Manor View Care Home Ltd

Madeley Manor Care Home

Inspection report

Heighley Castle Way
Madeley
Crewe
Cheshire
CW3 9HJ

Tel: 01782750610

Date of inspection visit:
03 May 2018
08 May 2018
30 May 2018

Date of publication:
22 June 2018

Ratings

Overall rating for this service	Inadequate ●

Is the service safe?	**Inadequate** ●
Is the service effective?	**Inadequate** ●
Is the service caring?	**Inadequate** ●
Is the service responsive?	**Inadequate** ●
Is the service well-led?	**Inadequate** ●

Summary of findings

Overall summary

This inspection took place on 3, 8 and 30 May 2018 and was unannounced.

Madeley Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Care and support is provided over three floors with communal areas on the ground floor. Madeley Manor Care Home is registered to provider care support for up to 42 people. At the start of this inspection 31 people were using the service.

There was a manager and they were in the process of becoming the 'registered manager'. 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.

This was the first inspection under this registration. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Risks to people's safety, health and wellbeing were not always suitably assessed and managed and plans in place to manage risks were not always followed by staff.

There was not always enough suitably skilled staff, deployed effectively to keep people safe or to meet their needs. Staff were not always trained to provide safe and effective care.

People were not always protected from the risks of avoidable harm and abuse because incidents of possible abuse were not always identified and reported to the local authority as required. Action was not always taken to protect people from further occurrences.

We found that medicines were not managed safely and people were at risk of not receiving their medicines as prescribed.

Systems in place to consistently assess and monitor risks to people and the quality of care provided were not operated effectively. This meant that issues with the safety and quality of the care were not reliably identified and rectified.

People were not supported to have maximum choice and control of their lives and staff do not support them in the least restrictive way possible.
The service looked clean and tidy, however, an infection control audit identified areas that required action and no action had been taken to resolve these.

People and relatives had made complaints that had not been responded to or investigated.

People were not supported to have detailed and personalised plans of care at the end of their life.

People told us they had access to healthcare professionals when they required them, however we found that professional advice was not always followed or incorporated into people's plans of care.

People enjoyed the food on offer. However, some people were not offered diet choices that promoted their health and wellbeing.

People's care plans did not contain enough detail for staff to provide consistently and personalised care.

People told us that staff treated them with kindness and compassion. However, people were not always offered the reassurances they needed because staff did not have time to spend with them. People's privacy and dignity was not always respected and promoted.

People enjoyed the activities provided for them. However, they felt that more could be offered to occupy their time.

We identified eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's risks were not always suitably assessed and planned for. Risk management plans were not always followed by staff to keep people safe and well. Medicines were not safely and properly managed to ensure that people received their medicines as prescribed.

There were not always enough staff to provide safe care to people.

People were not always protected from potential harm and abuse because unexplained injuries were not reported and investigated.

The service looked clean and tidy. However, an infection control identified some issues that required action and we saw that none had been taken.

Is the service effective?

Inadequate

The service was not effective.

People were not supported to consent to their care and treatment.

Staff were not always suitably trained to provide effective care to people.

People had access to healthcare professionals but professional advice was not incorporated into care plans to ensure it was followed by staff. Handovers were ineffective in sharing the information staff needed to provide effective care.

People enjoyed the food on offer, however some people were not always offered choices appropriate to meet their health needs.

Improvements were required to the adaption and design of the service to ensure it suitably met people's needs.

Is the service caring?

Inadequate

The service was not consistently caring.

People told us that staff were kind and caring towards them, however staff did not always have time to spend with people to provide the reassurances they needed.

People were not consistently supported to make choices and decisions and their choices were not always respected.

People felt that their dignity was respected. However, we found that people's privacy was not always respected because their personal care records were not always kept securely.

The provider had not ensured that systems and processes were in place to support the service to be as caring towards people as it could be.

People were supported to maintain important personal relationships and their relatives and friends could visit without restriction.

Is the service responsive?

Inadequate

The service was not responsive.

Complaints were not listened to and acted upon in order to make improvements to the care provided.

People who were receiving end of life care did not have suitable and personalised plans in place.

People were not supported to have accurate, individualised care plans that included their preferences and life history. Therefore staff did not always have the information they needed to provide personalised care.

People enjoyed the activities on offer but felt there could be more to occupy their time.

Is the service well-led?

The service was not well-led.

Systems in place to monitor and improve the safety and quality of the service were not effective and not operated by a person with the required skills and experience.

People's feedback had not been listened to or responded to.

There was a manager in post who was in the process of completing their registration with us. However, not all people knew who the manager was.

Staff felt the manager and provider were approachable but staff feedback was not always listened and responded to.

