use. The clinical governance and records needed to improve to aid communication amongst staff and people were not fully involved in assessing and reviewing their care. This would have the additional benefit of the records and people's care being more personalised.

People were not supported to have maximum choice and control of their lives. Staff spoke of trying to support people in the least restrictive way possible and in their best interests; however, the systems in the service did not support this practice. Staffing numbers were not always at the assessed level. This left staff short and put pressure on delivering tasks rather than ensuring all care was personalised.

We have made a recommendation in respect of the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand.

The provider had recognised there were issues at the service through their quality assurance systems however, there had been multiple managers leading to inconsistency and people continued to be impacted.

A new management team had started in the last six weeks, and people, family and staff were optimistic for the future of the service. One staff member has said, "I feel changes are being made for the best on a daily basis."

On the first day of the inspection, the manager showed us an action plan they had developed the day before which demonstrated many, but not all, of the areas we found on inspection had been identified. As areas were identified during the inspection, these were added to the action plan. For example, ensuring people had their chosen gender of carer and issues with food quality and timing of meals.

The regional director explained how the provider had placed two operation managers at the service and other senior staff in support roles to manage the service while the appropriate new manager was recruited.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (Published 11 April 2017).
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Manor on our website at www.cqc.org.uk.

Why we inspected
This was a responsive, comprehensive inspection and was completed due to a range of concerns received. A decision was made for us to inspect and examine those risks alongside the full range of topics covered on all comprehensive inspections.

The concerns included:
•People requiring percutaneous endoscopic gastrostomy (PEG) feeding (feeding through the stomach wall) were not being supported safely;
•People with a tracheotomy in place were not being cared for safely;
•Where people required suctioning this was not being carried out safely or hygienically. Also, the service was not ensuring the suction machines, and any other lifesaving equipment, were kept ready for use;
•The service was not ensuring good skin care;
•Medicines errors had occurred, and reports suggested peoples 'as required' (PRN) pain relief medicines were not being made available outside of the usual medication administration rounds;
•Reports staff were not ensuring people's GPs and/or other medical support was available when needed;
•Reports people were being injured during personal care;
•Reports a person had been scalded when given a hot drink without a lid on as per their care plan;
•Reports of people experiencing a high rate of falls;
•Reports people were not receiving good continence care;
•Reports of poor mouth care;
•Reports of records kept of people's care were not accurate or complete. For example, when people needed to be supported to move to prevent their skin breaking down;
•Poor staff and provider interactions with people and their family members;
•Reports of good levels of staffing not being maintained, with additional concerns about the number of nurses on duty at any one time;
•The appropriate and safe use of bed side rails;

•People who smoked were not being assessed and supported to do this safely;
•People's right to consent was not being ensured to be in line with the Mental Capacity Act 2005 (MCA) and there was low recording of Deprivation of Liberty (DoLS)
•Activities were not available for all to participate in. Reports said meaningful occupation/support to be active in mind and body were not available for people living with dementia and other cognitive and physical limiting conditions.

We have found evidence that the provider needs to make improvements. Please see all sections of this full report. The overall rating for the service has changed from Good to Requires improvement. This is based on the findings at this inspection.

Enforcement
We have identified breaches in relation to safe care, safeguarding people and staffing at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Manor

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

The inspection was completed by one inspector, a pharmacist inspector, a specialist nurse advisor, two assistant inspectors and two Experts-by-Experience.

An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case, someone with experience of older people services and one with experience of services for people with a physical disability.

Service and service type

The Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as A single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. However, the new manager was in the process of becoming registered with us. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The last registered manager was deregistered with us on 5 December 2018. The new manager had been in post six weeks.

The service was registered to provide the regulated activity Diagnostic and screening procedures which they were not providing, and we asked the provider to assess whether this regulated activity was still required.

Notice of inspection

This inspection was unannounced.

What we did before inspection

The provider was not asked to complete a provider information return prior to this inspection. However, a PIR was submitted on 8 March 2019. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We used all this information to plan our inspection.

During the inspection

We spoke with 11 people and four relatives about their experience of the care provided. We also spoke with people at lunch. We spoke with 11 members of staff including the manager, deputy manager, regional director, clinical lead, senior care workers, care workers and the chef. We observed how staff interacted with people at meal times and in the communal areas.

We reviewed a range of records. This included 26 people's care records and multiple medication records. We spoke with the people we reviewed where this was possible.

We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We reviewed accident and incident reports for July 2019 up to the date of the inspection.

We attended the 11 o'clock "Stand up meeting" which was a staff meeting that took place every day.

