Madeley Manor Care Home Limited

Madeley Manor Care Home

Inspection report

Heighley Castle Way
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Crew
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Ratings

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

Overall summary

We inspected Madeley Manor Care Home on 10 November 2014. Madeley Manor is registered to provide accommodation, personal and nursing care for up to 42 adults who need support with physical health problems or have dementia care needs. The service also provides short-term respite care to adults who need support with physical health problems. On the day of the inspection, 32 people were using the service and care and support was provided over three floors.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

People were not always protected against the risk of abuse because staff did not always recognise abuse and take appropriate action.

Summary of findings

People were at risk of receiving unsafe care because their care records were not always up to date to reflect the support they needed. Some people did not have risk assessments or care plans in in place to guide staff oh how their care should be provided.

Care records were not stored safely and securely. One person's care records could not be located in order for their care to be reviewed.

Staff were not always available to provide people with care and support when they needed it. We saw that people in communal areas did not have access to call bells. This meant that people with complex needs had to shout for assistance when they needed support.

Provider did not have effective systems in place to ensure that the quality of the service they provided was monitored and acted on effectively.

People's medicines were not always managed safely. Guidance was not always available for staff on how 'as required' (PRN) medications should be administered safely. Systems for managing medicines in stock were not effective.

People told us and we saw that fresh fruit were not always available for people who used the service. There was limited choice available to people during meals. People's food and drink intake including their weights were not monitored effectively to ensure that they remained healthy.

The provider did not always maintain accurate records to demonstrate people's wishes not to be resuscitated (DNAR) in case of a cardiac arrest.

Legal requirements of the Mental Capacity Act (MCA) 2005 were not always followed when people were unable to make certain decisions about their care. This meant that people's liberties were at risk of being restricted. The Mental Capacity Act 2005 and the DoLS set out the requirements that ensure where appropriate; decisions are made in people's best interest.

People's preferences on how they wished to receive care were not always respected. People cared for in their bedrooms were at risk of isolation.

People told us that staff were caring and understood their needs. The provider offered a range of diverse social activities which people enjoyed.

People who used the service told us that they knew the registered manager and the deputy and felt that a manager was always available and they were also approachable.

We identified that the provider was not meeting some of the Health and Social Care Act 2008 Regulations we inspect against and improvements were required. You can see what action we have told the provider to take at the back of the full version of the 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?
The service was not safe.

People were not always protected against the risk of abuse because staff did not always recognise abuse and take appropriate action. Risk assessments and management plans were not always up to date to indicate the support people during emergencies. People's care records did not always reflect the care they received. Staff were not always available to provide people with support and assistance when they needed it. People's medicines were not always managed effectively.

Inadequate

Is the service effective?
The service was not always effective.

People were not always given a variety during meals and were not always supported to eat and drink enough and maintain a balanced diet. Legislation was not consistently followed when people lacked the capacity to make certain decisions. People's liberties were not unlawfully restricted. People were supported by staff who understood their needs.

Requires Improvement

Is the service caring?
The service was not always caring.

People told us that care was sometimes rushed and we saw that care was task-led. People told us that the staff were caring and kind to them. People cared for in their bedrooms were at risk of isolation. We saw that people were treated with dignity.

Requires Improvement

Is the service responsive?
The service was not always responsive.

People's needs were assessed before they started using the service. However, they did not always have care plans with regards to how they wish to receive care and support. People's personal preferences with were not always respected. Complaints made were handled in line with the provider's complaints procedure.

Requires Improvement

Is the service well-led?
The service was not well-led.

The provider did not have effective systems in place to assess and monitor the quality of the service delivered. Auditing systems which were in place had not identified shortfalls within records held by the service. There were widespread shortfalls in the way the service was led. People who used the service and staff told us that registered manager was approachable and supportive.

Inadequate

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014

This inspection took place on 10 November 2014 and was unannounced.

Our inspection team consisted of two inspectors, a specialist advisor with knowledge of nursing care to people with complex needs 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. The expert by experience had experience of caring for people with mental and physical health problems.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report

We reviewed information held on our system about the service. This included notifications that the provider had sent to us about the care and information we had received from the public and the local authority. We used this information to formulate our inspection plan.

We obtained information from the local authority's safeguarding and commissioning teams to identify if there were any current concerns. There were no ongoing adult protection referrals for this service at the time of the inspection and commissioners had not received any recent complaints about the service.

We spoke with 13 people who used the service and four relatives. We also spoke with a nurse, six care assistants, the deputy manager, the registered manager and a management consultant who the provider had employed for the service.

We looked at 10 people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service. We observed how general care was provided and carried out a lunchtime observation to see how people were supported during meals.

Inadequate

Is the service safe?