Madeley Manor 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 checked 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 3, 8 and 30 May 2018 and was unannounced.

The inspection team consisted of three inspectors and an expert by experience who has personal experience of caring for someone who uses this type of care service.

Before the inspection, we checked the information we held about the service and provider. This included the statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also reviewed information we had received from the public and the local authority. We used this information to help formulate our inspection plan.

We spoke with eleven people who used the service and two visiting relatives. We did this to gain people's views about the care and to check that standards of care were being met. We also spoke with nine members of care staff including the deputy manager, a nurse and a domestic assistant. We spoke with the home manager and the provider to help us to understand how the service was managed.

Some people who used the service were not able to speak to us about their care experiences so we observed how the staff interacted with people in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also looked at the care records of nine people who used the service to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included six staff files, staff rotas, training records and quality assurance records.

Inadequate

Is the service safe?

Our findings

People's risks were not always suitably managed to keep them safe and well. Some people were assessed as being at risk of developing pressure areas and these risks were not managed safely and plans were not always followed. For example, one person had pressure sores and they had been assessed by a tissue viability nurse who had implemented a clear plan for staff to follow to promote wound healing. This plan included the need for a particular gel which had been prescribed for the person. Staff told us and records showed that this gel had been out of stock for four days so the treatment plan had not been followed accurately. The treatment plan also stated that they should be supported to change position two to four hourly to relieve the pressure on the wounds. However, records we viewed showed periods of five and six hours when the person had not been supported to move. We found that the person had an infection in one of their wounds. This meant that safe care and treatment was not provided because the risk to people's skin was not managed or mitigated to protect them from the risk of harm.

A number of people were assessed as being at risk of falls and these risks were not managed safely. For example, staff and people told us that one person walked around the corridors at night and they were at risk of falling. We saw their room was near a ramp and also close to a corridor with no carpet, a floorboard was dislodged and a pipe was exposed. This posed a risk to the person when walking around during the night. This person had a sensor mat in place to alert staff when they moving around because they were at high risk of falling and this was taken with them whilst in communal rooms. However, we saw that a table had been placed over the mat and if the person stood up and walked whilst alone in the lounge the sensor mat would not have alerted staff to provide support to lower the risk of the person falling. This meant that people's assessed risk of falling was not managed or mitigated effectively to protect them from the risk of harm.

Some people had diabetes and the risks associated with diabetes were not safely managed. We found that some people's eating and drinking care plans stated that they had diabetes and needed encouragement to eat a diabetic diet. There was no guidance for staff to show what foods were suitable to manage their diabetes. Staff we spoke with were not aware of everyone who had diabetes and how the risks associated with this needed to be managed. We saw that one person was eating ice cream and had been given biscuits. We asked the cook how they ensured that people with diabetes were encouraged to eat a diabetic diet. We were told that everyone ate the same; there was nothing specific for people with diabetes. When a person experiences a hypoglycaemic (low blood sugar) or hyperglycaemic (high blood sugar) episode, immediate action can be required to prevent a person from becoming more ill. There was no guidance to help staff recognise deterioration in a person's diabetic condition and staff we spoke with were unable to explain the actions they needed to take. This meant that risks in relation to diabetes were not safely managed or mitigated.

A number of people who used the service displayed behaviours that challenged such as verbal or physical aggression. We found that care with regard to behaviour that challenges was not managed safely. Staff told us that one person could shout at times and become agitated. However, staff gave inconsistent accounts of how they supported this person and did not know what may trigger these behaviours. The care plan did not give staff guidance to ensure the person was supported to manage these periods of anxiety. This meant that

people were at risk of receiving inconsistent support to manage their behaviours.

People did not always have access to the means to call for help when they needed it. This was because people's calls bells had been placed out of their reach meaning that they were unable to summon support from staff. We heard one person shouting, "Help, help, I can't shout any louder. Please help me I can't do anything." We went to the person and they told us that a staff member had wrapped their emergency call bell around the bed post so that they could not use it. We saw that the emergency call button was out of reach and wrapped around the bed post. This meant that people did not receive safe care because they did not have access to call for help in an emergency. We told the manager about this and they said they would ensure that people had access to their emergency call bells. However, later in the day we heard another person calling for help and we saw that their call bell was out of reach. On our last day of inspection, we saw that people did have access to their call bells and the manager had implemented a system to check this.