We spoke with a senior nurse practitioner from a linked GP Surgery.

After the inspection

We continued to seek clarification from the provider/manager to validate evidence found. We provided questionnaires that could be given to professionals, family and staff. We received three staff questionnaires. We also asked the service to identify relatives we could call with their consent. We were able to speak with one relative on the telephone.

Requires Improvement

Is the service safe?

Our findings

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement.

Requires improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

•Risks to people were not always responded to safely. People's records held a range of risk assessments to monitor their time at the service and keep them as safe as possible.
•People's care was not always reviewed when there were changes in their condition. One person had fallen twice in the month resulting in a hospital admission. However, though their condition had changed, the deputy manager told us the person's falls risk assessment would only be reviewed at the end of the month. The manager acknowledged the oversight of falls needed to be improved.
•People with wounds did not always have a wound care plan. A nurse told us there were issues recording wounds, and they had come on duty and discovered people with wound dressings they were unaware of. A senior manager also told us that people's care was only reviewed at the end of the month and this was when care plans would be updated.
•People's risk of skin damage was not managed safely. Two people's pressure-relieving air-mattresses were not set correctly increasing the risk of skin damage despite staff recording these were set correctly. Another person assessed as needing an air-mattress did not have one. The manager acknowledged that oversight of skin care needed to improve.
•Essential equipment was not always managed safely. Equipment had regular maintenance from contractors and we observed that several syringe drivers were being sent off to be repaired but for the suction machines there was no record with the equipment that showed they had been checked by staff on a regular basis to ensure they remained safe to use.
•People had individual risk assessments in place if they chose to smoke.
•Bedrails were used safely. Where people used bedrails there was a comprehensive assessment. Bedrail covers were used to reduce the risk of entrapment. Staff were made aware of who used bedrails.

Preventing and controlling infection

•People were not always ensured of being protected by safe infection control practices.
•Staff did not demonstrate they were managing the cleanliness of the suction machine's line using current guidance. Barchester had a policy in the care of people requiring Tracheostomy Care. We found however, that this policy was not always being adhered to in order to ensure this was protecting people from cross

contamination when suctioning.
•There was no guidance, and recording by staff, on how to clean, handle or change the disposable parts of different machines. This covered those requiring suction, PEG feeding, on Oxygen, and/or having a urinary catheter fitted.

•People's urinary catheters were not managed safely. Staff told us they used a tissue to wipe the end when the urinary catheter bag was changed or emptied which did not follow best practice and increased the risk of infection.
•The external clinical waste bins were open and unlocked, and not secured to the access gate. This was resolved during the inspection.
•Staff had received training in infection control and food hygiene. Audits of the cleanliness of the home were carried out. The home smelt clean and the manager's action plan addressed general areas to improve infection control measures.

Using medicines safely

• Medicines were not managed safely. One person's Medicine Administration Record (MAR) detailed that they had received a medicine for longer than prescribed. Another person's MAR detailed two different doses of a medicine had been administered, so it was not clear what dose the person had received.
•A person with a diagnosis of diabetes had no hypoglycaemic related care plan or PRN protocol in place for the administration of glucose. The instruction in their medicine records stated only, "glucose 40% as directed". This meant staff did not have clear details.
•We found one person's medicine had been reduced however, medical instructions had not been followed and they had continued to receive the original incorrect dose. Furthermore, the changes were not clearly recorded on the person's MAR chart, which could lead to further error.
•Systems were in place for recording the use of prescribed creams used on people's skin. However, these were not always completed by staff to show whether these products were being applied when needed, and in the way prescribed for people.

Risks to people were not managed safely including management of medicines and preventing infections. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•Prior to the inspection information received said that people were having the 'as required' pain relief medicine restricted to normal medicine rounds. We found no evidence on inspection to support this concern. People received pain relief and were offered it as required.
•Medicines were stored safely, and staff enabled people to administer their own medicines where they were able to do so. Medicines were administered in a personalised way. Regular audits to check record keeping and storage met best practice. These had been added to the manager's action plan where concerns had been identified. For example, in respect of gaps in people's medicine records.

