B Jugon

The Manor Care Homes

Inspection report

78-80 Lutterworth Road
Aylestone
Leicester
Leicestershire
LE2 8PG

Tel: 01162335040

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 28 March 2017 and was unannounced.

The Manor Care Homes is a care home that provides residential and nursing care for up to 67 people, many of whom are living with dementia. The accommodation is provided over three units, accessible by using the lift and stairs. At the time of our inspection there were 45 people using the service.

The service had a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and relatives were supported to share their views about the service. However, changes were not always made and improvements were not sustained when people requested them. The provider had systems in place to monitor the quality of the service. Quality assurance audits and checks were not effective in developing the service and driving improvements.

People told us they felt safe at the service and with the staff that looked after them. However, some relatives had concerns about their family member's safety due to the large turnover of staff. The provider had systems for ensuring there were adequate numbers of staff with the right skills and experience to provide safe care and support. Staff were recruited in accordance with the provider's recruitment procedures.

Staff demonstrated they understood the provider's safeguarding procedure (protecting people from abuse) and knew how to keep people safe.

People received their medicines as prescribed. However, further improvements were needed to ensure medicine records were completed accurately.

People's care needs were assessed including risks to their health and safety when they started to use the service. However, improvements were needed in relation to how risks to people's health and well-being were reviewed to ensure assessments were reflective of people's current needs.

Staff received an induction when they commenced work and on-going training to support people safely. We saw staff used equipment to support people correctly. Staff received support through regular supervision.

We found the requirements to protect people under the Mental Capacity Act and Deprivation of Liberty Safeguards had been followed. Mental capacity assessments reflected the choices and decisions they were able to make and the support they needed to make more complex decisions. Staff demonstrated they sought people's consent before providing care and support.

People were provided with sufficient meals and drinks that met their nutritional needs. People were supported to have access to health care appointments and referrals were made to health care professionals for additional support or guidance if people's health changed. However, records to monitor people's health and well-being were not consistently completed or accurate. This meant people's needs were not always effectively monitored to ensure people received appropriate care.

People told us they were treated with care and that staff were kind. We observed staff were respectful and kind when they spoke with people. Staff recognised and responded to people's distress or discomfort and people were supported to maintain their dignity.

People received care that was personalised and care plan reflected people's wishes and preferences. Staff had some knowledge of people's life history and things that were of interest to them, despite staff turnover. Further action was needed to ensure people's care plans reflected people's current needs and evidenced that people had been involved in reviews of their care.

People were supported to take part in activities and to go out into the community but it was clear there was a lack of meaningful for people to follow their hobbies and interests.

People and relatives were confident to raise any issues, concerns or to make complaints. People told us the registered manager was available and approachable. However, people and relatives felt that concerns raised were not always addressed or resolved in the long-term.

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 consistently safe.

Staff understood how to protect people from the risk of abuse. Risks to people had been assessed but records were not always up to date to reflect changes in people's needs. Staff had been safely recruited. Further review of how staff were deployed within the service would ensure sufficient staffing levels were maintained. People received their daily medicines as prescribed however improvements were needed to medicine records.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were cared for by staff that had induction, on-going training and support through supervision. The requirements under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were followed to ensure people's legal rights were respected. People were supported to have sufficient to eat and drink. People's health needs were not monitored effectively to enable them to maintain their health and well-being,

Is the service caring?

Good

The service was caring.

People and relatives told us staff were caring and kind. Relationships between staff and the people they supported were warm and compassionate. People were provided with opportunities to make choices and decisions. Care was provided in a respectful way which protected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff were committed to providing personalised care. Care plans did not always reflect people's current needs. Although some activities were provided, these were not always meaningful and people were not supported to develop their individual hobbies and interests. The provider had a complaints procedure in place

but was not always effective in resolving people's concerns.

Is the service well-led?

Requires Improvement 

The service was not consistently well led.