People's medicines were not safely managed to ensure that they received their medicines as prescribed. We found that people did not always have access to their prescribed medicines because they were out of stock in the home. One person was prescribed a daily medicine for anxiety. We saw that this medicine had been out of stock for nine days. The Medicines Administration Records (MARs) showed that the person had been receiving an 'as required' (PRN) medicine twice a day on a regular basis to manage their anxiety because their prescribed daily medicine was out of stock. This medicine was not intended for regular use when it was prescribed. The person's daily records showed that they were, "vocal and agitated, shouting at times, unsettled, calling out" during the period their medicine was out of stock which showed they experienced increased symptoms of anxiety. This meant there was a risk that people's health could deteriorate because the home had not taken action to ensure that people's prescribed medicines were available to them. Systems in place to ensure that people's prescribed medicines were available to them were ineffective as we saw multiple examples of 'out of stock medicines' and proactive steps had not been taken to ensure the prescribed medicines were available as soon as possible.

Some people were prescribed 'as required' medicines. Suitable protocols were not in place to guide staff on how to administer these medicines to people who were unable to request them. Some 'as required' medicines did not have any protocols at all whilst other protocols lacked clear guidance and detail for staff to follow. For example one person was prescribed an 'as required' medicine for anxiety. The protocol for this did not give detailed information for staff to follow in relation to how the person displayed anxiety and when this medicine should be administered. The nurse on duty was unable to give an explanation of the actions that needed to be taken before administering this medicine. We saw that the person was regularly administered this medicine with limited guidance in place. This meant there was a risk people's medicines may not be administered as intended by the prescriber.

We found the medicines room was left unlocked on one occasion for a period of at least ten minutes and the fridge inside containing medicines was also unlocked. This meant that people could have accessed medicines which were not prescribed for them and this was not safe practice. The home supported people living with dementia and complex needs who were exposed to the risk of harm as a result of the medicines being accessible to them.

We could not always verify if people had received the right amount of medicine as actual doses administered and stock levels were not always being recorded. For example, one person was prescribed a variable dose of, "half a tablet to one tablet when required". Staff were not recording whether half or one tablet was administered so it was not clear how much medicine the person had been given. Therefore we could not be sure the person was receiving their medicines as prescribed. This meant that the person's medicine was not managed safely or properly to ensure they received it as required. We also found that

medicines stock control was inconsistent. We checked stocks of some people's medicines and found they did not tally with the MARs so we could not be sure they were receiving their medicines as prescribed and as recorded. The provider did not have an effective system in place to ensure the safe and proper management of medicines.

Some people were prescribed topical creams. However, there were no topical creams administration records (TMARS) so neither we nor the provider could be sure that people were receiving their creams as prescribed. This meant people were at risk of their symptoms becoming worse, for example developing a pressure sore or having skin irritation, if they did not have their prescribed topical medicine.

The above evidence demonstrates that people did not always receive safe care. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff were not always available to provide them with the care and support they required in a timely manner. Comments from people included, "We are invisible," "I do think that they could do with more staff. The afternoon seems to be the worse, you wait a while then," and "When I press the buzzer they take a long time to get to me. I need help to get to the toilet and have to be hoisted." A relative said, "There appears to be more staff on today than at other times. I do think they do need more staff as I have had to go to get someone when [another resident] has called and staff have not come. I went to go and get staff but they still took half an hour." One person told us that they had experienced times when staff were unable to take them to the toilet and the person had been incontinent. They said, "It's not nice, I get very embarrassed about it". Another person told us that staff told them to open their bowels in their pad because they hadn't got time to support them onto the commode. This meant that there was not always enough staff available to meet people's needs.

We saw people were left unsupervised in lounges for long periods of time without staff supervision, despite people being at risk of falls. We saw that one person pressed their buzzer to call for help and no one responded. They told an inspector that they needed the toilet and were in pain. They became distressed and after ten minutes of waiting, the inspector went to find staff. There were no staff near the lounges to alert and the inspector found the nurse. Two staff members came into the lounge on separate occasions and told the person they would get another member of staff to help. The person told us, "They always fob me off like this". A staff member told us that people in the lounge were often left waiting for support to go to the toilet because staff were busy supporting people in their rooms and by the time staff got to them they had had an accident and had to be supported to change their clothes. The staff member said, "I don't think there's enough staff. Not for the dependency of people here. We can't get to buzzers quickly and people have to wait. It's frustrating." This meant that people's care needs were not always met as planned or in a timely manner because staff were not always available to do this.

The provider used a 'dependency tool' to help to work out the number of staff required to meet people's needs. However, this had not been regularly updated with an accurate assessment of people's needs and dependency levels which meant that the provider could not be sure that a sufficient amount of staff were planned for. The tool also did not adequately take into consideration the layout of the building which impacted on staff's ability to get to people quickly. The deployment of staff had recently been changed by the manager to try and improve people's access to staff. However, this was not effective as it meant that lounges were unsupervised and staff were not on hand to support people in the lounges when they required this. This meant that the provider could not be sure enough staff were effectively deployed to safely meet people's needs.