Systems and processes to safeguard people from the risk of abuse

•The provider had policies and processes in place to safeguard people. However, important information about safeguarding was not always shared with the local authority and CQC. The manager had investigated these but not all incidents had been reported to the local authority and us as required.
•We found an accident and incidents which required reporting to the Commission and safeguarding had not always occurred. This was in relation to alleged injury to people by staff and a potential choking incident. The manager told us they had not been aware of the level of information that was required to be notified to

CQC.
•We were notified of one person who had sustained a fracture. The person told us this had been sustained because of care provided by an agency member of staff. The person said the member of staff still worked at the service and did not prefer this. Following the inspection, the manager advised there were no restrictions made against the member of staff working in the service again as they did not feel that there was any evidence of intentional harm to the resident.
•People said they felt safe living at the service. Comments we received included, "Safe? Yes. People are very friendly and very open. I still miss my own home, but they are so friendly"; "I feel perfectly safe. They seem to have everything under control. It gives you confidence" and, "Yes, it's the home itself - people around. I speak very highly of them".

Staffing and recruitment

•People, relatives and staff all raised concerns with us about the staffing of the service. Staffing levels were safe during the inspection however, we found there were times in the rotas when staffing levels did not meet people's needs.
•We also received mixed feedback from people about staffing. Comments received included, "Enough staff to look after me. I can't grumble with anything, but I think we could do with more staff because they are so busy"; "As far as I know, enough staff" and, "Enough staff? Some of the time there is, other times, no. In a home like this never enough staff. Not really any impact on me. I get the care I need. If you are nice to people, they are nice to you". Another person told us the permanent staff were good but said, "The staff turnover is dreadful, two left last week. There are not enough staff." A relative said, "Never seems enough staff. Agency staff lack the big picture and knowledge of the individual.".
•The manager was actively recruiting more staff. This included nurses and care staff. In the meantime, shifts were being covered by agency staff as required. The manager's action plan highlighted and stated, "The effective deployment of staff should be regularly monitored to ensure people's care and well-being needs are met at all times."
•The service used a dependency tool to gauge the number of staff required. The manager advised they were in the process of reviewing all the information currently available to them to determine the number and deployment of staff.
•The dependency tool identified a nursing shortage. New nurses were in the process of being recruited to the service. A nurse said, "The [nursing] cover is better now, we usually have some agency but prefer our own staff. The care practitioners are very good, but I feel responsible for the entire home today when I am the only registered nurse on duty".
•During the inspection call bells were heard, some moving onto the emergency call bell due to delay in staff answering them. We were advised that staffing that day had been reduced by one care staff due to illness. We rang the call bell for one person who had slipped over in their wheelchair and was unable to move themselves back into position and they were shouting for help. They were not responded to by the staff member who came into the room. The call bell took 8-10 minutes to answer.
•Staff fed back that if planned staffing numbers were maintained it was possible to meet people's needs, however they were often working with less than planned numbers due to sickness and this made it "very difficult". The rotas showed that operating one care staff short of the assessed number was not uncommon.
•One staff member said, "Levels are improving. This unit is a complex care unit - it is hard unit to work on and back along it was difficult, but they are listening to us and we need five people as one lady is 1:1. I don't feel I have enough time to spend with people. I try and make time and make them laugh but we just don't have the time usually. It has got better though and have had some more time to have laugh and a sing with them so heading in the right direction." Another said, "At the moment we do not have enough staff and I feel we are struggling a bit. I think they mentioned we are trying to get some more people and they mentioned they are interviewing so hopefully things will improve."

•People shared concerns with us that the service's use a lot of agency staff. This was confirmed by the rota, especially at night. The manager advised they were trying to use the same agency staff so there was some continuity. Initiatives were in place to support regular staff to fill shifts. A staff member also said, "We are using quite a lot of agency. The residents need consistency and there quite a few residents that have complained about the continuity of staff, but I know that is something the manager and deputy manager are really working on and if someone is sick they do try and cover with permanent staff but if they have to use agency."
•A person said an important outcome from the inspection would be "Less agency staff. If I ring my bell, one will walk in and tell me they have to go and get someone else and don't come back. I ring the bell again". By this time, they explained their need to go to the toilet was urgent. They felt that the agency staff were not trained or as knowledgeable of their needs as full-time staff.
•There was an on-call system in place. The manager had covered the majority of this to date with plans to include other members of the management team.
•Staff were recruited safely with all required checks in place. Gaps in employment had been recognised in the manager's action plan and plans were in place to address this for future prospective staff.
•A person living at the service interviewed prospective staff alongside other senior staff and they told us their opinion was listened too.

Learning lessons when things go wrong

•We spoke with the manager about the service and whether they had been in a position to learn from events and when things went wrong. Due to a constant change of management, this had proved difficult. It was something they were developing. Recent staff meetings had raised safeguarding and other issues with staff, so they could learn from them.
•Barchester Healthcare Homes Limited had systems in place but staff could see that consistency in leadership was required to make them work effectively. Staff expressed their commitment to wanting change. A nurse told us, "I want to be honest as I want to make it better".

