

Countrywide Care Homes Limited

Manor Park Care Home

Inspection report

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Tel: 01977604242

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10 March 2017
16 March 2017

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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?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The inspection took place on 9, 10 and 16 March 2017 and was unannounced. The service provides accommodation and nursing care for up to 75 people, some of whom may be living with dementia. There were 53 people living at the home at the time of the inspection.

There was no registered manager in post, although the peripatetic manager was in still in place at the last inspection remained in post. The peripatetic manager had applied to be the registered manager until a new manager could be appointed. 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.

At our previous inspections in August 2016 we found three breaches in regulations, for good governance, safeguarding service users from abuse and improper treatment, and staffing. At this inspection we found improvements had been made, although there remained some shortfalls in the recording systems and in the systems for medicines management. This inspection indicated the home was continuing to make improvements.

Staff had an understanding of the safeguarding and whistleblowing procedures to follow to ensure people were protected from harm. Safeguarding information was available for all people in the entrance should they have concerns and wish to report them.

Risk assessments for individual potential hazards were still lacking in detail or conflicting in some people's care records for staff to be able to support people safely.

Staffing levels were appropriate to meet people's needs, which had improved since previous inspections, although the deployment of staff was not always effective, such as at staff break times and a member of agency staff had not received any basic information prior to starting their shift.

People were supported patiently with their medicines and staff gave good explanations to ensure people knew what each medicine was for. Systems for managing medicines with regard to topical creams, covert medicines and the storage of medicines no longer needed were not robust.

Continued improvements were ongoing with regard to the temperature in some parts of the home to ensure people's comfort although it was particularly warm on the nursing unit.

Training was evident and staff felt supported to gain relevant skills and competencies for the role they did. Staff had an improved understanding of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) which affected people's care. The manager had worked hard since the last inspection to ensure all DoLS authorisations were in place or renewed for people.

People were enabled to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff meetings and supervision meetings were more consistent and there was clear support and direction for staff overall. The system for handover of information between shifts was much more detailed and thorough since the last inspection. There were much clearer lines of accountability and systematic reporting to the manager of key risks. However, the nursing unit leader had recently left and the home manager was monitoring the nursing risks until a unit leader was appointed. However, due to the home manager's primary role of running the home, there were weaknesses in the oversight of key risks on the nursing unit.

People mostly enjoyed the food and there were improved opportunities for people to drink and stay hydrated. However, we noted a concern on the nursing unit on the first day of the inspection which we raised with the manager. People's weight was more closely monitored and appropriate referrals were made to other professionals where weight loss was identified.

Staff were respectful of people's rights and they supported their privacy and dignity when carrying out care tasks. Staff were patient, kind and caring and they interacted positively with people.

Care documentation continued to improve from previous inspections, although this still lacked detail and accuracy around people's individual needs. There were many generic statements in care records and some conflicting information. Where people were nursed in bed, unit managers were asked to account for this to the manager on a regular basis and people's needs were reviewed and monitored.

Quality assurance systems continued to be embedded and there was evidence of much stronger management oversight of the key issues in the home and action plans to improve.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Staffing levels were adequate, although deployment was not always managed well to meet people's needs on the dementia unit.

Individual risk assessments were not always thoroughly or accurately in place.

Medicines were managed safely overall, but there were weaknesses in the management of topical creams, covert medicine and storage of medicine no longer required.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff training and support was in place to enable staff to carry out their roles effectively and there was improved communication between shifts.

There was a much clearer system to ensure DoLS authorisations were in place and followed up.

People's nutrition and hydration needs were mostly well met and monitored appropriately.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Staff were kind, patient and sensitive to people's needs although there was little consideration in planning for people's cultural and spiritual needs.

People's dignity and privacy was mostly well respected.

Staff promoted people's independence and involved them in their day to day care, although there was little consultation in end of life care planning.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Care plans did not always highlight people's individual needs, although work was ongoing to continue to improve these. Care was not always fully delivered in line with people's needs.

There was work in progress to enable people to be purposefully involved in activity in ways that were meaningful to them individually, although some people were not purposefully occupied.

There was a system for recording and responding to complaints and people felt confident to approach the staff and managers with any concerns.

Requires Improvement ●

Is the service well-led?

The service was not fully well led.

The service had no registered manager in place, although the peripatetic manager was very visible and actively involved in the service.