Our findings

We saw in care records that one person with complex needs had been found by staff with the nurse call cable around them. 'Please observe' was recorded in their care notes following the incident. A staff member told us that they carried out observations of the person following the incident but expressed concerns that the records had not provided clear management plans for the person and were unclear as how to protect the person from further harm. Staff we spoke with were aware of the different forms of abuse; however, they did not feel that this had to be reported as safeguarding although we saw the person may be at risk. A safeguarding referral aims to notify the local authority's safeguarding team about a concern so that appropriate interventions can be put in place to prevent and to protect people from abuse. This was a breach of Regulation 11 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulations 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always have up to date risk assessments to identify the level of support they required with their mobility in the event of an emergency evacuation. People's personal emergency evacuation plans (PEEP) were not up to date. The registered manager told us, "The personal evacuation plans need to be reviewed weekly. We had a resident last week whose name isn't here [service evacuation plan]". We spoke with a relative who told us they had concerns about people cared for on the top floor because a staff member could not explain to them how these people would be evacuated in the event of an emergency. A recent fire inspection by the fire and rescue service had identified concerns regarding evacuation plans. These concerns meant that in the event of an emergency, relevant information required to evacuate people safely would not be available.

People's care records were not kept securely and staff had difficulty finding people's records when we needed it. We requested the care records of one person who had pressure ulcers to check if they received pressure ulcer care as planned. However, the person's care records could not be located on the day. We saw that people's care records were kept in the main lobby of the home and they were easily accessible to people who visited the service. We brought this to the attention of the registered manager and the deputy manager for their action.

We saw signage on two people's door that said "Barrier nursing". This meant that these people required specialist care and support in isolation from other people who used the service as a result of an infection. We reviewed their care records and found there was no reference to them having an infection or to their need to receive barrier care. The registered manager and the deputy manager informed us that one of these people had the infection but the other person was barrier nursed as a precautionary measure. Staff we spoke with told us that both people needed to be barrier nursed because they had an infection. This information was not reflected in both care records.

The concerns above relating to people's care records showed that there was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "I am waiting for someone to attend to me; I have been up since 8:00 am. I had my breakfast at about 8:30am but haven't got dressed or anything". We heard one person calling out for staff a number of times but there was no staff member available to attend to them. We asked them if they needed any assistance and they said, "I'm waiting for a nurse; no one comes. I'm waiting to have my bag (catheter bag) done". A staff member came shortly afterwards and took the person to have their catheter bad emptied. We observed another person trying to get out of their wheelchair unaided but there were no staff there to support them to move. When a staff member arrived, they told them they wanted support to go to the toilet but they had waited over 10 minutes.

We noted that people were left unattended for long periods when staff were at other parts of the building. People had complex needs and did not have access to a call button in the lounge areas. We spoke to people who told us they had to call out for help or wait for assistance if they needed support. The concerns above showed that there was a breach of Regulation 22 of the Health and Social care Act, 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

One person had not had their medicines to help them sleep, for four days. The nurse administering medicines on the day told us that the medicine was out stock. We brought this to attention of the deputy manager who checked and saw that the medicines had been ordered and was now available but the nurse not aware of this.

Guidance was not always provided on how and when people should be given 'as required' (PRN) medicine. The nurse we spoke with told us that most of the people could communicate when they needed PRN medicines. However we saw that not everyone who used the service could communicate when they needed these medicines. The deputy manager told us they used picture charts to find out if people needed PRN medicines. However, the nurse administering medicine on the day did not know about the chart or where it was located it to support people to communicate.

We observed medicines being administered and noted that the staff member administering the medicines checked that it was being administered to the right person and waited to make sure that the medicine had been taken before leaving. We saw that people were not rushed during and the nurse explained to people what their medicine were for. We saw that people's medicines were stored securely.

Requires Improvement

Is the service effective?

Our findings

Some people had Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) agreements in place. However, the agreements did not always indicate if the decision had been discussed and/or agreed with the person or where necessary, with a nearest relative or other professionals. We saw that where the forms had indicated that the person lacked capacity to make decisions, best interest assessments did not always take place to indicate that the decision was made in the person's best interest. This meant that in the event of a cardiac arrest, these people were at risk of not receiving care according to their wishes.

We saw that when people had been assessed as lacking the capacity to make certain decisions assessments had not always identified what decisions could be made in their best interest. Staff we spoke were aware of the Mental Capacity Act but did not demonstrate an understanding of what was required if a person was deemed to lack the capacity to make certain decisions. The Mental Capacity Act 2005 (MCA) sets out requirements that ensure that where appropriate, decisions are made in people's best interests when they are unable to do this for themselves.

We asked people if they always had a choice during meals. Most people told us that a variety was not always available. One person said, "They [staff] just keep saying: "try, try" if they did not like what was offered during meals". Another person said, "We have to have what's given to us". Staff had informed us earlier on in the day of only one meal option for lunch. However, another option was made available during lunch. We observed during lunch that some people asked for fresh fruit and this was not available. One person told us, "I'd like a bit more fruit if there is any in the kitchen". Another person told us, "I've had to provide my own fruit because they haven't got any fresh fruit: the biggest issue here has been my diet".

One person had a condition that affected their muscle coordination. The person told us that the staff understood their needs and how to provide them care and support. Their relative said, "The carers seem to be spot on". We observed how care was provided to the person and so that the person was supported appropriately by staff. Staff told us that they had obtained additional guidance from the internet on how to support people who had this type of condition. This showed that the person received care from staff that understood their needs and knew how to care for them.

We observed members of staff using moving aids to transfer a people who had been assessed as requiring such assistance to move. We saw that the staff took time to explain to the people what they were about to do and obtain their consent before they proceeded to move the person.

People we spoke with did not express the wish to leave the services and we did not see that the people's liberties were deprived or restricted inappropriately. Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (2005). They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The registered manager gave us examples of when they had applied to have a person's liberty deprived but told us that no one was currently subject to DoLS and no applications had been made to deprive anyone of their liberty. Staff we spoke with demonstrated an understanding of the principles of Deprivation of Liberty Safeguards (DoLS) and gave us examples of when these could be applied.

We saw that health care professionals visited the service regularly to ensure that people received appropriate care that met their needs. Visiting health care professionals told us that staff made regular contact with them when there were concerns. A GP visited the home regularly to review people's healthcare needs.

Requires Improvement

Is the service caring?

Our findings

We observed that the morning period was the busiest time of the day with staff supporting people with their personal hygiene. We saw that people's needs were sometimes ignored during this period. One person said, "They [staff] are busy messing about and I'm, sick of it". We saw that those who required the use of a wheelchair to mobilise were brought to the lounge and left sitting in their wheelchairs for long periods while staff went to provide care and support to other people. We observed that the people were sat watching the television for most of the morning period. We noted that staff interacted during this period mostly when they came to engage in a particular activity with them such as to offer a drink or assistance of some sort. This showed that care was task-led.

Three people told us they had not been involved in decisions about their care. We saw that their relatives were involved in decisions about their care and not the people themselves. These people were able to make certain decisions about their care.

People told us that staff were kind and one person said, "They [staff] are a nice lot to be with. They are helpful and make you feel at home". When staff were less busy, we observed good interactions between them and people who used the service. We saw a staff member go round to enquire from the people if they were comfortable and asked how to help them get more comfortable. The staff member then covered some people's legs with blankets to keep them warm and put other people's feet on foot stools on their request.

We saw that staff spoke with people respectfully and treated them with dignity. We saw that staff knocked on people's doors and waited before entering their rooms. We saw that when staff moved people using hoists, they ensured that the people were covered so that their legs or other parts of their body were not exposed. We saw that staff explained to people what they about to do before using hoists to move them or to transfer them from one place to another. This helped to ensure that people felt included and less anxious during the moving and handling process.

People told us that no restrictions had been places as to when they could be visited by their relatives and friends. Relatives visiting on the day told us that they visited whenever they wanted and were made to feel welcome. Relatives we spoke with told us that they could visit their relatives in their rooms if they wished and the staff were always supportive of this.

Requires Improvement

Is the service responsive?

Our findings

One person told us they preferred having showers but they were assisted with washes instead. The person's care record said they preferred to have a shower but we saw that the only shower was on the top floor which the person could not access. The person said, "I asked if I could have a bath this morning but no one came to me". The person told us they had not had a bath for several months. Staff we spoke with confirmed this, saying that this was because a suitable shower room which the person will be able to access with their wheel chair was not yet available. Two other people who told us they preferred baths or showers but they had been receiving only washes for over a week. Their daily care records confirmed this. This meant the provider had not responded to how these people wished to receive care and support.

There were mixed views about activities which people enjoyed at the service. People who could not mobilise and spent most of their time in their bedrooms felt that there was a lack of stimulation for them. One person of these people said, "The only activity I get is sitting here doing my knitting". A relative said, "A lot of people on the higher floor are isolated. I worry about them". We saw that there was minimal social interaction between people who lived on the top floors who required assistance with their mobility to access the lounges downstairs and/or those who were cared for mainly on their beds. We saw that most of the interaction they received was when staff went to provide them with care or to give them food or drink or when they had visitors. One of the people responsible for activities told us time was allocated to spend with people who were cared for in bed but we did not see this happening on the day. We observed the people downstairs engaged in a variety of activities but this was not same for those on the top floors who stayed in their bedrooms.

One person said, "I like a game of dominoes; a chap comes on a Wednesday and plays with us". The registered manager told us that staff had taken one person to a local football stadium because the person was a fan of the football club. The person responsible for coordinating activities told us they had carried out an analysis of people's abilities with the new registered manager. This included their likes and dislikes and used they used this information to plan activities. People told us that meetings took place where people who used the service decided on what activities they wished to engage in. We saw that activities had been planned for the weeks ahead. People told us they had taken part in discussions about these activities and were looking forward to them.

People told us that a pet dog and its owner came to the service on a fortnightly basis. The registered manager said, "People absolutely love the dog coming in". The provider called this "Pet Therapy". We saw that there were scheduled days for the dog to be brought to the premises and people told us that they enjoyed having the dog around. Some people told us they went out on trips and they had recently gone a trip to a garden centre which they enjoyed.

People told us that they would speak to any of the managers or to any member of staff if they had concerns. One person said, If I had a complaint, I would just peak to the carers". A relative told us that they had raised a complaint in the past and felt that it was deal with appropriately. W The provider had a complaints policy and procedure in place. We looked at records of complaints made and saw that the complaints had been responded to appropriately.

Inadequate

Is the service well-led?

Our findings

The provider carried out regular audits of the service and maintained a clear audit trail of audits and actions taken. However, we saw that systems put in place for managing people's medicines were not effective because care staff were not always aware that medicines which had been ordered had arrived. This meant that people were at risk of not having their medicines.

We saw that care record audits had not identified that people had not being weighed regularly. Some of these people were on dietary requirements and had to have their weights monitored regularly to ensure that they remained healthy, but this was not happening regularly. Care plan audits had not identified that some people did not have up-to-date risk assessments or care plans.

We noted that some accidents had not been recorded in the provider's accident monitoring records. Therefore, systems put in place for monitoring accidents and incidents were not effective. The provider had not ensured that people's views with regards quality of the care they received were obtained regularly. This meant that people were at risk of not receiving quality services.

The provider did not have systems in place to ensure that resources needed to provide people with care were available when required. Staff told us supplies such as groceries and continence aids were not always available because they were either not being ordered in a timely manner or had not been supplied due to concerns with financial arrangements. They told us that because of this people sometimes did not have the food they wished for or other items for their personal hygiene. Staff told us that the service was in need of some basic equipment but the provider had not bought them. We saw that a recommendation had been made following a recent food and hygiene inspection for some equipment to be put in the kitchen to prevent cross contamination but this had not happened.

Concerns relating to people's care and welfare were not always identified; and were not always acted on to ensure that people received quality services. Care and support provided to people was not always guided by good practice. Staff told us that they did not always receive the support they required to enable them carry out their roles effectively. All these concerns showed that there were widespread shortfalls in how the provider ensured that quality services were provided.

These concerns meant that the provider was in breach of Regulation 10 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the provider organised meetings and they were encouraged to take part and share their ideas about the services provided at the home. The provider had carried out surveys to obtain the views of people and their relatives about services. We saw that the provider had acted on some of the suggestions made and others had not been acted on. The registered manager told us there were plans to complete renovations work which had begun but slowed or stopped down due to other priorities.

People told us that they knew who the managers were and that the registered manager or their deputy was always available and were approachable. A relative said, "The manager is around most of the time and seems to be nice". The registered manager said, "I never leave the home without someone to take responsibility for things". They told us that they carried out daily rounds to chat with people and to find out if they had any concerns they wished to discuss. This ensured that someone in authority was always available to deal with people's concerns.

Staff told us that they received supervision and staff meetings took place. These were opportunities for them to express their concerns. Staff told us that the registered manager was supportive and they could approach them if they had any concerns. They told us that the registered manager acted on their concerns. One staff member said they had raised concerns about the need for some safety equipment and the registered manager took appropriate action. Specific roles and responsibilities such as an 'infection control champion' and a 'Fire safety Champion' had given to some staff members. However, we identified concerns with how risks to people were managed where people had infections which could be passed to other people.

Inadequate

Is the service well-led?

The provider supported apprentices and volunteers to gain work experience at the service. We spoke with a volunteer involved in administrative duties. They told us they enjoyed working for the provider and had learned a lot during their time at the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not respond appropriately to allegations of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not protected against the risks of unsafe care because the provider did not keep accurate records in relation to people's care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems were not in place to identify, assess and manage risks to protect people against the risks of receiving inappropriate or unsafe care. The provider did not regularly assess and monitor the quality of care provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There provider did not take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons to provide care.