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement.

Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

•People were not having food served that was always of good quality. Drinks were served but the monitoring and support to help people drink them required improvement.
•People and relatives shared concerns with the inspection team about the quality of the food, the availability of food outside meal times, and the timing of meals.
•Everyone told us that the quality of the food depended on who was chef for the day. For example, one person said, "I'm not really happy with the food. New chef has improved it a lot." and, "Lunch is variable. Today is ok. Not nice yesterday. Different chef today". The chef on the second day was highly regarded by people and we saw a huge improvement in the quality of food served on the second day.
•A staff member said, "Sometimes it's good and sometimes it's [not]. They do have a choice but sometimes it's too much (choice) and sometimes they do beef chilli and then veg chilli -that is not a choice. I say to people can I get you anything in between meal times and they can get drinks anytime and ask us. Most people we have to give drinks to anyway as they can't do it for themselves."
•The manager had already started to address the concerns raised by people, relatives and staff about the kitchen service and the quality and quantity of food coming out of the kitchen. Their action plan stated they would add the availability of specially prepared snacks to the action plan and nutritional meetings were due to commence.
•The manager advised that they are in the process of reviewing the whole dining experience. A nutrition and dining audit was completed on 25 July 2019 and prior to this on 11 April 2019
•During lunch, people were asked what they would like to eat and or drink. People could have water, juice or an alcoholic drink. A relative said, "The whole menu was read to (their relative). They couldn't hear or memorise the list so didn't want anything". We did not see any other communication methods in use such as pictures to help people who struggled to communicate verbally.
•We were told by the manager that lunch was at 12.30pm but through our observations, and people confirmed, it was never at this time. People were moved into the dining room from 12.25pm onwards; then eating from 12.50 or1pm up until 2.10pm over the two days. Although staff appeared to work together, interact well and at a pace led by people, people were also waiting too long for their meal to start and to continue.
•"Supper" was at 5.00pm. People told us they generally had breakfast around 8.30am but the timing was flexible. People told us they were therefore often not hungry by 5pm after eating a late lunch. People said

biscuits were available with the morning drinks round.
•One person told us they did not eat supper and would not eat until breakfast unless they asked for something. They told us they would then be given a couple of biscuits. They advised staff did not check on them if they knew they had not eaten supper. We spoke with the manager about how staff are therefore ensuring people were not hungry. The manager stated they would review this immediately.
• There were snacks and drinks available for people and their relatives however, these were not accessible to all people, for example those with mobility or communication needs. The manager told us they would address this.
•We were concerned that we did not see more drinks being offered on the first day of our inspection, despite there being a national alert that a heatwave was taking place. We mentioned this to the manager and in the afternoon, we saw people being given ice creams. On the second day of our inspection more drinks were seen being offered. The manager advised following the inspection that, heatwave advice had been received from the provider and communicated to all staff.
• Where concerns were being monitored, fluid intake records had no target volumes indicated on the chart. One person was noted as requiring fluid intake monitoring but there was no record being used. The manager advised this was being addressed as part of improving recording across the service.
•People at risk of choking on their food and drink had SALT (Speech and Language Team) assessments in place. It had been noted that the kitchen was not informed of a person's needs and action was not taken to inform the kitchen and ensure against the potential of such an incident taking place.
•People who needed support at mealtimes were not rushed but supported carefully and in their own time.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

•People had detailed initial assessments in place. People on short stay, quickly had an initial care plan put in place so staff knew what their needs were.
•People told us they did not have much involvement in planning how their care was designed. Care plan reviews did not always involve them. This had been recognised by the manager in their action plan and work had started with staff to ensure this took place at least six-monthly. The manager further advised, people's care and care documentation are reviewed monthly as part of 'Resident of the Day'. Staff meet with residents and ask for their input and feedback if they are able to communicate this. Telephone calls are made to relatives for feedback if the person lacks capacity to understand the process. The discussion is then recorded on a monthly review form."
•We saw information from the initial assessment did not always make it through to the full or further care plans. Details of personal choices such as what radio station people liked to listen to was missed. For example, the records for two people who had difficulty communicating said they liked to listen to Radio 5 and another Radio 4. Neither had these stations on when we visited them. One person's radio was tuned to Radio 1.
•The manager told us, and this was reinforced by their action plan, that these issues had been recognised and work was going on to improve how people's likes, dislikes and preferences were being recognised and met.
•Some people living with Dementia and Parkinson's disease, were not having these needs identified in specific care plans. This was identified by the manager in their action plan and work was underway to put this right. The completion date for this work was expected to be 31 December 2019.