Systems and processes for monitoring the quality of the provision had improved and were becoming embedded in consistency and practice.

The management team had responded positively to the findings of the previous inspection and were proactive in identifying and securing improvements.

Requires Improvement ●

Manor Park Care Home

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 took place on 9, 10 and 16 March 2017 and was unannounced.

This inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service. We reviewed information we held about the service, such as notifications, information from the local authority safeguarding team and the contracting team. We displayed posters to inform people and visitors that we were inspecting the service and inviting them to share their views. The registered provider had not been asked to complete a Provider Information Return (PIR) since the last inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked around the home, in people's rooms with their permission and in communal areas. We spoke with 16 people, five care staff, the cook, the peripatetic manager, the quality manager and the regional manager as well as three visitors.

We looked at care documentation for seven people, three recruitment files and records relating to quality assurance monitoring and the safety of the premises and equipment.

Is the service safe?

Our findings

People told us they felt safe. One person said, "Yes, nothing bothers me here". Another person said, "It's a safe place, it's alright". Another person said, "There's plenty of them [staff] around if I need any help". Another person said, "I've got peace of mind in here". Another person said, "There's always two or three [staff] around".

Relatives we spoke with said they thought their family members were safe, and most thought there were enough staff. However, some relatives said they did not think there were enough staff around at times on the dementia unit. One relative said, "It can be busy or quiet-ish when we visit. If we can't see the staff they're usually in someone's room or in the office but we can always find them". Another relative said, "It depends what's happening, sometimes it can get lively in here and then they could do with more staff".

Staff supported people's safety in enabling ways, encouraging them to use mobility aids where they had them. Where people were living with dementia, staff were observant of people's change in mood and they intervened to prevent altercations and divert people's attention. Staff knew the individual risks to people and supported them effectively. Individual risk assessments were not always in place or accurately completed where there were known hazards. For example, one person's care plan stated they were at high risk of choking, yet there was no clear assessment of this in place or detail of what staff should do to support the person. Another person had poor eyesight and poor hearing, yet these factors had not been considered in the person's risk assessment for falls and they were assessed as being low risk.

This illustrated a breach of Regulation 12 (1) (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found there was a breach in the regulation for staffing, on the nursing unit. At this inspection, we saw on the whole there were enough staff to meet people's needs and the staff rotas showed consistency in staffing levels. We observed at busy times within the dementia unit, there were not always enough staff immediately accessible to support people, such as at staff break times or early in the morning. On the first day of the inspection we observed the dementia unit had no visible staff for five minutes as the night shift prepared to go off duty and people's demands were high, for support with getting up. Staff on duty said they had been short staffed overnight, unexpectedly and the peripatetic manager said they had addressed this at the earliest opportunity with the use of agency staff. On the second day of the inspection during staff break times we saw there were only two care staff available to support all the people on the dementia unit and people were not fully supported during this time, although staff were in the building and available to call upon. The peripatetic manager said they would give consideration to staff break time cover to ensure people's needs were fully supported.

Staff recruitment procedures were robustly followed and all necessary checks made to ensure staff were vetted before working with vulnerable people. However, we found one agency care staff member had been allowed to work without any basic information about the home or induction checklist. The peripatetic manager told us it was unusual to need agency care staff but they had needed to fill an unexpected staff

shortage at short notice. The peripatetic manager told us there had been an unexpected absence of the recently appointed clinical lead for the nursing unit and they were trying to ensure this post was filled, as well as continuing to recruit to the registered manager's post.

Staff knew how to ensure people were safeguarded from possible abuse and what to do if they had any concerns about a person's safety or wellbeing. Staff told us they would not hesitate to use the whistleblowing procedure should they have concerns about a colleague's conduct or poor practice in the home. We spoke with the peripatetic manager who had a clear understanding of the safeguarding procedures and we saw all relevant notifications had been made to the local authority and CQC. Where poor practice was identified the peripatetic manager took swift action to ensure people's safety.

The peripatetic manager told us they discussed key risks and particular aspects of people's care, such as reasons for them being in bed, pressure care and hospital appointments at regular meetings with senior staff from each unit. We observed one such meeting taking place and there was very clear information shared from each unit to the peripatetic manager, who maintained an overview of what was happening in the home, key issues and risks.