We told the provider about the issues with staffing and they arranged for an additional staff member to be

added to the rota during the day time and for increased supervision of lounges. However, we found that people still had to wait for support. An incident form showed that one person was not supported for a period of eight hours and 45 minutes to go to the toilet. This occurred following the increase in staffing. This showed that there were not enough staff available at the service to ensure that people's needs were met and their safety maintained. The provider further increased staffing levels by the time of our last day of inspection.

The above evidence demonstrates that there were not always sufficient numbers of staff, effectively deployed to meet people's needs. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider could not be sure that staff were safely recruited. We found that not all staff had adequate references that had been checked prior to them commencing employment and starting to support people. This meant that the provider could not be sure that robust recruitment procedures had been followed to ensure that staff were of suitable character to work with people who used the service. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure staff were suitable to work with people who used the service. However, when staff had convictions, a suitable risk assessment was not carried out to ensure that they were safe to work with people who used the service. The deputy manager and provider were unaware of these issues with staff recruitment. This meant that the provider could not be sure that all persons employed were of suitable character to provide support to people.

People were not consistently protected from avoidable harm or potential abuse. We found that unexplained injuries to people had not been investigated and/or reported as a safeguarding concern. For example, daily records for one person showed that a bruise with an unknown cause was recorded by staff. No further action had been taken to investigate the cause or safeguard the person from further injury. There were no records that showed this concern had been investigated or reported to the local safeguarding authority for investigation. This meant the provider could not be sure how this injury had occurred as no action to investigate had taken place and therefore no plans were put into place to reduce the risk of a similar injury occurring again. This meant that people were not sufficiently protected from potential abuse.

Staff we spoke with were not knowledgeable about the safeguarding adults procedures in place to protect people from avoidable harm and abuse. Care assistants told us they would report any concerns to a senior care assistant or nurse in charge. We spoke with a nurse about one person's unexplained bruising and they had not considered investigating the cause or completing a referral to the local safeguarding adult's team in line with safeguarding adult's procedures. The provider's training records showed that the nurse's annual safeguarding adults' training was out of date, along with a number of other staff. This meant that effective systems were not operated to safeguard people from potential abuse and improper treatment.

We gave feedback about our concerns to the manager and provider. Following the feedback we found further incident forms had been completed by staff detailing further unexplained injuries to four people and still no action had been taken to investigate the cause of the unexplained injuries and referrals to the local safeguarding adult's team had not been considered. This meant that action had still not been taken to ensure that people were adequately safeguarded from potential abuse and avoidable harm. The provider had not learned lessons and made improvements when things had gone wrong.

The above evidence demonstrates that people were not consistently protected from potential abuse and improper treatment. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us and we saw that the home was clean and tidy to help protect people from the spread of infection. However, improvements were required to ensure that all staff were aware of their responsibilities and an oversight of infection control issues was maintained by the provider. We found that monthly infection control audits had been completed by the administrator in February and March 2018. The administrator confirmed that they had not had any training or guidance in how to effectively complete an infection control audit. In March 2018 the administrator identified that not all staff had received infection control training, inappropriate jewellery was being worn by some staff and not all staff were aware of the provider's infection control policy. This meant that people could people at risk of the spread of infection. However, no action had been taken to address these issues and no further audits had been completed. This meant there was a risk to people's health and safety and systems in place to manage infection control had not effectively ensured that this was addressed.

Inadequate

Is the service effective?

Our findings

People were not always supported effectively by staff who had the required knowledge and skills. For example, we saw staff supporting people to move using equipment such as hoists and wheelchairs. We observed that staff did not always use wheelchairs effectively by ensuring that footplates were in place to protect people's feet, so we checked whether staff had received the required training to be able to support people to move safely and effectively. We found that the provider could not be sure that all staff had the relevant training and skills to provide support to people. When we looked at the training matrix we found that some staff who were working on the day of the inspection were not included on this matrix. We saw one staff member working alone and supporting people to move. This staff member was not included on the training matrix and the provider had no record of their training so could not be sure they had the skills to support people safely. We saw that a number of staff had not completed moving and handling training and at least five staff members were not included on the training matrix. This meant the provider could not be sure that staff had the skills and knowledge to provide effective care.

A number of people were living with dementia or had mental health needs and some people displayed behaviours that challenged such as verbal or physical aggression. Staff told us they had not completed sufficient training to help equip them with the skills to support these people effectively. Staff gave different accounts of how they supported people with anxiety and aggression which meant that people received inconsistent support from staff who had not been trained effectively to meet their needs. We looked at training records which showed these gaps in training. We also saw that a number of people were living with diabetes and staff had not been trained to support them with this and could not demonstrate an understanding of how to support people with this condition.