Staff support: induction, training, skills and experience

• Staff had the training to carry out their role. The new manager had identified where the gaps in training for care staff were, and plans were in place to ensure all staff would soon have up to date training. A training matrix was available to support the service to identify when training should be provided.

•People told us the permanent staff were trained to meet their needs. Comments we received included, "I suppose they have been well trained. They look after me well. They are very kind"; "I expect the staff to be well enough trained" and, "I think – well trained. Good staff. Meet all my needs. Good initiative".
•Staff (including non-nursing qualified staff) had recently received venepuncture training but there was no evidence of a competency assessment having been completed for these staff. Venepuncture refers to drawing blood from a vein. Management said that the policy was that staff new to the skill being trained for would have three competency checks before being signed off, but staff that were refreshing their existing training would not. This record was not available to us during the inspection to ensure all staff were safe to complete this task. The manager has since confirmed that the evidence of competency will be actioned.
•All the nurses told us they had been supported to revalidate their registration and felt supported to continue their personal and professional development.
•Staff continued to receive an induction to the service. This gave staff the basic skills to start work. For example, how to carry out manual handling techniques safely. All the staff who had attended the induction training praised it highly.
•Staff supervisions were being delivered at 40% when the new manager came into post. This had increased to 74.4% at the time of the inspection. Appraisals were planned, however the manager advised she felt it was more important to ensure each member of staff had one to one time with a manager to ensure they had the right support, appropriate training, and to highlight how they were feeling.
•Unit managers had protected time to complete supervision and management tasks, the manager was working with them to develop their leadership skills.
•Management told us basic catheter care for care staff was included in the provider's induction training.

Supporting people to live healthier lives, access healthcare services and support

•People had their health care needs met, however the recording of this could be improved to support better care.
•People told us, "Yes, I can see the doctor. Yes, the staff pick up quickly if I'm not well. All, very, very kind"; "As I need, I see the doctor. They are very quick to pick up if I'm not well. They know immediately by my face. The staff here do my dressing, usually in the mornings. I have a pressure sore (sacral) not sure how long. It is dressed as needed. I'm happy with my care"; "Yes, my health needs are met. I can see the doctor if I need to. They dress my leg. I have an ulcer on my right leg which is swollen" and, "Oh yes, I can see the doctor. They pick up quickly if I'm not so good, but my health is good".
•Records relating to people's healthcare needs were not always accurate. We found incidences where it was difficult to follow through health events for people. For example, one person had a significant cough and they told us it was being monitored. However, there was no record of any monitoring and the person had not been highlighted in the staff handover, or the 11 o'clock 'stand up' staff meeting on either day. When we asked the person, they told us seeing their GP had not been discussed with them and they would like to speak to their doctor. We passed on this message, so it could be arranged for the person to see their GP.

Staff working with other agencies to provide consistent, effective, timely care

•Staff worked with a range of other agencies. Evidence was seen within care plans of SALT, GP, Physiotherapist, Nutritional Nurse and Respiratory Special nurse involvement.
•The service employed the services of a physiotherapist.
•A GP visited the service every Friday.
•The Nurse Practitioner from a separate GP surgery felt the service communicated well with them and staff knew people well.

Adapting the service, design, and decoration to meet people's needs

•The service was designed to meet peoples' mobility needs. People needing wheelchairs or to walk with a frame could do so safely.
•People had the equipment made available to meet their assessed needs. Where people required a hoist to be used, they had their own sling.
•People could personalise their own rooms and use the many communal areas and the garden as desired.
•We discussed with the manager that as the service supported people with short term memory loss and early dementia, some signage in line with recommended dementia care around the service could support people to move around independently.

Ensuring consent to care and treatment in line with law and guidance

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 when this is in their best interests and legally authorised under the MCA. In care homes 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

•People's records had varying evidence of the MCA and DoLS being identified.
•There was no evidence of any undue restrictions. The front door was open and observed by reception staff.
•The manager's action plan addressed inconsistencies regarding the MCA and were acting to improve consistency on this issue across the service.
•A review of DoLS had been completed in the service and a plan to ensure people had a DoLS application made as needed, and this was reflected in their care records.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement.