Staff supported people safely in moving and handling techniques. Staff we spoke with told us they had done moving and handling training and been shown how to use equipment. We saw certificates for moving and handling in staff files.

Systems and processes for recording and analysing accidents and incidents were in place and consistently monitored. Staff we spoke with were aware of how to ensure accidents and untoward incidents were recorded and reported.

The room temperatures in the home were more consistent than at previous inspections, although the nursing unit felt very warm and people made comments about this. Staff took steps to ensure people's comfort by opening windows and asking people how they felt. We saw on the whole, people were offered regular choices of hot and cold drinks although this was not evident on the first day of the inspection on the nursing unit. We did not see a drinks trolley during the first morning of the inspection and we raised this with the peripatetic manager who acted promptly to deal with this. We spoke with the peripatetic manager about a safeguarding concern which occurred in October 2016, since the last inspection, which resulted in staff disciplinary action being taken for people not receiving suitable hydration. The peripatetic manager assured us they were taking our observations very seriously and acting upon these.

People were supported well to take their medicines, with staff giving patient support and explanations to help people understand what they were taking and why. Staff checked whether people required any pain relief and were observant of non-verbal cues in people who had difficulty expressing their needs. People told us they received their medicines on time.

We saw there were systems for ordering, storing and recording medicines. However, although the home manager stated they had overall responsibility for medicines management, we identified some weaknesses in this area. For example, we saw the storage of medicines no longer required was not secure and there was potential for these to be unaccountable. Keys to medicines storage were exchanged at handover, but also given to the care staff and district nurse to access drinks thickener and insulin. There was no staff specimen signature list and there were excess stocks of creams and drinks thickener. Protocols for PRN medicine (as required) were not all in place, there were no body map records for when people had topical creams applied and there was no evidence of pharmacy checks before some people's medicines were needed to be given covertly.

The above examples illustrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The medication administration records (MARs) were held on the computer system. Staff we spoke with, including agency staff, were confident in the use of the electronic system and demonstrated their knowledge of this to us.

The home was visibly clean, with no significant malodours in the home. The peripatetic manager told us and we saw evidence that refurbishment was taking place in the home. Staff wore personal protective equipment (PPE) such as gloves and disposable aprons as required and we saw these were in good supply throughout the home. We found there was a lack of accessible tissues for people to use throughout the home.

Is the service effective?

Our findings

People told us staff had the right skills and experience to support them effectively. One person said, "Staff have plenty of experience, they all know what they're doing". Another person said, "They're doing it right as far as I know" and another person said, "I'd know if there was summat up but they do a good job".

One relative told us, "I can't fault them, they are professional and seem on the ball". Another relative said, "There's never a problem with staff. They know what to do, you can tell".

Staff we spoke with all said they felt they had sufficient training opportunities and they were well supported. One member of staff said, "There's always training we can do and it keeps us up to date with things". Another member of staff said there was plenty of training available for the role, although limited opportunities for expanding their knowledge and skills beyond this. Another member of staff said training was always available as well as being able to ask colleagues and the manager for advice and support.

We saw evidence of plenty of ongoing training for all staff. Forthcoming courses were posted in staff areas and recent training certificates were in the staff files we looked at. The peripatetic manager told us they maintained a clear overview of people's training needs and continued to encourage staff to undertake opportunities provided. Training information identified which staff had attended which training and highlighted where training needs were. Induction of new staff was carried out at an individual pace to each staff member's needs.

The peripatetic manager told us they continued to monitor staff practice through being present and visible in the home and they did spot checks including night visits. Staff we spoke with said the peripatetic manager made checks of how well they did their job and they understood the reasons for this. We saw supervision meetings were more regular and consistent with staff and staff we spoke with said they felt professionally and personally supported to carry out their role and maintain a suitable work life balance. We saw supervision meetings were clearly documented with action plans and agreed future meeting dates.

We found communication in the home had improved since the last inspection and there was evidence of much stronger teamwork; staff informed one another when they were taking breaks or if they were busy supporting a person in their room. We saw staff freely approached the peripatetic manager with queries. There was good communication between staff and other professionals, such as when people were discharged from hospital to the home. At the last inspection, handover documentation had lacked detail about people's care needs and we saw this had been improved, along with a clear verbal handover between shifts.