The above evidence shows that staff were not always suitably skilled to meet people's care needs in a safe and effective manner. This was an additional breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the last day of inspection, the provider told us they had updated the training matrix to include all staff members and that essential training including moving and handling had now been completed by all staff providing support to people. However, we saw that annual safeguarding adults training remained out of date for some staff who could not tell us the process for reporting safeguarding adults concerns. This meant that further improvements were still required.

The principles of the Mental Capacity Act 2005 (MCA) were not followed correctly to ensure people consented to their care and their rights were protected. The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Most staff we spoke with did not have a good understanding of the MCA, so they were unaware of their responsibilities in supporting people's decision making. One staff member said, "I don't know much about it, I'm just reading about it at the moment." Training records

showed that all staff had not completed training on the MCA.
We found that people's capacity to consent to their care had not been assessed when required. For example, we found that some people had bed rails without the necessary consent in place. One person said, "I can't get out because of these things [bed rails]." We looked at their care plan and saw that a consent form was blank and had not been completed. There was a bed rails risk assessment which stated that consent was recorded but we could find no record of this and the person told us they had not consented. There was no evidence that their mental capacity to consent to this specific decision had been assessed in line with the principles of the MCA. This meant that bed rails were put into place which restricted the person, without their consent. We also found that one person had been given their medicines covertly (crushed and hidden in their food). There was no evidence that the person's capacity to refuse their medicines had been assessed and there was no evidence that the decision to give them medicines covertly was in their best interests. This meant the person's decision to refuse their medicines had not been respected and the MCA had not been followed to ensure the person's rights were upheld.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. The manager and provider told us that no one had an authorised DoLS in place, though authorisations had been applied for when required. We looked at the DoLS 'tracker' that was completed in April 2018 and this stated that one person had an authorised DoLS. We looked at this and found that it had expired in March 2017 and no new authorisation had been requested by the service, which meant that the person was being unlawfully restricted because the necessary authorisation was not in place and had not been requested.

The above evidence demonstrates that consent was not always sought in line with MCA and people's liberty was restricted unlawfully. This was a breach of Regulations 11 and 13(5) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed the food on offer and that they were provided with a choice. One person said, "Lovely the food is. I had cornflakes with cold milk, two toast and bacon and egg with a cup of tea for breakfast. You get a choice of two items and for a sweet. My only complaint is that the cup of tea comes after and I like it with my food." We observed that at lunch time, people did not always have access to drinks with their meals. One person asked for a drink with their meal; however this was placed out of their reach. On the last two days of the inspection, we saw that the provider had taken action to ensure that people had regular access to fresh drinks. We saw that when people needed support to eat, staff supported them in an unrushed manner.

Some people required a diabetic diet and we saw that they were not always offered diabetic choices. We spoke with staff and the cook who were not clear about which people had diabetes and what their specific requirements were in relation to this. This meant that people were at risk of not receiving the specialist diet they required. We spoke with the provider who took action to ensure that options suitable for people with diabetes were available on the menu and that staff had access to information about which people had diabetes.

Staff handovers were not always effective in ensuring that all staff had the required information to provide effective care for people. For example, one person had a dressing on their leg and no staff knew why the person had this or what the required treatment plan was because information had not been effectively documented or shared during handover. A number of agency staff and new staff were working at the service

and the lack of effective handover of information meant that people were at risk of receiving support that did not meet their needs. For example, not all staff were aware of which people had diabetes. This meant that staff did not always work effectively together to deliver effective care, support and treatment to people.

People told us they had access to healthcare professionals when they needed them. One person said, "[Staff] have made appointments for samples and blood tests for me and the doctor comes round every Thursday. I have also had the Optician visit to see me and to get me fitted with these glasses. I also have a chiropodist that comes in." We spoke with the doctor who told us they visited routinely each week and made additional visits if requested. They told that staff referred to them appropriately when people required medical attention. Records showed that people had access to healthcare professionals, however their advice was not always incorporated into people's care plans to ensure it was understood and followed by staff. For example, we saw that a physiotherapist had assessed one person and advised how they should be supported to move by two staff using a hoist. However this information which was recorded in the person's daily notes did not match what was written in their care plan. Their care plan said that they walked with a frame. This meant that people were at risk of receiving support that was not in line with advice given by professionals because care plans were not updated and reflective of professional advice.