People were involved in sharing their views on how the service was run, however changes were not always made when people requested them. The systems in place to monitor the quality of the service were not effective in bringing about improvements in the service.

The Manor Care Homes

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on 28 March 2017 and was unannounced.

The inspection team consisted of one inspector, a specialist advisor who specialises in nursing care and an expert-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. Our expert-by-experience had knowledge of the needs of people living with dementia.

Before the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care. We refer to these as notifications. We contacted commissioners for social care, responsible for funding some of the people who use the service, and asked them for their views about the service.

The Provider Information Return (PIR) had not been sent to the service prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gave the provider opportunity to discuss this information during the inspection.

During the inspection we spoke with ten people who used the service and five visiting relatives. We spoke with eight members of the nursing, care and senior care staff team, the registered manager and the registered provider.

We observed care and support in communal areas. We looked at the care records of five people who used the service, medicine administration records and staff training records, as well as a range of records relating to the running and management of the service. These included quality assurance audits and checks carried

out by the registered manager and senior staff. We looked at the environment including bathrooms and communal areas.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe in the service. One person said, "I have never had any problems here. I feel safe as nobody who wasn't supposed to be here would even get in." Another person told us, "I feel safe because the door to my room is always closed so nobody wanders in there." A relative told us "[Name of family member] is safe because staff make sure they check on him throughout the day and night and he has equipment in his room, such as a crash mat by his bed, to keep him safe."

However, three relatives we spoke with expressed concerns about their family member's safety. One relative told us, "I worry about [name of family member] safety sometimes. There is a high turnover of staff and the new staff are not familiar with her medical needs. It is frustrating and a little worrying to say the least." Two relatives told us they were concerned that there was not enough staff around to meet people's needs and there were times that communal areas were left unstaffed as staff were busy elsewhere. They felt this put people at risk as they were not being supervised. Prior to our inspection visit, one visiting health professional had also raised concerns that they felt staffing levels were not sufficient to meet people's needs.

The care staff we spoke with thought there were mostly enough staff on duty to meet people's needs. One care staff told us "There are sometimes enough staff, sometimes not, We meet people's needs but the quality of the service becomes compromised, we are not able to give the personal touch. The problem is mainly due to staff sickness. We rely on agency staff to make sure we are able to keep people safe."

We checked staffing levels immediately on arrival and they appeared adequate. We observed there were enough staff on duty to meet people's needs. We discussed concerns surrounding staffing levels with the registered manager. They told us the provider had reduced staffing levels for a short period of time but these had since been restored to ensure sufficient staffing was available to meet people's needs. They explained that a number of staff had left the service and they were in the process of completing recruitment to vacant posts. This meant many care staff were new to the service and there was a heavy reliance on agency staff to ensure staffing levels were maintained and people were kept safe. Records confirmed that rotas were planned in advance and the registered manager had systems in place to ensure sufficient numbers of staff were deployed within the service. The registered manager told us they would ensure new staff and agency staff employed had the skills and competence needed to keep people safe.

We looked at the recruitment records for four staff employed at the service. These showed that staff had been safely recruited as the provider had carried out the necessary checks to ensure staff were suitable to work with the people who used the service. Checks included a current DBS (Disclosure and Barring Scheme) certificate on their file. The DBS helps employers to make safer recruitment decisions.

Staff we spoke with demonstrated they knew how to recognise and respond to allegations or incidents of abuse and how to escalate concerns. One care staff told us, "I have recently completed my safeguarding training as part of my induction. It helped me to understand types of abuse, how to report it and the importance of recording." Another staff member said, "People are safe here. I have never seen anyone being ill-treated. If I did, I would report it straight away." The provider's safeguarding and whistleblowing policies

supported staff to raise concerns and included the role of external agencies in any safeguarding investigations. This helped to ensure people were protected from abuse as staff were confident about how to raise concerns.