Requires improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care

•People told us they were not always included in making decisions about their care and they were not always listened to by staff.
•Two relatives told us that their relative had a male carer for their personal care despite having stipulated that only female carers should do so. We reported this to the manager who acted immediately. They advised staff in 'handover' and the next 11am 'stand up' meeting to ensure staff were clear that people must only have care from their preferred gender of carer. The manager told us they would add this to their action plan to ensure gender choice was recorded and delivered.
•Staff said the inconsistency of management and staffing had affected their ability to deliver care as they wanted to. One staff member said this could be improved by, "More staff -definitely, it just gives you time to do the little things and you can have one to one interaction and do things like their nails and once in a blue moon we get time to do this but it's not good enough."
•All staff were optimistic with the new manager and deputy manager that they could improve the care of people.
•The manager was clear in discussion with us that they had identified the improvements that need to be made. They expressed the desire to ensure people, relatives and staff felt cared for.

Ensuring people are well treated and supported; respecting equality and diversity

•People's records did not always accurately highlight issues around equality and diversity. For example, one person was recorded as having a practising religious faith in the initial assessment but in their full care plan it was stated they had no faith. When we spoke with the person they told us they attended faith sessions at the service. We advised the manager of this, so this could be corrected in their care plan.
•People praised the staff despite their mixed views about the service. People wanted to tell us how they appreciated the staff. People told us, "I can't say anything against anybody. All very kind"; "They are very caring. Couldn't be more caring" and, "Yes, good staff. You are treated with respect. They can't do enough for you".
•We saw staff interacted with people in a kind, supportive manner. A relative said, "Yes, kind, caring and respectful".
•Another relative said, "[The physio] comes every day to give [my relative] physiotherapy. The physio always

greets my wife with a smile kisses them on their forehead speaking softly about the weather and asks how they have been since they last met. [The physio] offers the light banter and makes them laugh and smile from the minute she walks in till she leaves".
•A staff member said, I'm proud of everything I have done here. I am very, very passionate about my job and I try and instil it in others. The proudest thing I ever did was look after somebody with Huntingdon's disease and he wanted to go and watch Newcastle United play, so we arranged it and to see his face when we took him up there and he met Alan Shearer and to be able to something like that with someone."

Respecting and promoting people's privacy, dignity and independence

•People felt staff respected them and promoted their privacy and dignity. Comments included, "Yes, they are kind and caring. All different ages. They keep your dignity. You don't mind different ones because the staff are all so well trained" and, "I do find them kind and caring and yes, they treat me with respect". Another said, "Oh yes. We're all treated as individuals".
•A relative told us that they were advised politely by staff that they were going to give their relative personal care or apply creams therefore, they would ask them to wait outside to maintain their dignity and privacy.
•People were observed maintaining the garden in raised beds that were accessible. Some people had cars and went out independently; they brought their own shopping back. People in wheelchairs had accessible areas where they could sit outside.
•People had made friends and completed activities together or just chatted with each other.
•The doors were not locked if someone was on reception; this meant people could come and go but still be kept safe.
•People were supported to have their pets to enhance their well-being. A person had a guide dog, so they could move around safely. Another family had been able to bring their dog to live with them.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement.

Requires improvement: This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

•People had care plans in place. The quality of information and personalisation within these varied.
•One person said, "Oh yes, I have a care plan. They change it sometimes". Other people and their relatives told us they were not involved in the writing and reviewing of their care plans.
•Further comments from people included, "I'm not familiar with a care plan. I expect my daughter does it"; "No care plan" and, "I must have a care plan. I let them get on with it. They know what they're doing. My daughter will have a lot to do with that".
•A relative said, "My wife has been a resident at the Care Home for 12 years if there has ever been a care plan in the 12 years it's so far back to remember." They added they checked the daily records in their relative's room, "I can work out how good or bad her day has been from the information recorded about her daily care and interactions."
•Another relative said, "I've said what [my relative] likes and dislikes. I've not seen what is written".
•People's care plans had been recognised in the manager's action plan as requiring improvement in respect of, "People had not had the opportunity to express their views and be actively involved in their care, treatment and support. Care plans did not show how staff had involved people or their families in discussions around care needs". They expected to achieve full compliance with the managers objectives by 31 December 2019, with work to commence straight away.
•People gave us mixed views as to whether they felt their needs were being met at the service. We received both positive and negative feedback. Comments included, "Yes, I get the care I need"; "I definitely get the care I need. I couldn't be cared for better. They're genuine – and make sure you and others are well cared for" and, "Yes, happy I get the care I need. I'm independent still. I like to get up early. They know I get up early and they get coffee for me". However, another person said, "It is 12 o'clock and I have only just been got up. The only decent thing here is the carers. There is no point in complaining, nothing ever gets done. I pay a lot each a year for this [place]. No-one ever checks how we are. I have not had a bath in over a month, I don't want a shower I want a bath."
•A relative said they had to ensure only staff with the necessary experience delivered care to their loved one. They added that staff had not understood their relative's condition to ensure the care delivered recognised their limitations.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

•The details in people's records could be improved to ensure full compliance with AIS is evidenced.
•We did not see alternative means of communication, for example in the dining room. Staff were heard to read a menu options out to people. For people with delayed or limited cognition this could be too much information at once. Otherwise the menu was only available in a written form.