We saw that the environment had been adapted to help meet people's physical needs; however improvements to the environment were required. Bathrooms had been adapted to help ensure that people with physical health needs could have their personal care needs met. However we saw that one bathroom was used for storage of a hoist and chairs which meant that people could not access it. We saw that floorboards had been taken up on one corridor outside people's bedrooms and not replaced which meant that people were at risk of falling. The provider was not aware of this until we pointed this out to them. On the second day of inspection we saw that action had been taken to make this safe for people. Some people who used the service were living with dementia and we saw a resident's board showed the day and date to help orientate people to time. However, we saw the wrong day and date was displayed which could be confusing for people living with dementia or memory loss. We saw that the maintenance person had identified some areas of the building which required improvement such as guttering needing replacement and two broken windows needing repair. However, there were no improvement plans in place to address these concerns with the premises which meant that action was not being taken to address concerns with the suitability of the premises.

Inadequate

Is the service caring?

Our findings

People consistently told us that staff were friendly towards them but that they did not have time to spend with them as they were too busy. One person said, "Staff are nice and all that but don't take time to stop and talk to me. They leave me to it and come if I call them eventually." Another person said, "The staff are all very good and kind. They don't come and talk though as there's probably not enough of them, which is why they don't notice when my water bottle is low." A staff member said, "It's frustrating, we can't care as much as we want to. We are all trying to do our best but it's so frustrating." Our observations confirmed what people and staff told us. For example, one person appeared anxious in the lounge and repeatedly pressed their call bell. When staff attended they asked the person what they would like and the person responded, "Stay with me please." The staff member knelt down and held the person's hand in a very caring manner and replied, "I can but only for a bit." We saw the person was smiling and kissing the staff member's hand and was visibly calmed by their presence. However a few minutes later the staff member was called away to complete another task and the person appeared anxious again. This meant that staff did not have the time to give this person the reassurance they needed.

People were not always supported to express their views and be involved in decision making about their care. For example, we saw that a relative had complained that a person did not get a choice of food. The person needed to be shown two options in order for them to make an informed choice but the relative complained that this was not happening. We did not see that anyone was given visual aids to help them make choices and the relative's complaint had not been responded to. Another person told us that their choice of when to get up and go to bed was not always respected. They said, "It's a bit of a nuisance sometimes this. I like to get up at 8.30 and it was 9.30 this morning when they came and sometimes it's as late as 10.00. I ache if I am left for too long and it makes breakfast late and I don't get it until 11am. Bedtime can be anytime when they come." This meant that people were not consistently supported to make choices and decisions about their care and support. When people did make choices, they were not always respected.

People told us their privacy and dignity was respected and promoted. One person said, "I have a bath in the bathroom, they close the door and get a towel to go around me when coming out. This is all fine." Another person said, "I have a bed bath daily and a shower on Mondays. I turn over in the bed myself and they make sure that I am covered up. Privacy and dignity is certainly respected." However, we observed that people's privacy was not always maintained because their files with personal details about the care provided to them were left out in corridors which anyone, including visitors to the home could access. We also saw that undignified language was used in care plans. One person was described as 'cantankerous' in their care plan. This was not a respectful or dignified way to refer to a person. We heard loud music and shouting coming from the kitchen area on all three days of inspection. The kitchen was close to people's bedrooms where some were sleeping including one person receiving end of life care. This was not respectful of people's peace and privacy. People also told us and we saw they were not supported to the toilet in a timely manner which could result in them having an accident. One person told us they were told by staff to open their bowels in their pad because they did not have the time to support them to get onto the commode. These examples showed that people's privacy and dignity were not always respected and promoted.

The above evidence demonstrates that people were not always treated with dignity and respect. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured that the necessary systems and processes were in place for the service to be caring. For example, there were not enough staff, there were no residents meetings and people's feedback was not always listened to and acted upon. This meant the service was not as caring as it could be.

People and relatives we spoke with said that staff treated them with kindness and compassion. Comments included, "I love it here and the care is good and yes I do feel valued here" and "I am happy here and I do feel they [staff] like me." We saw that staff addressed people by their first names when this was their preference and we observed some caring interactions between people and staff. For example, we saw a staff member noticed a person's cardigan was ruffled at the back and it was causing them discomfort. They asked if they could help the person to pull their cardigan down to help them, "stay comfy". This showed that staff showed concern for people's wellbeing and dignity. The person smiled when the staff helped them as they were treated with kindness.

People told us and relatives confirmed that they could visit at any time and were made to feel welcome. One person said, "My relatives visit me anytime there are no restrictions as to when they can come." We saw that one person's spouse visited them daily and were provided with a lunch so that the couple could enjoy their meals together because this was important to them. This showed that people were supported and encouraged to maintain personal relationships that were important to them.

Inadequate

Is the service responsive?