People's care records included risk assessments. These included guidance and advice for staff and covered areas of activities related to people's health, safety, care and welfare. For example, where one person was at risk of falling out of bed, their risk assessment instructed staff to ensure their bed was on the lowest position and a sensor mat was in position at the side of the bed to alert staff of any movement. We saw this was in place when we met with the person in their room. We saw staff followed this guidance through our observations in communal areas. For example, where people required staff support to enable them to walk or transfer, we observed staff provided this safely using approved techniques and giving each person time and encouragement. This showed that staff understood the potential risks people faced and measures required to keep people safe.

Records showed that risk assessments were reviewed regularly. However, records did not demonstrate that risk assessments had been routinely reviewed in response to incidents or accidents. For example, one person had recently experienced a significant increase in falls. The risk assessment had not been reviewed following each fall. This is important to enable staff to identify and respond to any new risks to prevent people coming to harm. We discussed this with the registered manager who told us they would update risk assessment records to ensure they reflected the review they undertook with senior staff following each accident and incident. This would help to ensure risk assessment records were accurate and reflected people's current needs.

We looked at how medicines were managed in the service and we saw people were receiving their daily prescribed medicines. People and relatives told us they were happy with the support they received to manage their medicines. One person told us, "My medication comes like clockwork, morning, noon and night." A relative told us, "I know [name of family member] gets her medication. Her health changes when she doesn't so this would be very obvious."

We observed a medicines round and saw that staff sought consent before administering medicines and people were given time to take their medicines. We observed nursing staff were diligent in checking medicines were correctly dispensed before supporting people to take them and consulted with people to check they were happy with the support provided. Nursing staff told us they had undertaken training in the medicine dosage system and this was confirmed in training records that we reviewed.

Medicines were stored securely and temperatures of storage areas were monitored regularly. However, in one unit we found that the storage area had no ventilation and temperature readings were above the acceptable range on some days. This meant the effectiveness of medicines could have been compromised to treat people's health conditions as prescribed. We discussed this with the registered provider who told us they had ordered a new air conditioning unit as a result of our findings which would ensure the temperature of the storage area was regulated and within recommended ranges. This would help to protect the condition of people's medicines and assure them their medicines were being stored safely.

Medicine records were not always completed consistently or accurately. For example, we saw where people were prescribed topical medicines, such as creams and lotions, staff had not consistently signed medication administration records (MARs) to indicate they had been applied as prescribed. MARs did not always include instructions to show where the topical medicine should be applied. Where people were prescribed medicines that were to be taken as and when required (PRN) these were not consistently supported by a protocol. This is important information to ensure staff who did not regularly work in the service gave people

their right medicines as prescribed. We saw that where people were prescribed transdermal medicines (skin patches) records did not show the rotation of the patch on application and the removal of the previous patch. This is important to ensure transdermal medicines are removed and applied in accordance with medical guidance to prevent the person experiencing any adverse effects. We discussed medicine records with the registered manager who told us people received their medicines but nursing staff were not always remembering to sign MARs. They told us they would ensure all nursing staff completed medicine records correctly and accurately.

People told us they liked their bedrooms and the areas of the service they spent their time in. However, we found some areas of the service were not safe. For example, a corridor from one unit to the garden was cluttered with old furniture and various other items. A member of staff told us, "I have mentioned this to the owner and I got told it's because of the refurbishment but to be honest, it has been like that for the past two years, although it has got worse." Although the corridor was not used by people, it was accessible to visitors and staff. We observed one unit had deck chairs which were at angles and fixed to the floor. Staff were unable to confirm if these had been risk assessed as they posed a risk of entrapment or a trip hazard. We also observed ground floor windows without restrictors which would prevent people from falling out of them and without curtains to preserve people's privacy and dignity. We raised these concerns with the registered manager who told us they would review these areas and assess risks to ensure people were kept safe.

We observed staff were diligent in wearing appropriate personal protective equipment when supporting people with personal care. These included gloves and aprons which staff were seen to dispose of after supporting each person. However, we found one sharps box, used to safely dispose of syringes, was overflowing and presented a potential infection control risk for people and staff. The registered manager and provider told us they would arrange for this to be disposed of following our visit.

Requires Improvement

Is the service effective?

Our findings

People and relatives provided us with mixed feedback about the staff that supported them. One person told us, "Some of the staff are really lovely, but they don't stay long at all so we always have new staff being trained." Another person said, "Most of the staff I can't understand but you can't keep asking them to repeat themselves." Two people told us they had not been introduced to new or agency staff. Comments included, "They [staff] just turn up in the room and do their job. Sometimes they [staff] don't speak much either." One relative told us, "It would be nice if the new staff communicated more with the residents. Sometimes they don't utter a word when they are moving them, and they certainly don't seem to give much if any encouragement. It just takes a little extra time doesn't it?" One relative expressed concern about the impact of the high staff turnover on their family members' care as they felt important information about health needs was not consistently communicated.

Staff we spoke with told us they had received the training they needed to support people safely and effectively. We spoke with three new care staff and asked them about their induction and training. Comments included, "In my first week of working here I shadowed [worked alongside] experienced staff and was introduced to people gradually. Senior staff took time to explain what I would be doing. I have also completed e-learning training, such as safeguarding and recording. Staff have been really helpful," and "I am still on my induction. So far I have shadowed senior staff and had time to meet and talk with people. I have also been shown how to fill in records. I have an induction book which I am working through." Staff who had worked at the service for some time confirmed they regularly undertook refresher training, for instance medication, and qualified nurses told us their competency in administering medicines was regularly assessed.

Records we saw supported what staff told us. For example, we saw that all staff had recently completed essential training, such as manual handling and food hygiene. In addition, we saw that staff undertook specific training to support them in their roles, for instance dementia awareness and mental capacity. This showed that staff were provided with appropriate training and professional development to enable them to meet people's needs effectively.

The registered manager told us wherever possible they employed regular agency staff who were familiar with the service and had the skills and experience they required to meet people's needs. Whilst this helped to ensure people received continuity in their care, there were occasions when agency staff were new to the service and therefore not familiar with people's needs. The registered manager told us they ensured these agency staff worked alongside experienced staff who provided guidance and advice in meeting people's needs. The registered manager told us there would less reliance on agency staff once vacant posts had been recruited to.

Staff told us they felt they received regular supervisions with senior staff and the registered manager. One care staff told us, "[Name of registered manager] is very supportive. This is a hard job but it helps to know I have that support and you are appreciated by the management. Senior managers have a good management style." Another care staff told us they received regular supervision and were comfortable in

approaching senior staff and the registered manager at any time for advice 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 decision and are helped to do so for themselves. 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 provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that general mental capacity assessments had been completed for people where staff were concerned that people lacked capacity to make decisions. For example, a person was assessed as being able to make day to day choices and decisions, for instance what time they wanted to get up and what they wanted to eat, but was unable to make significant decisions about their care and welfare. Their assessment clearly detailed the process required to ensure decisions were made in their best interests. This included a best interest assessment and meeting with the person's relatives and medical professionals. This helped to ensure people did not have decisions made for them when they had mental capacity.

We saw some people had restrictions placed on them, for example, if they were unable to leave the service without support. These people had been assessed as not having the mental capacity to make a decision about how safe they were when they were out alone. The appropriate deprivation of liberty safeguard (DoLS) applications had been made to the authorities. Records confirmed that the registered manager kept the DoLS authorisations under review and met any conditions within the authorisations. This helped to ensure people were not being deprived of their liberty unlawfully.

The registered manager and staff demonstrated an understanding of the MCA and we observed this was applied in practice. We observed staff supporting people in communal areas and saw good practice of staff seeking consent to support before providing it. For example, one care staff asked a person, "Can I put your feet up?" before supporting a person to elevate their feet. Another care staff asked a person, "Can I help you with that?" before supporting the person to use a mobility aid.

Prior to our visit we received concerns about a shortage of food in the service and poor standards of food hygiene. When we spoke with people about their meals, comments included, "I have breakfast which I like. Lunch is at 12.00 noon and often I am not all that hungry but as we only get sandwiches at tea time which is five hours later, you can't really afford to go without at lunchtime," and "The food here is okay, I never go hungry," and "The food is okay. Sometimes it's not very hot and they [staff] sorted it when I said something. There is plenty to eat and drink." Throughout our inspection we saw people were provided with a range of drinks and snacks between meals.

We observed the lunchtime meal in two units to help us to understand people's mealtime experience. We saw that people were offered a choice of two meals and people were provided with a choice of where they wanted their meal. Where people required support to eat their meal, we observed staff provided this support sensitively, taking time to explain what was on the plate and enabling people to eat at their preferred pace. Staff were responsive to people's preferences. For example, one person complained that they found the food too bland and was given additional spices in line with their preferences. Another person showed no interest in the main meal but was encouraged to eat through staff providing a pudding and yoghurt as an alternative. Staff were vigilant in monitoring people who became distracted during their meals, providing

prompting and encouragement whilst supporting people to maintain their independence during the mealtime. We saw that the food served was of sufficient quantity and quality to meet people's nutritional needs.

The service has been rated as requiring improvement by food safety officers. We looked at the main kitchen and found it to be well stocked and in the process of being cleaned following lunch service. The registered manager told us they monitored the supply of foodstuffs, which had been overseen by the provider for a short-time, and ensured that foodstuffs were of sufficient quantity and quality to meet people's needs. They told us they had implemented 'Safer Food - Better Business' to improve food hygiene within the service. This is a nationally recognised set of standards which provides guidance on provider's legal responsibilities and best practice. The registered manager had introduced new cleaning schedules for kitchen staff to adhere to. Although these had been implemented, new ways of working were yet to be embedded and so it was not possible to determine if improvements were sustainable. The registered manager told us they would monitor food hygiene and meal service through quality assurance.

Records showed that an assessment of people's health care needs had been undertaken and a plan of care was completed which took into account their health and dietary needs and well-being. People had access to a range of health professionals, including GP's and dieticians. We found that records to monitor people's health needs were not always accurate and not consistently completed. For instance, one person was assessed as being at risk of weight loss. Their MUST (Malnutrition Universal Screening Tool) had been incorrectly completed, assessing them at low risk when in fact they were at medium risk. MUST is considered best practice in health and social care and is a calculating tool to establish nutritional risk for people. The outcome of this tool determines the measures that are required to reduce the risk of weight loss and therefore the person may not have their nutritional needs maintained effectively. We also saw numerous gaps in health monitoring charts such as turn charts and re-positioning charts to support people to change position and avoid the development of pressure areas on their skin. This meant that people may not receive the support they need to maintain their health and well-being. We shared this with the registered manager who assured us they would review and update health monitoring charts and ensure staff maintained accurate records.

Good

Is the service caring?

Our findings

We asked people using the service and their relatives if staff were kind and caring to them and people mostly said they were. One person told us, "The staff are really kind to me here, I can't fault it." Another person told us, "It doesn't matter which carer is helping me, they all treat me well." However, some people and their relatives felt staff could "Communicate more" when they were supported people. This was in relation to staff who were new to the service.

We saw some examples of staff being very kind and caring to people and instances where staff sat with people and supported them with a meal, spent time chatting with them and involved them in interaction. One person became anxious and a member of staff who knew the person well was very quick to reassure the person and distract them, thus reducing their anxiety. We observed staff spending time talking with people in communal areas. Staff encouraged people to be involved in conversations through banter and shared humour. Interactions between staff and people were warm and compassionate and staff used different ways of communicating. For instance, by touch, altering the tone of their voice and ensuring they were at eye level with people who were seated.

Staff we spoke with had a good knowledge of people's likes and preferences and we saw people's bedrooms were personalised to people's likes and dislikes. For instance, people were able to bring in personal items, such as pictures and photographs which were important to them. Bedroom doors had a photograph of the person and a short profile which included the person's name, key information and what was important to them to show this was the person's private space. The registered manager told us these had been developed with people and their families. This personalisation supported people to have a sense of ownership of their personal space.

People were supported to maintain their independence as much as possible. For example, we saw staff supported people to make choices about their meals and where they wanted to spend their time. We observed staff providing support that enabled people to move around the service with as much independence as possible, demonstrating patience and encouragement and giving people time to do things for themselves.

We saw staff were respectful when they spoke with people and mindful of people's privacy and dignity when assisting them with personal care. We saw staff were discreet when prompting people who required support with personal care. We also observed staff knock on doors, announce themselves and wait for permission before entering people's rooms.

Requires Improvement

Is the service responsive?

Our findings

People and relatives we spoke with told us they were mostly happy with the care they received. One person told us, "I only have to ask someone [staff] for help and they will do it." A relative told us, "When [name of family member] first came here, she really needed nursing care and was on [name of unit]. She has slowly got better and they [staff] suggested she move to another, less dependent unit so she had more people to interact with. What we have asked for, in terms of her care and the service, we have got."

We found that staff who were familiar with people's needs knew about people's preferences. For example, one person told us that staff supported them to maintain a friendship within the service. They told us, "They [staff] know we are best friends so they help us to sit together all the time." They told us staff understood how important the friendship was to both people and recognised their preference to spend time together. Another person told us staff respected their preference to spend time alone in their room. They told us, "I choose to stay in my room. Staff know I am really okay with my own company If I ring my buzzer (for help) they [staff] don't take long to come at all." Staff who were new to the service demonstrated that they had been given the time to get to know about people's individual likes and dislikes and how they preferred their care to be provided.

People's care plans reflected their individual wishes and preferences as to how they preferred to be supported. Care plans included a summary of the person's life history, including employment and people who were important to them. Information about hobbies and interests was also included alongside key choices and decisions, such as preferred gender of carer and time the person preferred to get up. For example, one person's care plan stated it was important to maintain their appearance. This involved maintaining their hair and clothes to specific standards. Records of care reviews and comments from the person's relatives confirmed staff were supporting the person to maintain their appearance in line with their wishes. This information supported people to provide people with care that was personalised to their individual wishes and preferences.

We found that although people's needs had been properly assessed and planned for, plans did not always reflect people's current needs. For example, the care plan of one person stated they were not at risk of falls as they had no history of fractures. Records within the care plan stated the person had sustained two fractures previous to moving to the service. Therefore the care plan did not accurately reflect the person's needs and potential risks from falling. Where people were at risk of developing or had a pressure sore, there was a lack of management to reduce the risk and prevent pressure areas developing. For instance, two care plans informed staff to reposition each person every two hours. We saw from the records kept that there were frequent gaps in the recording, so it was unclear if people were repositioned every two hours. A third person had a care plan in place guiding staff to monitor the amount of fluid the person had each day. Records showed that frequent gaps in recording, that staff had not totalled up the daily fluid intake for the person. Additionally, charts did not include a target amount of fluid for the person to intake each day. This is important to ensure the person was not at risk of dehydration.

A fourth person did not have a full care plan in place despite moving to the service three months ago. The

temporary 72-hours' care plan showed that the person's needs had been assessed and planned for but had not been updated to provide evidence that the person'' needs and been reviewed since moving to the service.

We discussed gaps in recordings with the registered manager. They told us they would review recordings to ensure staff completed these accurately and consistently. They told us they would review the 72-hour care plan to ensure this was updated and reflected the person's current needs.

Although the recordings did not always reflect that people were receiving care that was responsive to their needs, staff who we spoke with demonstrated a good understanding of responding to changes in people's needs. They were able to explain how they responded to changes in people's health through identifying changes to the person's physical well-being or through observing changes in the person's behaviour. Records showed that staff had sought the appropriate medical assistance in response to changes in people's needs. This was confirmed by relatives who we spoke with.

Relatives told us they had been fully involved in the development of their family member's care plan and were kept informed of changes to the care plan. One person told us they had been involved in the development of their care plan. Records showed that care plans were reviewed on a regular basis and, wherever possible, people and relatives views were recorded as part of the review. However, we saw many care plans where the review had simply been recorded as 'care plan reviewed, no change.' There was no evidence as to whether people had been involved or supported to participate in the review. The registered manager told us some people were not able to participate in a review of their care and staff undertook the review based on observations and feedback from other staff and medical professionals. They told us they would improve records of care reviews to reflect that people were given the opportunity to have a say in how they liked to be cared for.

People had been supported to take part in activities and to go out into the community. However, it was clear there was little structure for people to be supported to follow their hobbies and interests. One person told us they enjoyed going to the local shops with the activity co-ordinator and another person told us they had enjoyed a day trip as it brought back a lot of memories. However, other people we spoke with spoke of the activities as not being appropriate or in line with their interests. Many people spoke of feeling bored. We observed an overall lack of stimulation in communal areas, relieved only by occasional interactions between people and staff.

There was a member of staff dedicated to providing activities for people. We observed an arts and crafts activity session where people were supported to make Easter eggs. The member of staff responsible for activities told us the session was open to all people. However, there were only a small number of people who attended. Of those people that were present, one had fallen asleep and others appeared to be struggled with the fine dexterity required to complete the task. When we questioned the use of equipment with a staff member, they told us limited resources restricted which materials they could buy. There was a programme of activities displayed in the service but staff confirmed this was not always followed. For example, bingo had been cancelled on the day of our visit due to staff absence. There were no contingency plans in the event activities could not be provided as planned.

We discussed the lack of meaningful activities with the provider and registered manager. The provider and registered manager told us they would review the provision of activities to ensure they were sufficiently resourced and personalised to support people's hobbies and interests. They also told us they were in the process of redecorating the communal areas to provide more stimulation and interest for people living with dementia.

The provider's complaint procedure was clearly displayed and available in communal areas. People and their relatives knew how to complain and told us they would inform the staff and the registered manager if they were unhappy about their care. Two relatives felt their concerns were listened to but did not have confidence their concerns would be resolved to their satisfaction. One relative gave an example where they had been unable to get a response from the service by telephone. They told us they had raised this concern with staff and things had improved for a while, but had "slipped back" after a short time which they found frustrating. Another relative told us they found their family member wearing another person's clothing. Although they had raised concerns and received assurances that measures had been taken to resolve this, they had found their family member in another person's clothing again. These were examples that the provider was not effective in making sustainable changes as a result of people's concerns.

Although there had been no formal complaints since our last inspection, the registered manager kept records of any concerns raised by people, relatives or visitors. Records showed the registered manager reviewed the concerns log and recorded any action taken to resolve the concerns. The registered manager assured us they would ensure any action taken to resolve concerns would be sustainable to ensure people's concerns were responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

Concerns raised with us both prior to and during the inspection showed there was a lack of openness and transparency in the service. Staff and relatives told us they could talk to the registered manager and senior staff if they had concerns. Staff spoke about the registered manager as being supportive and approachable. Relatives felt the registered manager worked hard and was very caring.

However, relatives and staff spoke about raising concerns with the registered provider and that changes had not been made to improve concerns they had raised. A relative told us, "I have never been asked what I think about the service but I have told them what I think on occasion. Sometimes it gets acted on, other times it seems to fall on deaf ears." A staff member told us, "Relatives who visit the home raise concerns, such as areas of maintenance, and we raise it with the [name of provider] but to be honest, nothing gets done." Another staff member said, "[Name of registered manager] and [Name of clinical lead] are both really good and support you all the way. They get things done but sometimes even they get frustrated a decisions taken by the owners."

A high number of staff had left employment at the service and we were told this was because staff morale was low, and that some staff felt unappreciated and under-valued by the registered provider. One member of staff told us they felt the registered manager listened to them but in turn they were prevented from making the changes they wanted to through a lack of support from the provider. It was clear that the relationship between the provider and some members of the senior management had broken down.

We found that meetings were held with people and relatives. However, the meeting minutes showed where issues had been raised there was not always a record of how those had been actioned or reviewed through the provider's quality assurance system. For example, in January 2017 relatives had raised concerns about a visiting policy that had been introduced without consultation. Relatives also raised concerns about not being able to get through to units directly by telephone. Although these concerns had been recorded, there was no evidence of a response from the provider and details of action they had taken to resolve people's concerns. Where people and relatives raised individual concerns, they felt these were listened to but action taken to resolve concerns was short-lived. This meant people's concerns were not always resolved to their satisfaction.

Staff meetings were used as a source of information between management and staff. Staff meeting minutes showed that the registered manager and senior staff used meetings to provide information to staff, discuss changes, review working practices and enabled staff to share their views. For example, where staff had requested revisions to working rotas, we saw arrangements had been made to discuss these. The registered manager had also discussed how staff should be deployed across the units to ensure people were kept safe. Although improvements in working practices were discussed, records showed that action taken to make improvements was not always effective. For instance, poor record keeping was raised in November 2016 as a concern and was raised again in February 2017. During our inspection, we found records that were not accurate or had not been fully completed. This showed that, although the provider had identified where improvements were required, they had not taken action to improve working practices.

We saw that registered manager and senior staff were undertaking regular audits and checks of the care and environment as part of the provider's quality assurance. Audit systems were comprehensive and included infection control, records and health and safety. The registered manager also undertook spot checks on quality through walking around the service and carrying out observations within communal areas. We found that some improvements had been made as a result of audits, for example staff training had been developed to ensure staff had the skills and knowledge they needed to provide safe and effective care.

We found that although checks and audits were regularly undertaken, they were not always effective in bringing about improvements within the service. For example, an audit in February 2017 identified that a person was still on a temporary care plan since they moved to the service in December 2017 and this needed to be updated to a full care plan. However, during our inspection we saw this had not been actioned and the person remained on a temporary care plan. An audit of care planning in February 2017 noted missing signatures and gaps in recordings by staff. However, these was no evidence as to when or if any remedial action had been taken. Indeed, we found several records that had not been completed accurately or correctly. The temperature records of a medication storage area in one unit showed temperatures had exceeded the recommended range. However, the provider had not taken action to resolve this until we raised it during our inspection. This showed that the provider's quality assurance was not effective in monitoring and improving the service to ensure people received good care.

The above evidence shows that effective systems were not in place to ensure the quality of care was regularly assessed, monitored and improved. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in post who was supported by a clinical lead and senior nursing staff. The provider shared his plans to improve and develop the service which included a new senior staffing structure. They told us they had already begun to implement changes and felt this would address concerns regarding communication and leadership.

We saw evidence that an annual satisfaction survey was carried out in November 2016 for people and relatives. The results had been shared with people and their relatives. People's views were clearly detailed against a range of questions about the service and their care. There was an action plan in place detailing what action would be taken to address any concerns raised. In the main the results of the survey were positive about the quality of the care being provided. Where relatives had raised individual concerns about their family member, they had been provided with a separate meeting with senior staff to discuss and agree action taken to bring about improvements.

Prior to our inspection visit we contacted the local authority responsible for the service they commissioned on behalf of some of the people who lived at The Manor Care Homes and asked for their views about the service. They told us that although the provider had made some improvements, there was evidence improvements had not been sustained or embedded into working practices. Further monitoring visits were scheduled to assure themselves the people that they supported received good care.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place to monitor and improve the quality and safety of the service provided to ensure the safety and welfare of people.

The enforcement action we took:
we brought forward a scheduled inspection