We recommend the provider consult a reputable source to ensure full compliance with the AIS.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

•Prior to the inspection we had concerns shared with us about the availability of activities for everyone of all abilities. The manager's action plan recognised this was an issue. They told us work was underway to improve the activity experience for all people. They were also seeking for staff to be recognised as drivers of the minibus, so more trips out could be arranged.
•During the inspection we observed that there was a staff member dedicated to activities and people responded well and spoke highly of them.
•People told us, "I'm quite happy in my room. They look after me. I join in activities if it's something I can do"; "I have no involvement in activities"; "I could get involved in activities. I usually get on with my own activities. Knitting and sewing"; "I go to singing" and, "I don't want to play bingo".

End of life care (EoL) and support

•People had forms completed that said what action and/or treatment plan they preferred at their EoL. These were easily accessible at the front of their care records. However, these forms had not yet evolved further. The component of the care plan that might cover advanced care planning in preparation for EoL was not being developed. For example, people's preferences in life were not being translated into how they wanted this to look like at their end of life.
•One person had just been identified as entering their final days of life. Specific medicines had been ordered and were on standby. The clinical nurse lead had created an EoL care plan using the provider's paperwork. This care plan was very task orientated with no personalised detail added to give staff guidance on what this person or their relatives would want their end of life care to be like. The manager advised further that staff were in close discussion with the family to develop a person-centred end of life care plan.
•The manager's action plan recognised that advanced care planning needed to improve.
•A nurse told us they had completed End of Life training at a local hospice and could contact them for advice if needed.
•A relative had written following their passing of their loved one, "I want to thank you most sincerely for the dedicates care and attention you gave to my husband…It ensured his final days were as good as possible under the circumstances of his many problems and gave me peace of mind that all was being done that could be done. My daughter always found staff courteous and helpful and visitors commented on what a wonderful place it was - a lovely peaceful atmosphere, delightful surroundings and an abundance of refreshments. We were all very emotionally touched by the way in which you left my husband's glasses on his bible together with family photographs, it was so thoughtful. Thank you so much."

Improving care quality in response to complaints or concerns

•Prior to the inspection we had concerns raised with us about how relatives were treated when they raised a concern. Relatives told us they were met with a defensive response if they raised a complaint or concerns. We discussed this concern with the manager. The manager advised she would be creating a way to record concerns as well as complaints.
•The provider's complaints policy explained how to complain, who to contact and in what timescales people and relatives could expect to hear about their complaint. There was no complaints policy given to people and relatives, to refer to. The manager advised that this would be addressed. The manager advised further, there was a notice of the complaints procedure in reception. A person living at the service supported people to complain and raise concerns. This was in their role as people's ambassador.
•We saw people's complaints had been investigated and the outcome reported back to people or their relative. Checks had been made to ensure they were satisfied with the outcome.
•The manager advised us they were committed to improving the learning from complaints and concerns to improve the service for everyone. We saw the staff meetings in July 2019 covered recent complaints, so staff could learn from them.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Requires improvement: This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
Systems were not operating effectively to ensure records held about people met requirements. This meant in the safe, effective, caring, responsive and well-led sections of this report we have reported that people's records were not always accurate or/and complete. This meant people were at higher risk of unsafe, inappropriate and inconsistent care and of not having their preferences and needs met.
This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