Our findings

People were not always supported to raise concerns and complaints. When people had made complaints we found that these were not responded to in order to improve the quality of care. There was no information displayed in the home to inform people about how to make a complaint. We saw there was a complaints policy in place but it was not readily available for people and visitors to access. We found that a number of complaints had been made but they had not been responded to in line with the provider's complaints procedure. For example, one person made a complaint that their relative did not have access to a call bell when they visited. They also complained that another person was shouting for help and did not have access to their call bell. The complainant could not find any staff to help the person. We could not see that an investigation had taken place and we also found that these issues were still apparent during our inspection. This meant that necessary action had not been taken to address the complainant concerns. The complainant had not received a response to their complaint which meant that the provider was not following their own complaints procedure in order to listen, respond and improve the quality of care people received.

The above evidence shows that complaints received were not investigated and action was not taken in response to any failures identified by complainants. This was an additional breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were receiving end of life care. However, their care plans were not fully reflective of this. We found that people's wishes for their care at the end of their life had not always been sought at a time when they were able to be involved in these discussions. For example, one person's future wishes care plan said this would be discussed with them when and if their health deteriorated. However, we saw that this person had been receiving palliative care for a number of weeks and this discussion had still not taken place. Another person had been prescribed anticipatory medicines and still had no end of life care plans. The provider told us they knew about this and that a plan needed to be developed but this had not yet been done. This meant that people did not have suitable care plans in place to meet their needs at the end of their lives.

End of life care plans we looked at were generic and contained the same information for each person, they were not individualised to suit each person's differing need at the end of their life. For example, care plans stated that people wanted to be, "free from pain" but it did not state how this would be achieved for each person. There was a lack of personal information such as who they would like to be visited by, any particular music that may be important to them or whether religion was important to them. For example, one person's care plan said they were Roman Catholic and had always enjoyed communication with the church. However, this was not mentioned in their end of life plan and we could not see that they had been asked if this was an important part of their end of life care. This meant that people were at risk of receiving care at the end of their life that was not responsive to their individual needs, wishes and preferences.

People were not supported to have individualised care plans that reflected their care needs and provided staff with the information they needed to provide personalised care. For example, one person displayed

agitation and repeatedly called for staff. We found that their community psychiatric nurse had advised that the home needed to implement, "clear care plans to manage the current level of risk and to minimise behaviours." We saw that professionals had provided lots of information to the home about the person's life history which could have been used to help plan how staff responded to the person in order to meet their needs. However, this information had not been incorporated into the person's care plan and therefore staff were unaware of it, meaning the person received inconsistent support and responses which could have exasperated their behaviours. We found that a number of care plans were out of date and did not reflect people's current needs. This meant that staff, including agency staff did not have access to up to date information in order to provide people with consistent, personalised care.

People and relatives were not always involved in the development and review of their care plans when they were able to be and we found that people's diverse needs such as culture, religion or sexuality were not always planned for. We found that pre-assessments were brief and people's diversity and equality was not considered. When people's cultural needs had been considered, they were not clearly planned for. For example, some people were noted as Catholic but it did not state whether they were practising and how this was important to them. The deputy manager told us they had contacted a Catholic priest when one person was nearing the end of their life and we saw that church services were arranged at the home. However, it was not clear how each person's diversity had been assessed and planned for to meet their individual needs.
The above evidence demonstrates that person did not always receive person-centred care. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed participating in activities that had been arranged for them, however they told us and we observed that they spent much of their time with little to stimulate them. One person said, "Activities are ok when they have them but we don't have a lot though. I like dominoes but don't get a lot of it. It could be better." Another person said, "We don't get too many activities to do, we could do with some more. I mostly stay here in the day with the others watching television." A relative said, "[My relative] likes some of the activities and took part in the singing and dancing. [They] also love animals so loved last week when they bought some in. I think perhaps it would be nice for [staff] to take [my relative] out for a walk when the weather is nice but they don't do this probably because they don't have the staff or time." A part time activities co-ordinator had recently been employed to help increase meaningful activity and stimulation for people. They told us they provided one to one activity to people who spent time in their rooms as well as facilitating group activities such as art and crafts and games. We also saw that external entertainers were arranged for people to enjoy such as an exercise group, various visiting animals and musical groups. This showed that the provider was making improvements to help people engage in activity though further improvements were required.

Inadequate

Is the service well-led?

Our findings

Systems were not operated effectively to assess, monitor and improve the safety of the service. We found that some potential safeguarding adult's incidents had not been reported the local authority and staff were not aware of the systems and processes in place in relation to safeguarding people. The provider did not have an effective system to ensure that all staff had completed the necessary training in order to provide safe care to people. We found that audits completed to check the safety and quality of services provided were completed by the administrator who had not received any training or support to ensure they were competent in completing these tasks. For example, monthly care plan audits were completed by the administrator. These audits did not identify the issues that we found with the quality of care plans and risk assessments during the inspection. The audit was a 'tick list' to identify whether a care plan was in place or not and therefore it did not allow the provider to monitor or improve the quality of care plans.

We found that governance systems and processes to continually assess, monitor and mitigate risks to people's health, safety and welfare were not operated effectively. Audits of people's clinical needs and risks were completed by an administrator who did not have the skills, competency and clinical expertise required to effectively complete these tasks and ensure that necessary action was taken when required. For example, an audit of people's weights was completed by the administrator. This identified that one person had lost weight during the month. The administrator had advised that the person should be weighed weekly to monitor further weight loss and their doctor should be liaised with. However, we found that this did not happen. This meant that the system in place to monitor people's risk of weight loss was ineffective because necessary action was not taken to monitor and mitigate the risk.

We saw that a monthly accident/falls 'analysis' had been completed. This 'analysis' consisted of a list of incidents rather than an analysis of triggers or trends which meant it was ineffective in assessing, monitoring and mitigating risks to people. For example, falls analysis lists showed that one person had been 'found on the floor' unwitnessed' fifteen times in January 2018, another fifteen times in February 2018 and once in March 2018. There was no analysis of the triggers or trends and therefore suitable action was not taken in a timely manner to manage this risk. The person's records showed that they were assessed as high risk of falls only following being found on the floor thirty times following an unwitnessed fall. This showed that ineffective systems were in place to monitor incidents and mitigate risks to people in an effective and timely manner.

A medicines audit identified gaps in Medicine Administration Records (MARs). Further action required recorded, "Nurse not worked before, doesn't know residents or building well, missed lunch meds." No further action had been recorded. This meant that people were at risk of harm due to missed medicines, however no action had been taken to address this and no plans had been put into place to reduce the risks of this happening again. Other concerns were also not being identified such as medicines going out of stock, people not always receiving their medicines as prescribed and no records of topical medicines being administered. This meant that systems and processes were not effective in mitigating risks to people.

We found that the provider had not listened to or acted on feedback from service users and their relatives

about their experiences of care at Madeley Manor Care Home. Residents and relatives questionnaires had been sent out to gather people's feedback in January 2018. We looked at the completed questionnaires and found these identified a number of issues and concerns including; people having to wait for support, staff shortages, poorly organised staff and a number of other issues. These questionnaires had not been analysed and no action plan was in place to address the concerns raised by people. No feedback had been given to people who raised these concerns. No resident or relatives meetings had taken place. We found that some issues raised in the questionnaires were still apparent during our inspection. This meant that the provider had not acted on feedback received in order to improve services to people. We raised this issue with the provider and they told us they were planning to formulate an action plan in response to people's feedback but this had not yet been completed. They told us they would arrange a relative's and residents meeting to try and involve people in the development of the service and gather and respond to their feedback.

The above evidence demonstrates that systems and process were not established or operated effectively to ensure that people received a good quality and safe service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a manager in post who was in the process of registering with us, as this is a requirement of the provider's registration with us. We saw that a newsletter was completed by the provider which introduced the new manager to people. However, this had not been effective in communicating with people who used the service because a number of people told us they did not know who the manager was. One person said, "I don't know the manager. If they walked in I wouldn't know them." There had been no resident or relatives meeting with the new manager. This meant that improvements were required to the way in which people were involved in the development of the service.

Staff told us that the manager and provider were approachable and supportive. One staff member said, "I feel well supported now but I didn't when I first started." However, staff told us they felt the home was short staffed and that that they had told the provider but their feedback had not been fully responded to. A staff member said, "We have all told the managers, it has got a bit better but not much." This meant that staff were not always listened to and involved in the development of the service.

The service worked in partnership with other agencies including their local general practitioner (GP). The GP told us they had a good relationship with the service and that staff would contact them when required. The provider was making linking with other external agencies such as activities providers to try and improve the experience of people who used the service.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks were not always assessed, mitigated and planned for and risk management plans were not always followed by staff. Medicines were not safely managed so that people received them as prescribed.

The enforcement action we took:

We issued an urgent Notice of Decision to impose positive conditions on the provider's registration, including a restriction on admissions. You can see these conditions in full under the 'registration's tab.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff available at the service to ensure that people's needs were met and their safety maintained.

The enforcement action we took:

We issued an urgent Notice of Decision to impose positive conditions on the provider's registration, including a restriction on admissions. You can see these conditions under the 'registration' tab.