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 so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the last inspection we found the provider was in breach of the regulation for safeguarding service users from abuse and improper treatment in relation to people's deprivation of liberty rights. Staff had an improved awareness of the legislation that affected people in relation to their mental capacity and they were confident in what they had learned through training. Staff told us training for this had improved and we saw recent training evidence to confirm this.

We looked at the file of DoLS applications for people whose mental capacity was considered and we saw authorisations were in place. The peripatetic manager told us they had worked very hard to ensure all necessary DoLS applications were made and reviewed regularly. In people's care records we saw evidence of mental capacity assessments and best interest discussions having taken place where it was agreed a person may lack capacity to make a specific decision about their care. This was an area identified for improvement at the last inspection and we found this had been largely addressed, although there was still some unclear information in care records. For example, it was not always clear what specific decisions had been agreed in a person's best interests.

People were consulted and their consent was gained before staff supported them with any aspect of their care. People were offered good choices and supported well to make their own decisions.

We observed mealtimes within the home and found these to be pleasant and sociable, with people's dietary needs met well on the whole. People's preferences were taken into consideration about the content and size of their meal and whether they wished to eat at the dining table or elsewhere. Staff offered people a choice of different drinks with their meals. We noticed where people were asleep in bed, staff brought their lunch and left it on their table, but this was not always eaten. Staff assured us people would be encouraged to eat or offered alternatives when they woke up.

Staff we spoke with said the meals had changed to a light lunch service and a more substantial evening meal for people. People told us they enjoyed the food and comments included: "The meals are good, I'm no chef but I like what they make", "I have no problems with the food here, it's always nice", "If I don't fancy what's there, they make me summat else" and "There's always something different to choose from". One person told us, "They have a right good breakfast here, puts you in good stead for the day, it's top notch".

We spoke with the kitchen staff and saw the kitchen had been refurbished since the last inspection; the kitchen and mealtime organisation was very efficient and well managed.

People living with dementia were supported appropriately to eat and drink and to retain their independence. Staff supported people according to their individual needs and offered choices in clear, easy to understand ways. We noticed people living with dementia had plastic cups and plates to use and we discussed this with the peripatetic manager and staff, as these were not person-centred and may compromise people's dignity. We were told crockery was plastic because people sometimes dropped or threw these, yet we did not see any recorded incidents of a time this had happened. The peripatetic manager told us they were continuing to consider improving the environment for people living with dementia and they would give further consideration to this.

Some relatives we spoke with told us they thought the food was good. However, one relative said they were not always happy with the food and 'twice, it was ice cold'. Drinks and snacks were regularly offered and where people stayed in their rooms, drinks were available and replenished regularly. However, on the first day of the inspection we saw people were not served drinks until the day staff came on duty in the dementia unit. On the nursing unit we saw the drinks trolley did not come round during the morning.

People's weight was monitored and where there were concerns referrals were made to dieticians. Where dieticians had been consulted, information was recorded in people's files. However, in one person's file we saw they were to be given a pureed diet but there was no corresponding dietician advice or advice from the speech and language therapy (SALT) team. The peripatetic manager reacted promptly to this by making contact with the SALT team and requesting a review of the person's needs.

There was evidence in people's care records where other professionals involved in people's care and health. People and their relatives told us staff sought medical help when this was needed.

There were continued improvements to the environment for people who were living with dementia. For example, the peripatetic manager told us they were expanding the use of wall murals which helped to create different facades and we saw a new mural had been put up in the main area of the dementia unit.

Is the service caring?

Our findings

People said the service was caring and some people and relatives said there had been an improvement in staff attitude since the last inspection. One relative said, "Previously, some staff were very rough but there's been a change of staff which is good. On a scale of one to 10, maybe caring is six. There is one agency nurse who is absolutely brilliant". Another relative said, "Some staff care more than others, but yes I think staff do care. When it was 'Christmas jumper day' I promised to bring a jumper for [my relative] but I was late getting here. One of the carers had gone home during their break to fetch a jumper for [my relative] to borrow". One person said, "Things are better than ever before". Another person said staff cared about them 'a great deal'. They told us, "I've fallen a few times and they always pick me up and sort me out. [Staff are] very kind, most are nice, they always tell me what's going on. It's lovely here".

It was clear through our discussions with staff they enjoyed their role and cared about the people they supported. Staff told us they related to people in the same way they would their own family members and told us care at Manor Park would be good enough for a relative of theirs. Staff were passionate about their work and they were very proud to show what was happening in each unit. Staff said they 'loved' their work with people and we saw they were friendly and smiley, helping to create a happy atmosphere.

Staff interaction was kind, compassionate and respectful. Staff took an active interest in people, acknowledged them in personal and meaningful ways and took time to listen to them. When some people living with dementia became confused and anxious, staff supported them calmly and gave reassurance. Staff noticed when people may not be comfortable and offered ways to support them. For example, one person rubbed their arms and staff asked if they would like a blanket or an extra jumper. When people spontaneously showed affection to staff, this was reciprocated. For example, one person said, "Giz a kiss and a love" to staff who supported the person with a hug, a smile and a friendly chat.

People's independence was encouraged and staff enabled them to do as much as possible for themselves, whilst being on hand to support if needed. For those people who wished or needed to be in bed, staff understood the reasons why and involved them in discussions about their care. Staff encouraged people who were able to get out of bed and sit with other people, but if they chose not to staff respected this

As at the last inspection, we found care records detailed some aspects of people's social, cultural and spiritual needs, although there was far more emphasis on people's social information and very little about anything else. For example, several people's care plans stated '[Person's name] would like the opportunity to participate in social, cultural and spiritual activities of their choice' but then did not indicate what their choice may be. We found on occasion some entries in care records were not always objective in the terminology used.

Similarly, end of life care planning was not personalised and people's wishes for the last days of their life were not fully discussed. Generic statements were repeated across people's care plans. Relatives we spoke to said they felt involved and included as their family member approached the end of their life and staff were appropriately attentive to their needs.

People's privacy and dignity was respected in the way staff provided care for them. Staff knocked on people's doors before entering and they were sensitive and discreet when offering personal care. However, some people's bedroom doors were open whilst they were in bed and it was not always evident this was their choice.

Confidentiality was respected in the way care records were stored and maintained. Staff questioned whether inspectors were allowed to access people's records before making them available.

Is the service responsive?

Our findings

People told us care was responsive and met their needs. Relatives confirmed they were satisfied with how staff responded to their family members' needs. Comments included: "They know what I need and I don't have to wait long", "If I had anything to say I'd say it and the staff respect that", "My relatives are always made welcome and I like that", "I go to bed when I feel like it, but I don't like laying in of a morning so they help me with my routine" and "I've been to the races, they know I like sport. I've been fishing a few times since being here".

We saw many aspects of people's care was person-centred. Staff conversations with people centred around their families and social histories, with many staff able to relate to the local area when chatting with people and reminiscing. It was evident from the content of staff discussions with people they knew what was relevant to individual people.

We looked at care records and found the detail in these continued to improve. For example, people's individual preferences such as their preferred clothing style, was highlighted. One person's care plan said they liked a particular singer and we heard they had this person's preferred music playing. However, there was still information that was contradictory and not always accurate. For example, one person's weight management care plan stated they had to be weighed weekly, yet in another section it stated monthly. Several statements were the same from one person's care plan to another. Where people were new to the home, the pre-admission assessment information was completed, but assessment of individual risks was not promptly completed and some information was too vague for staff to be able to manage their care adequately. We raised this with the peripatetic manager who said the computer took time to populate the care plan from the pre-admission assessment.

Some aspects of people's care was not delivered in line with their care plan or their needs. We saw one person's care plan stated they should be individually supported to take thickened fluids from a teaspoon with a specified length of time in between to swallow safely. However, we saw, although the person was supported by staff, the pace the fluid was offered was much faster than stated in the plan and a large quantity of fluid was given in a shorter space of time than was recommended. We saw some people used particular seating, yet there were no individual seating assessments for this.

We saw some people had remained in their chairs on the dementia unit and the nursing unit for long periods of time without staff attending to their personal care needs. We checked these people's care records and found long gaps of several hours between people's continence needs being recorded, which along with our observations indicated people's needs were not sufficiently met.

These examples demonstrate a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with said they were more confident with using electronic care records and we saw they regularly updated these with information as it happened.

We saw where people were newly admitted to the home, staff were communicative with other professionals and with relatives to ensure smooth transition. Staff ensured all necessary equipment was in place before accepting people to be discharged from hospital to the home. We saw people were greeted well on entry to the home and given time to settle in and rest as required. We observed the residential unit leader contact the family of one person to say they had been admitted safely to the home.

Some people told us they had enough to do, but other people said they felt bored at times. We found there was a lack of meaningful activity taking place on the days of the inspection, with people sitting for long periods of time not engaged. Staff spent available time between care tasks chatting with people as much as they were able. We saw a member of activities staff spent some time between each unit and there was an activities planner with a general theme for each day. The activities staff spent some time in the dementia unit trying to engage people in a game, but it was evident people's cognitive abilities meant they struggled to join in and this was not successful. The peripatetic manager said it was planned for activities staff to undertake dementia training and we saw an action plan around improving dementia care in the home.

We saw there were resources available for people to use and explore, such as items of interest, although we did not see these used well or with meaning. For example, on the dementia unit there were books, bags, dolls, pencils and coloured bricks, although we saw limited attempts by staff to encourage people to use these.

Some relatives we spoke with said they felt involved and informed about the running of the home through relatives' and residents' meetings. We observed one such meeting and found various aspects of care were discussed, such as care plans, changes to the mealtime regime and examples of good practice.

People and relatives told us they would bring any complaints to the peripatetic manager or to any of the staff if they needed to. One person said, "I'd go straight to the manager's office, fill out a complaints form and it would get sorted out." Records showed complaints had been recorded and responded to appropriately. We discussed with the peripatetic manager the actions they were taking to resolve people's complaints or concerns, or those of their families.

Is the service well-led?

Our findings

People, relatives and staff said the home was being run and managed well and they had confidence in the peripatetic manager. One relative said, "Management has improved and it's better than it was." One person said, "I know who's in charge and I'd go see them if I needed to, I'm sure they'd sort anything out".

The peripatetic manager who had been running the home since the last inspection was still in post. Recruitment for a new manager was ongoing at the time of the inspection and the peripatetic manager told us they would continue as support once a new person had been appointed. Support for the running of the home continued to be provided by the quality manager and we saw there were documented provider visits.

People and relatives told us the peripatetic manager was very approachable and visible in the service and we saw this during the inspection. Staff we spoke with said they felt the home was very well run and they were hopeful any new manager appointed would provide continued leadership.

Maintenance records were kept up to date in relation to premises and equipment, such as fire equipment, lifting equipment, gas, electricity, and water supply. We saw there was evidence of ongoing improvements to premises and the maintenance staff actively engaged in checking the premises were safe and suitable and they supported staff's awareness of fire safety in the home by explaining how the fire alarm system worked. Records relating to the care and treatment of people had improved but there were still some inaccuracies.

At the last inspection we found there was a breach in the regulation relating to good governance. We reviewed the latest action plan in response to the last inspection. This plan showed actions needed, staff responsible for completing the actions, the timescale and details of progress made. The peripatetic manager said they remained confident in the staff's willingness to help make the necessary improvements and they had an open door wherever possible for staff to speak with them.

Audits had become more embedded and there was more consistency and detail to these, although some were still deficient, such as medicine and care plan audits. There was clear evidence of manager walk rounds, competency checks, spot checks and meetings held in various ways and with staff, people and relatives. Minutes of meetings included documented actions. We saw quality audits in relation to the dining and mealtime experience for people as well as the general presentation of the home. Where a night visit was undertaken, this resulted in a report and actions raised.

The peripatetic manager told us they had been trying to maintain oversight of the nursing unit in the absence of a consistent clinical lead, although acknowledged that since this key person had been absent, standards had begun to decline as it was a difficult task to run the home as well as carry out this role. At the last inspection we had continued concerns about the oversight of practice on the nursing unit, particularly regarding clinical risks to people and how these were being monitored and managed, with no ownership or responsibility for the unit. The peripatetic manager and the quality manager assured us there were attempts to resolve this issue through identifying and establishing the right staff to be in post, and acknowledged this was a potential area of weakness.

The provider ensured the ratings from the last inspection were clearly displayed in the home. We found marked improvements to the quality and standards of care being provided at Manor Park and the management team were aware of the strengths of the service and the areas they needed to continue to improve. It was not possible at this inspection to see how far the improvements were sustained due to the limited time since the previous inspection, although we found enough improvements to take the provider out of special measures.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not always detailed enough for staff to provide person centred care. Care was not always delivered in line with people's needs, such as continence care
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were weaknesses in the management of medicines. Risks to individual people were not always robustly assessed.
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 Some audits, such as medicines and care plans lacked rigour.