•There was inconsistent leadership at the service. The management of the service was changing at the time of the inspection and had been for some time. The last registered manager was deregistered with us on 5 December 2018. People, relatives and staff told us that in 2019 there had been several different managers of the service.
•On inspection there was a manager, deputy manager and two unit leads; a third unit lead had been recently employed and was on induction training. There was also an operations manager and clinical lead nurse. The new manager had been in post for a month and the deputy manager three months. When we spoke with the manager, they had good insight into the concerns we shared with them and were able to demonstrate the plans they were already implementing to address these concerns.
•Barchester Healthcare Homes Limited had quality assurance processes in place. The regional director was aware the quality of the service was causing concern. Time had been taken to appoint the right manager to take the home forward and address these concerns.
•The inspection confirmed the concerns held by the manager and Barchester Healthcare Homes Limited. This showed the issues identified had recently become known to management, but the action being taken had not yet improved people's experiences of care. This has been recognised in the ratings for the service across all key questions.
• On the day before the inspection started, the manager had developed their action plan. This brought together responses to the provider quality assurance concerns and their own observations.
•Staff said, "With having the different managers it has been tough"; "The last 18 months has been quite difficult because of all the managers and they all have different ideas. They are working us so hard and it is mainly because of all the managers we've had - I've lost count. It's unsettling for staff and residents and I've not known staff morale so low"; "I think it's OK working here. Obviously, we've had a few problems with change of management, so it has been a bit touch and go with things. With guidance and advice, managers being in and out you're never sure who to go to" and, "Seven managers since January. If you'd come six weeks ago we had three people employed as managers, all telling us different things to do."

•The new manager was in the process of registering with CQC. People, relatives and staff were positive about the new manager. There was an air of optimism attached to this appointment and that of the recently appointed deputy manager.
•People said, "They keep changing the manager. I met her once. Seems nice"; "Oh yes, I know the manager. I see her often" and, "I see the manager most mornings. Yes, approachable".
•Relatives said, "The manager running The Manor now is much better than the other managers. She takes the complaints more seriously than the others and doesn't try to dismiss them or not acknowledge them. The Manor has had more managers than Manchester United but she's the best one so far" and, "The person I deal with most is the deputy manager. She is approachable, shows a high level of empathy and remembers comments".
•Staff said, "[The manager] and [deputy manager] seem really nice. We've had some managers come in and we haven't got to know them much but [these] seem really nice and approachable"; "[The manager] and [deputy manager] have been fantastic. They are making small changes that need to be done and they are doing things gradually so it's good and I do enjoy working here" and, "The current management now have not been here long, but we do feel listened to, but it's a work in progress. I f you'd spoken to me 6 months ago it would have been a totally different story".

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

•There culture at the service was not inclusive, but there were plans to develop one.
•People, relatives and staff all told us that they hoped the service would be more open, inclusive and empowering under the new manager. Their first impressions of the manager and deputy manager's willingness to listen to them and treat their concerns/views with respect was highly regarded.
•Internal communication had been identified as one of the areas needing to improve. One way of doing this was to ensure the provider's required 11 o'clock 'Stand up meeting' and the 'Resident of the Day' processes were implemented fully. This would be the time to discuss concerns about individuals and across the service. These new processes had been implemented by the 20 July 2019 (the end of the week before the inspection) and had been welcomed by all involved. The aim of these changes was to improve outcomes for people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

•The service's accident and incident reports had a section to ensure the Duty of Candour (DoC) was adhered to.
•Action was taken by the manager during the inspection to address the required statutory notifications identified as missing; this included ensuring the DoC was followed.
•The manager had identified in their action plan that the DoC could be better evidenced.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

•The new manager had held a "Meet the manager meeting" for people and their relatives and was planning to hold further consultation meetings with all interested parties.
•Staff meetings had been held for each unit, and night staff, in July 2019 since the new manager started.
•Prior to this we were told a questionnaire had been sent out to people, but the responses had not been collated. People told us there had been residents' meetings, but no minutes were taken of these. Therefore, we could not review the outcome of how people's views had been listened to and acted upon. We were told

further residents' meetings were planned.
•People did not have a positive view of their ability to influence how the service was run. Comments included, "Meetings – most times when they say they're looking into it, it means nothing"; "We are told 'it's in hand' and nothing changes" and, "I don't know about resident meetings. I've not made any suggestions".
•A relative said, "I've never been asked".
•The new manager advised us that they had an open-door policy to encourage people, relatives and staff to approach them with any concerns or suggestions.

Continuous learning and improving care

•The service was prioritising the changes that needed to be made. The action plan was being refined to prioritise tasks to be completed, and that all were to be completed by a projected compliance date.
•The aim was continuous learning and improving care and improving care would result from full operation of the manager's action plan.

Working in partnership with others

•The manager advised they had introduced themselves to all support and networking systems and had made contact with appropriate authorities.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12(1)(2)(a)(b)(e)(g)(h) Care and Treatment of service users was not always provided in a safe way. Risks to health and safety of service users was not consistent. All that was reasonably practical was not done to mitigate risks. All equipment was not ensured to be safe and ready for use. Medicines were not always managed safely. Systems did not operate effectively to ensure infection control was assured.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Regulation 17(1)(2)(c) Systems and processes were not operating effectively to maintain records that were accurate and complete in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided.