Embrace (England) Limited

# Manor House Nursing Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |
| Is the service safe? | Inadequate |
| Is the service effective? | Inadequate |
| Is the service caring? | Requires Improvement |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

## Overall summary

We visited The Manor House Nursing Home on 8 and 10 October 2014. The Manor House Nursing Home is a home which provides nursing care for people who are living with dementia or with mental health issues. The home offers a service for up to 102 people. At the time of our visit 54 people were using the service. This was an unannounced inspection.

There was a registered manager in post at the service. 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.

We last inspected in June 2014. We looked at how people were respected and involved in their care, and also how the provider managed the quality of service they provided, managed safeguarding concerns and recruited workers. We found no concerns at that inspection.

# Summary of findings

Arrangements for the administration of as required (PRN) medicines did not protect people as staff were not following the prescriber's directions. Medicines at the home were not always stored securely.

There were not always enough staff to meet people's care and welfare needs. This meant people were at risk due to inconsistent levels of care and support.

People were at risk due to inadequate planning and delivery of their treatment and care. People were not always protected from the risk of malnutrition, choking and pressure damage.

The registered manager had knowledge of the Deprivation of Liberty Safeguards (DoLS). They understood DoLS and had made applications to apply it in practice. All applications were made lawfully and with the person's best interests at the heart of decision making. Deprivation of liberty safeguard is where a person can be deprived of their liberties where it is deemed to be in their best interests or their own safety.

There were limited social opportunities, activities and stimulation for people who were cared for in bed or people who were living with dementia. People who found it difficult to initiate contact did not always get the support they needed to prevent them from getting bored or lonely. We observed occasions where people without stimulation became anxious or withdrawn.

Quality assurance processes required improvement. There was a lack of quality assurance and audits. We found issues which had not been identified by the provider's own processes. This included where people had exhibited behaviours that challenge, where incidents had not been reviewed to identify any triggers which may have caused these behaviours.

Staff did not always treat people with dignity and respect. Some staff assisted people with care without talking to them. People did not always receive the support they needed to be independent. Most staff spoke to people with warmth and affection. People recognised care workers and responded to them with smiles which showed they felt comfortable with them. The home was in a small rural village. Relatives told us the provider made minibus transport available for them to visit and maintain contact with their relatives which was "a big help."

There were systems in place to identify and respond to abuse but these were not always effective. Records relating to recruitment showed relevant checks had been completed before staff worked unsupervised at the home. There were arrangements in place to keep the home clean and hygienic.

Where people refused their medicines but did not have mental capacity to make decisions around their health needs, staff took appropriate action. Best interest decisions were made with staff, people's representatives or advocates and the person's GP.

Staff felt they had the training and support they needed to meet people's needs.

People who use the service and staff spoke positively about the new home manager and the positive changes made by the new manager. People and staff told us the manager listened and acted on comments and concerns. People and relatives were encouraged to give their views about the home through a quality assurance survey. However, feedback was not always used to make improvements to the home as a whole.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

## 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 always safe. The arrangements for the management and the administration of medicines did not ensure the prescriber's directions were being followed. Medicines were not always stored securely.

There were not always enough staff to meet people's needs. When people were distressed they were not always reassured by staff.

Staff did not always record accidents and incidents in the home and ensure these were communicated to the registered manager. The service was unable to use this information to protect people from the risk of future occurrences.

Relevant checks had been completed before staff worked unsupervised at the home.

**Is the service effective?**

**Inadequate**

The service was not always effectively meeting people's needs.

People were at risk of their wellbeing and health needs not being met due to inadequate planning and delivery of their care.

Where people refused their medicines but did not have mental capacity to make decisions around their health needs, staff took appropriate action. Best interest decisions were made with staff, people's representatives or advocates and the person's GP.

We found that staff had the necessary training and support to carry out their roles effectively.

**Is the service caring?**

**Requires Improvement**

The service was not always caring.

People were not always treated with dignity and respect and were not always supported to be independent. People were often left without engagement and staff did not always explain what they were doing when supporting people.

Staff spoke to people with warmth and affection. People recognised care workers and responded to them with smiles. People and their relatives were involved in making decisions about their care and treatment.

**Is the service responsive?**

**Requires Improvement**

The service was not always responsive.

There were limited social opportunities, activities and stimulation for people. People who found it difficult to initiate contact might not always get the support they needed to prevent them from becoming isolated.

# Summary of findings

The provider had helped encourage relationships between people and relatives as they provided minibus transport available to relatives and visitors to visit and maintain contact with their relatives which was “a big help.”

**Is the service well-led?**

**Requires Improvement**

The service was not always well led.

People who used the home and staff spoke positively about the new manager at the home and on the positive changes they had made. People and relatives were encouraged to give their views about the home through a quality assurance survey. However, feedback was not always used to make improvements to the home as a whole.

Quality assurance processes required improvement; the issues we found during our inspection had not been identified by the provider’s own monitoring and audit processes. Where audits had been conducted these were not informing improvements to the service.

# Manor House Nursing 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 was 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 8 and 10 October 2014. It was unannounced. The inspection team consisted of four inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We carried out this inspection because we had received concerning information from local healthcare professionals about people's care and welfare. These concerns had been raised with the local authority safeguarding team and a strategy to protect people using the service had been implemented local authority safeguarding.

Before the visit we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. This enabled us to ensure we were addressing potential areas of concern.

We spoke with two of the 54 people who were living at the Manor House Nursing Home. We could not speak to more people as most people were living with dementia. We used the Short

Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with seven people's relatives. We spoke with two registered nurses, two activity co-ordinators, four care workers and a housekeeper. We looked around the home and observed the way staff interacted with people

We looked at 15 people's care records including their medicine records and at a range of records about how the home was managed. We reviewed feedback from people who had used the service, and a range of other audits.

Inadequate

# Is the service safe?

## Our findings

Relatives and staff told us there were not always enough staff to meet people's needs. We observed on the afternoon of 8 October 2014 that staff appeared rushed. During the afternoon of the first day of our visit, we observed four people who were constantly walking up and down the first floor corridor. Two of the people appeared agitated as they wished to go for a cigarette; however there were no staff available to assist them. We observed that for 20 minutes there were no staff to assist these people and their agitated behaviours increased. There were no activities or stimulation to support these people. We also observed two care workers on the ground floor were assisting people at 6:30pm to get ready for bed. They appeared rushed to assist people. Two people were walking along the corridor; one of these people was calling for assistance. Neither of the care workers were able to assist and were focused on ensuring people were ready for bed.

The registered manager used a system called a dependency tool to calculate the numbers of care staff required on each shift. The dependency tool considered the number of people living at the home and their care needs. We looked at staffing rotas for four weeks. The rotas showed that the number of care staff required using the registered manager's dependency tool was only met on three occasions. Staff we spoke with felt staffing levels were not always sufficient and this impacted on the care they could give to people. They told us they were frequently short of staff and often did not have time to engage with people or spend time with people when they became anxious. One care worker told us they had worked days with only three care staff, instead of five, they told us this impacted on the level of care people received as they rushed to meet people's basic needs. Staff felt that sometimes they weren't able to give people enough time when assisting with care tasks and weren't always able to involve people or promote independence. Additionally the home were using high levels of agency staff. One care worker said, "We've only had agency staff for the last couple of weeks. Staff shortages are affecting staff morale." One relative told us, "The staffing on the first floor is a bit low. People would benefit from more one to one support." Another relative felt the care staff and nurses were brilliant but that they were often rushed.

We discussed these concerns with the registered manager. They told us there had been problems with the care agency they used to cover their shifts. They had sought permission from their regional manager to use another care agency to improve staffing levels whilst they completed recruitment of permanent care staff. This had been agreed on 10 October 2014. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The arrangements for the administration of as required (PRN) medicines did not protect people. One person was prescribed an anti-anxiety medicine twice a day and if needed, they could also be given one extra dose of this medicine each day. We looked at the person's medicine administration records and saw that on two days in September nurses had signed to say they had administered two additional doses of this PRN medicine instead of one. The prescription directions for this person had not been followed and the person had received an excessive dose of this medicine.

There were systems to show medicines which were administered through a monitored dosage system (a blister pack containing several medicines that has been prefilled at the pharmacy) were administered as prescribed. However, some people were prescribed medicines which were stored in boxes. Where this was the case, staff did not consistently maintain a record of people's prescribed medicine stocks on medication administration records. Therefore they could not evidence if people had received their medicines as prescribed. The lack of records meant people may have been at risk of not receiving their prescribed medicines, which may affect their health. These systems were not in line with pharmaceutical guidelines.

People's controlled drugs (medicines which are controlled under the Misuse of Drugs legislation) stocks were stored correctly. However the keys to these cabinets were left in an unlocked drawer. We asked a nurse why these keys were stored in the drawer, they told us, "I know I should hold them but I have no pockets today." We also saw that three people's prescribed medicines were stored in unlocked drawers at the nurses' station. As there were not systems in place for safe storage of medicines, there was a risk that a person, visitor or care worker could access people's prescribed medicines.

Inadequate

# Is the service safe?

These matters are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they had received safeguarding training and would raise any concerns to management or with external agencies such as the local authorities or the Care Quality Commission (CQC). Staff knew how to identify potential abuse and understood their reporting responsibilities. Staff told us they would immediately raise any concerns with the nurse or manager and they were confident they would take action to address concerns raised. Staff also told us they would report incidents where people exhibited signs of challenging behaviours to enable people to be protected, however incidents had not always been raised to the registered manager

We saw a number of incidents had been recorded each month where incidents had occurred when people had become distressed.. There was no evidence that staff had assessed these incidents to identify the reasons for such behaviours and to ensure further incidents could be reduced. One person had a pre admission assessment which stated they often became agitated around their birthday. We saw incident records where the person had become agitated. The person's care plan provided no information relating to this symptom of their dementia. Care workers and nurses we spoke with were unaware of the person's pre-admission information.

When accidents and incidents occurred within the home, staff were not taking appropriate action to ensure people were kept safe from harm. We saw two incidents that occurred in June 2014 were recorded in peoples' care records. However, incident forms had not been completed and there was no evidence of how staff had acted to protect people from harm. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. There was no evidence that staff had learnt from these incidents to ensure the risk to people of future occurrences were reduced. The manager was not aware of these incidents and therefore no learning had been identified. This was a breach of Regulations 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Following our inspection the provider had raised a referral to safeguarding and was investigating these concerns.

Records relating to the recruitment of new staff showed that relevant checks had been completed before staff worked unsupervised at the home. These included employment references and disclosure and barring checks (criminal record checks) to ensure staff were of good character. In addition staff told us they received induction training and a period of shadowing of more experienced staff.

There were four domestic workers who were cleaning the home the morning of our inspection. Staff told us and we saw evidence they had the appropriate training and knowledge about how to protect people from the risk of infection. All staff were aware of the importance of keeping the service clean and demonstrated good knowledge of controlling the spread of infection in accordance with the provider's policies. We saw that all staff used personal protective clothing, including gloves and aprons when needed. We observed that, when necessary, care staff responded appropriately when dealing with bodily fluids. They wore protective clothing and ensured the area was thoroughly cleaned.

Inadequate

# Is the service effective?

## Our findings

We spoke with one member of staff who told us they did not always have the information they needed to meet the nutritional needs of people. We identified two people had lost a significant amount of weight in the last six months. For one of these people, staff had recorded weight loss; however no action had been taken to meet the person's needs. There was no care plan or guidance on how staff were to meet this person's nutritional needs. Staff had identified the second person had lost weight, and had been asked to refer this person to their GP and dietician due to continued weight loss. Although a nurse told us they had referred this person to the GP, there was no evidence in the person's care file to show if an external professional had assessed this person in relation to their continued weight loss. Staff had taken no action to explore the reasons for this person's weight loss nor protect them from malnutrition. We asked the registered manager if they were concerned about anyone's weight however they had just returned from annual leave and were unaware of any concerns

We discussed these issues with the registered manager and they raised safeguarding alerts with the local authority safeguarding adult's team for both people as staff had not identified concerns around their weight loss.

One person had been assessed by nurses as being at risk of choking. Nurses had sought advice from Speech and Language Therapists (SALT) to meet this person's needs. We looked at the guidance the SALT had provided. This stated the person required a soft pureed diet with no peas. We observed a care worker assisting this person with lunch which included peas. The care worker offered the person peas and therefore was not following the directions from the SALT; therefore the person had been placed at risk of choking.

People in communal areas were offered regular drinks. However people who were cared for in their rooms were not always offered fluids. We observed three people who were cared for in bed who had been identified as at being at risk of dehydration. Staff had clear guidance on how much each person should be supported to drink. This was recorded in their care plan. Each person had jugs of orange squash in their rooms which staff told us, and we observed were refilled at breakfast. We observed that all three people's jugs remained full until lunchtime when a glass of squash was served. We observed these people throughout the first day of our inspection and saw that no further squash was served from their jugs. Staff told us that these jugs had not been refilled since the morning. None of these people had any other fluids available to them in their rooms. These people's care plans were therefore not being followed which placed them at risk of dehydration.

We observed one person, who was cared for in bed, was not supported to change position throughout our inspection. Their care plan stated they were "at high risk of developing pressure ulcers". The person did not have a pressure sore however staff had guidance to prevent pressure ulcers which stated "To be assisted to change position 3 hourly". At 10am we observed this person was sat up in bed. They had a "position change" chart in place. This documented that they were sat up in bed at 9am. There were no further entries to the position change chart throughout the inspection. We observed this person every half an hour from 12:15pm to 1:50pm on the first day of our inspection and then observed frequently till 4:45pm. The person's position had not changed during our observations. This person was not protected against the risk of pressure ulceration as staff were not following the person's plan of care.

These matters are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us communication within the home was not always effective. The home was using agency staff (staff employed by another healthcare professional to provide care and support at the home). Staff felt agency staff did not always have the information they needed. Some care plans, such as for nutrition, were not available and there were no other ways to communicate people's needs to agency staff to support them in understanding people's needs and preferences.

People had access to other healthcare professionals such as opticians and doctors. We spoke with one person who told us they were able to request a doctor's visit or another medical appointment when needed. Staff told us, and we saw through care records, when concerns had been raised around someone's health often referrals were made to enable staff to continue to meet people's needs. We saw that the home utilised the support of speech and language therapists, occupational therapists and local falls teams.

Inadequate

# Is the service effective?

One relative told us the staff and manager were approachable and always phoned them if they were concerned about her relative. She told us she was happy with the amount of input she had into the care and support her relative received. Relatives also told us that when their loved ones were unwell staff ensured that if a GP visit was required this was arranged promptly.

Staff had completed training in the Mental Capacity Act (2005) (MCA) and DoLS. MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The registered manager had applied for deprivation of liberty safeguard authorisations (DoLS) for people where staff may be restricting their liberty. Deprivation of liberty safeguards is where a person can be deprived of their liberty where it is deemed to be in their best interests or for their own safety.

We found that where people refused their medicines but did not have mental capacity to make decisions around their health needs, staff took appropriate action. Best interest decisions were made with staff, people's representatives or advocates and the person's GP, including where people needed to have their medicines administered covertly.

We looked at the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms for eight people. Most forms had been completed fully; however one person's form had not been completed in accordance with their and their representative's views. The person and their representatives had stated a certain condition in which the person would not wish to be resuscitated. This instruction was not reflected on the person's DNACPR. The person may not be resuscitated in accordance with their wishes because their instruction had not been documented. We raised these concerns with the registered manager who agreed to discuss them with the person's doctor and family.

Staff told us they had the training and support they needed to meet people's care needs. Staff said training was carried out by e-learning and classroom based training. Staff said they were expected to complete e-learning whilst on duty, however they found this difficult, particularly when staffing was short. We looked at training records for all staff. These showed that staff had completed their training. The registered manager was implementing a new system of assessing staff competence following completion of e-learning. We saw evidence of this in the file of a new member of staff. This included practical assessments in safeguarding, dignity, COSHH, and conflict resolution. The manager also told us they planned bespoke dementia training for all staff in the near future. Staff also told us they had received an annual appraisal and had regular one to one meetings with their line manager, which enabled them to raise concerns and discuss professional development.

Requires Improvement

# Is the service caring?

## Our findings

People were not always treated with kindness, compassion or with respect. We conducted an observation in the first floor lounge on the first day of our visit. We saw that 11 people were in the room, eight of these people appeared withdrawn or asleep. We observed care staff come into the room at numerous times, but they did not talk to or acknowledge people. One person was sat in the room for 50 minutes and no staff talked to this person during this time. We saw a care worker place a wheeled frame in front of the person, but they did not talk to them.

During the afternoon of our inspection we also observed four people watching a television in a lounge. The television did not have any sound coming from it. People were not being engaged by staff during this time.

We observed a staff member assist a person to reposition in bed. They went to the person and supported them in a calm manner; however they did not explain what they were going to do before they supported them. The person cried out; the staff member apologised immediately. The person was not caused any harm but was clearly upset. The staff member told us they "did it to make them comfortable, but I should've talked to them." These observations showed people were not always respected, or involved in their care.

Staff treated people with respect and supported them by giving them time to express their preferences and make choices. For example, when drinks were offered during the mid-morning drinks round we heard a care worker ask in a friendly and respectful way "would you like tea or coffee sir?" We also observed care workers being kind and talking to people in a reassuring way when they appeared anxious or upset.

People who lived at the home and their relatives told us they were treated with kindness and compassion and their dignity was respected. People said: "I can't fault them, they do me well." Relatives told us the staff were very caring, nice and kept their relatives comfortable.

Care workers used people's preferred names and we saw warmth and affection being shown to people. People recognised care workers and responded to them with smiles which showed they felt comfortable with them.

People were treated with dignity and respect by staff and were supported in a caring way. We observed one person who was sitting in the lounge. They stood up and walked to the door. The person required personal care. A care worker came to the person immediately. They asked the person discretely if they needed help and reassured them "everything is okay." The care worker assisted this person to the toilet. The person came back to the room and had been assisted to change. The person appeared comfortable and was smiling.

People were supported in a way that respected their dignity. We observed staff supporting other people to use the toilet. This was done discreetly and in a caring and kind manner. Doors were closed when personal care was being provided.

One person told us they were involved in their care and could request support from their doctor when needed. They said they were able to talk to the manager about their care and were actively involved in planning their care. A relative told us they were involved in their relatives care and had the opportunity to discuss their relatives care plan with staff. They told us they were always informed if staff had identified any concerns with their relative.

We saw one care worker who was assisting a person with their meal; they were focused on the person and talked to them throughout. The care worker asked the person if they could wipe their face when needed. The person enjoyed their meal in a calm and relaxed manner.

People's bedrooms were personalised and contained photographs, pictures, ornaments and the things each person wanted in their bedroom. One person had picture of themselves and their family in their room; this was something which they said, and we saw, made them happy as they looked at the pictures. Another person had pictures and items from their favourite football team. This gave the feeling that this was the person's private room. Staff also told us this enabled people to recognise their room.

Staff demonstrated a good understanding of how supporting people to be as independent as possible helped them to feel valued and empowered. One staff member spoke positively about how they assisted people to do as much for themselves as they were able to. They told us, "I assist. There are things they can do, it takes them a bit longer, but I respect that. It helps them stay as independent as possible."

One person in the home was receiving end of life care. We spoke with a nurse about end of life care; they told us how

Requires Improvement

# Is the service caring?

it was important to meet people's religious and spiritual needs. They said they had the training they needed and the person's GP and family were always involved in the person's care. We saw that some people had made advanced decisions around their end of life care needs.

One person had stated in their care records that they wished to be at the Manor House at the end of their life and did not wish to pass away in hospital. This showed people's preferences about their end of life care were sought.

Requires Improvement

# Is the service responsive?

## Our findings

We observed people in their rooms who were withdrawn or sleeping. We observed four people's rooms for an hour and saw that none of the four people received any engagement from staff during this time. People in these rooms were unable to use their call bells and received no assistance during these times.

Most people's care records did not contain any information on the person's life history. For one person we could see that their hobbies and previous employments had been recorded. However for many people there was no evidence of what people liked to do, or what they had done before they came to stay at the home. There was limited information for staff and activity co-ordinators to enable them to provide activities and stimulation which could meet people's individual needs.

The home employed two activity co-ordinators who told us they provided stimulation to people as required. We saw one activity co-ordinator spend most of their time assisting people to have cigarettes during the inspection. One activity co-ordinator told us how they engaged with people to improve their well-being by singing or using mementos important to the person. They told us they felt there was never enough time for staff to just "be" with people. They also told us they felt people's care plans were not personalised. They had raised these concerns with the registered manager. Following this the registered manager had agreed for an activity co-ordinator to be involved in assessing people before they came to the home, to ensure people's social and wellbeing needs were documented.

We observed one staff member assist a person with arts and crafts. The person was not fully engaged. The staff did not seem to notice this or change the way they were engaging with the person. Staff told us they rarely saw activities in the lounge or in people's rooms as planned activities were not organised. Staff said the people who participated in activities were those who were able to interact. Staff felt there were no activities for people living with dementia. However, some social activities were provided. For example, some people had been to a tea dance in Banbury and another tea dance had been held in the home.

One person told us they had raised concerns with staff around their diabetes medicine. They felt the GP did not understand their needs. We discussed this with the registered manager who explained the person used to have control of their own medicines, however they liked to go out and have several drinks and this had affected their diabetes medicines. Discussions had been held with the person to enable them to live their life as they chose, but to also ensure they were protected from the risks associated with their life choices and diabetes medicines.

We spoke with one person who told us they were able to discuss their care with both the nurse and with the registered manager. They were very complimentary about the registered manager and felt that they were responsive to their needs. They told us that since the registered manager had worked at the home, they felt confident that any concerns they raised would be effectively dealt with.

Relatives told us the provider made minibus transport available for relatives. They told us as the home is in a small rural village well off bus routes this was "a big help" to be able to visit their relatives. Relatives and visitors all confirmed there were no restrictions on their visits and they were always warmly welcomed. The family of one person told us about their relatives care. They said, "they have been here a very long time but we don't have any problems with their care. Staff will always ring us if they have any concerns about them. We can come in at any time to see how they are."

There was guidance on how to make a complaint displayed in the home in an accessible location for people and their visitors. The provider's complaints policy stated all complaints would receive a written response within 28 days. We looked at the complaints file and saw all complaints had been dealt with in line with the provider's policy and people were happy with the outcomes.

Staff told us the action they would take if a person or a relative made a complaint. This included escalating to the nurse or manager if they were unable to resolve the matter promptly themselves.

People who lived in the home and relatives told us the registered manager and staff were receptive to comments and feedback and they always acted on them promptly. One relative told us they had complained about a dirty carpet in their relative's room. They reported this had been dealt with effectively by the registered manager.

Requires Improvement

# Is the service well-led?

## Our findings

There was a lack of quality assurance systems and where audits had been conducted these were not informing improvements to the service. During our inspection we found concerns over how people's medicines were managed, including the home not following the prescriber's instructions. We saw these concerns had not been picked up or addressed through medicine audits. We saw people's care plans were not always current and in cases provided conflicting information. For example one person had a "quick look" care plan for staff which stated they should be left snacks and drinks in their room. However, the person's care plan stated they needed to be supervised with all food as they were at risk of choking. We saw in one of these people's file there was a monthly review of their care plan, but this had not identified any changes needed to ensure care records were accurate. We did not see evidence that this file had been audited to ensure it was current and reflected the person's needs.

Incident and accident records were made when someone fell or became physically aggressive. The registered manager conducted an audit of incidents and accidents to see who the incident affected and when the incident occurred. However, we saw that not all incidents had been reported and did not inform the audit. These included incidents of aggressive behaviours which had led to people physically striking other people. We found there were multiple incident and accident folders held by the service, which contained different records. Therefore the registered manager's audit was not effective because an accurate record of incidents and accidents had not been made, and where they had been made the home's systems made them complex to audit. This was a breach of Regulation 10 and Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw people and relatives had completed a survey in November 2013, and the results of this were documented in 2014. Some relatives had commented about the lack of activities. There were no actions or response from the provider in response to this concern. Relatives told us there were still a limited number of activities available for people living at the home.

The Manor House Nursing Home had a registered manager in place. People and relatives spoke positively about the registered manager. One person told us, "The manager has only been here a while but she has done a lot for this place." A relative told us, "The manager is very approachable; they've made some great improvements."

The registered manager told us they had a vision to develop and improve dementia care at the Manor House Nursing Home. We saw records of staff meeting minutes from 2014. These meetings were used to discuss dementia care and changes to the culture of the home. We saw ideas such as staff not wearing uniform, the use of snack boxes and for staff to just "be" with people. We observed that staff had adopted a no uniform policy, but other ideas had not been implemented. We discussed this with the registered manager. They informed us that they were planning to use performance development plans for all staff to drive a change in the caring culture of the home. They told us they were aware that in some cases the culture of staff needed changing, however progress had been slow due to a range of staff vacancies.

The provider was making a number of changes to the Manor House Nursing Home with the goal to provide good quality dementia care. A representative for the home told us that refurbishment work was on-going and the home were looking at ways to develop best practice in dementia care.

Staff commented on the positive changes being made since the registered manager had come into post. One nurse told us "we have very good support, I feel very supported. There are a lot of changes. Morale is better since the new manager came. The changes are good." Another staff member told us the manager was "approachable" and "she checks if you are OK" and "It's [the home] managed well. I am very happy working here." Staff however felt that a lack of staff had caused stress for staff and affected their ability to provide a high quality service.

Staff told us that one to one meetings gave them an opportunity to discuss what was going well in their role, any areas for improvement and training and development needs. A nurse told us there was a plan to have nursing students at the home and said "I am going to do mentorship training."

The provider monitored and provided support to the registered manager. The registered manager had been in post at the Manor House Nursing Home since November 2013. We spoke with a representative of the provider who

Requires Improvement

# Is the service well-led?

told us that frequent support was provided. The registered manager told us they had access to support if needed and had recently agreed changes to agency staffing within the home.

Staff had knowledge of the whistle blowing procedures for the organisation and told us they would raise any concerns to CQC or the local authority safeguarding team if they felt the provider or registered manager hadn't acted on them. Staff told us that they felt confident that the manager would act on any concerns they raised. Staff meetings were arranged and these enabled staff to talk about their concerns.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision<br><br>How the regulation was not being met: The provider and registered manager did not have systems to protect people against the risks of inappropriate or unsafe care and treatment as they were not effectively or regularly assessing and monitoring the quality of services provided. They were also not identifying, assessing and managing risks relating the health, welfare and safety of people using the service, staff and others. Additionally they were not making changes to treatment or care provided to reflect information relating to analysis of incidents that had the potential to result in harm to a person. Regulation 10 (1)(a)(b)(2)(c)(i). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br><br>How the regulation was not being met: The provider and registered manager were not ensuring people were protected against the risks associated with the unsafe use and management of medicines as they did not have appropriate arrangements for the recording, handling, using, safekeeping, dispensing, safe administration and disposal of medicines. Regulation 13. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing<br><br>How the regulation was not being met: The provider and registered manager had not ensured the health, safety |

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
| --- | --- |
| | and welfare of people by taking appropriate steps to ensure that, at all times there were sufficient numbers of suitably qualified, skilled and experienced persons employed in the home. Regulation 22. |
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse<br><br>How the regulation was not being met: Staff were not always reporting safeguarding concerns to the management of the home. Regulation 11 (1) (a)(b). |

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 | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br><br>How the regulation was not being met: The provider and registered manager had not taken proper steps to ensure that each person was protected against the risks of receiving care or treatment which is inappropriate or unsafe. This was because they had not carried out appropriate assessment of people's needs. They were also not planning and delivering care and treatment to meet the person's individual needs and ensure their welfare and safety. Regulation 9 (1)(a)(b)(i)(ii)(iii). |

**The enforcement action we took:**
Warning notice issued to the provider: Embrace (England) Limited and the Registered Manager: Jane Ritchie.