

Essington Manor Care Home Limited

# Essington Manor Care Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

Essington 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. Essington Manor accommodates 41 people in two buildings that are adjoined and support is provided on two floors.

When we completed our previous inspection on 17 January 2017 we found concerns as medicines were not always administered as prescribed and there were no system in place identifying stock levels within the home. We also found improvements were needed as people felt there could be more to do in the home. We could not be sure the needs of people living with dementia had fully been considered. The provider was rated as requires improvement overall. At this inspection we found improvements had been made however further improvements were needed. This is the second consecutive time the service has been rated Requires Improvement.

We found that risk assessments were in place for individuals however when changes occurred these had not always been considered and reviews taken place. Correct medicines management procedures were not always followed in the home so we could not be assured that risks associated with medicines had been fully considered.

We received mixed views on staffing levels within the home and some people felt this could improve. We saw that interaction from staff were positive however this was often when they were competing a task with someone. Improvements were needed as to how agency staff were inducted to ensure they had all the relevant information. Some staff were not trained in areas they were supporting people with.

People who lacked capacity were not always supported to have maximum choice and control of their lives. The policies and systems in the service did not support this practice. We have made a recommendation about decision specific assessments to support people when they lack capacity.

Quality audits were not consistently completed and the information was not always used to drive improvements within the home. There were no current systems in place so that improvements could be made and lessons learnt when things went wrong. When people and relatives identified areas for improvement we could not see how this information had been used to make changes.

People enjoyed the food and were offered a choice and people's individual needs and preferences were considered in this and other areas. When needed people had information available to them in different format to help them understand the choices they were making. We found people were happy with the staff and the care they received. People's cultural needs had also been considered by the provider. People were encouraged to remain independent and make choices for themselves, including the activities they participated which people felt had improved. People's privacy and dignity was also considered. When people needed support from health professionals this was provided for them and the registered manager

worked in partnership with these agencies.

Staff understood safeguarding procedures and when to report concerns. Staff working within the home had checks to ensure their suitability. The provider had considered end of life support for people and this was individual to people's needs and wishes.

There were infection control procedures in place and these were followed by staff. The provider had received no complaints however people knew how to complain and felt they would be listened to. Staff felt supported by the management team and were happy to raise concerns.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

We could not always be sure that risks associated to the administration of medicines had been fully considered and that correct procedures were always followed. Risks to people were not always reviewed when changes occurred. There were mixed views about staffing levels within the home and support people reviewed was often task focused. When incidents occurred or things went wrong within the home there were no current systems in place so that improvements could be made and lessons learnt. Staff understood safeguarding and when to report concerns. The provider ensured staffs suitability to work within the home. Infection control procedures were in place and followed.

**Requires Improvement** 

### Is the service effective?

The service was not always effective.

Some capacity assessment were in place however all areas had not always been considered. There was not always evidence as to how best interest decisions had been made. Some staff supported people without having the relevant training and agency staff did not always receive the relevant induction. People enjoyed the food and were offered a choice. People had access to health professionals when needed. The home was clean and decorated.

**Requires Improvement** 

### Is the service caring?

The service was caring.

People were supported in a kind and caring way by staff they were happy with. People's privacy and dignity was protected and they were encouraged to maintain contact with people who were important to them. People were encouraged to remain independent and make choices.

**Good** 

### Is the service responsive?

The service was responsive.

People were supported to receive care that was individual to them. People's cultural needs were considered. People had the opportunity to participate in activities they enjoyed and knew

**Good** 

how to complain.

**Is the service well-led?**

The service was not always well led. Quality monitoring systems were in place however this information was not consistently completed or used to drive improvements within the home. Feedback was sought from people and relatives however this was not always used to bring about changes. There was a registered manager in post who understood their responsibilities around registered with us. Staff felt support and listened to and The registered manager worked in partnership with other agencies.

**Requires Improvement** 

# Essington 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.

Essington Manor is a care home. People in care homes receive accommodation and 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. Essington Manor is registered to accommodate 43 people in two large houses which are connected through a walkway. At the time of our inspection 41 people were using the service. Essington Manor accommodates people in the two buildings and support is provided on two floors. There are two communal lounges, two dining area, two conservatory and a large garden that people can access.

This inspection visit took place on the 16 January 2018 and was unannounced. The inspection visit was carried out by two 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.

The inspection was informed by feedback from members of the public, the local authority and Healthwatch. We also checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service. We reviewed the quality monitoring report that the local authority had sent to us. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this to formulate our inspection plan.

We spent time observing care and support in both the communal areas. We observed how staff interacted

with people who used the service. We spoke with six people who used the service and three relatives. We also spoke with the registered manager who is also the provider and three members of care staff, the activity coordinator, the hairdresser and two visiting health professionals. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at the care records for eight people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service, including quality checks and staff files.

# Is the service safe?

## Our findings

At our last inspection we found improvements were needed as medicines were not always administered as prescribed and there were no systems in place identifying stock levels within the home. At this inspection we found some improvements had been made, however further improvements were needed.

During our inspection we saw that a tablet was accidentally dropped on the floor and therefore not administered. Later, we checked to see what action had been taken following this and what procedures had been followed. Although the registered manager and the staff member administering the medicines told us this had been discarded correctly and a replacement tablet ordered, on checking the medicines administration record (MAR) we saw this had been signed as given. As this medicine had not been administered to the person this meant the records were inaccurate. On our request this was rectified. This meant that records were not always completed in line with guidance as this medicine had been signed for before it had been administered safely to the person. Furthermore we observed that another person was sitting at the table with their medicines. They told us that staff gave them their tablets in their room each morning and that they brought the tablets down to the dining area to have with their breakfast. There was no risk assessment or guidance in place in relation to this and this person was not self-medicating. The staff member who signed for the medicine did not observe these tablets being taken. As there were other people sitting at the table with this person and no staff member was supervising, this meant there was an increased risk that the wrong person could take these medicines. Therefore we could not always be sure that risks associated with the administration of medicines had been fully considered.

Other people received their medicines as required. One person said, "I am happy with how the staff look after my tablets for me, they are very good with them". We saw staff administering medicines to people. The staff spent time with people explaining what the medicine was for. When people had medicines that were on an 'as required' basis we saw this was offered to them first. When people had been receiving as required medicines regularly we saw that the GP had reviewed this to ensure it was correctly prescribed. We saw there was guidance known as PRN protocols available for staff to ensure people had these medicines when needed. A daily audit was completed by staff on medicines and we did not see any areas of concern. Stock checks were now being completed by the provider. There were effective systems in place to store medicines to ensure people were safe from the risks associated to them.

Individual risks to people had been considered however risks assessments were not always reviewed after changes occurred. For example, we saw documented that one person needed to be referred to the falls team. We spoke with staff about this as it was unclear why this was needed. One staff member told us, "They keep falling, it's like their legs give way. We find them on the floor or hanging onto the door handle for support". Another staff member said, "They are very unsteady on their feet, it's been going on for a few months". They went on to say, "We raise our concerns with the support manager and then they would complete the relevant paperwork". We looked at the risk assessment for this person and in January 2018 their risk assessment had been reviewed and they were identified as being 'low risk'. The information staff had shared with us had not been considered as part of this review. Furthermore on checking other records we did not see any documentation including incident forms in relation to this. During our inspection we



observed this person was unsteady when mobilising. We asked staff how they offered support to this person. One staff member said, "We keep an eye on them. If we see them stand up if we can, we go and offer support". Another staff member said, "We observe them all the time and we don't let them walk independently". We saw that this person mobilised around the home independently at times. There was no information recorded as to how this person should be supported to keep them safe whilst advice was sought from other professions. We saw similar concerns for another person.

When other risks had been identified for people we saw risk assessments and care plans were in place, for example when people were at risk of developing sore skin or at risk of weight loss. When people needed equipment to keep them safe we saw the provider had maintained and tested this to ensure it was safe to use. We saw plans were in place to respond to emergencies. These plans provided guidance and information on the levels of support people would need to be evacuated from the home in an emergency situation. The information recorded was specific to individual's needs. Staff we spoke with were aware of the plans and the support individuals would need.

When incidents occurred or things went wrong within the home there were no current systems in place to show that improvements could be made and lessons were learnt. We spoke with the registered manager who confirmed that they were not currently completing this and recognised it as an area of improvement.

We received mixed views about staffing levels within the home. One person said, "If there are only two staff on I have to wait. I would like to be up by 08:30 but it's usually 10am. I wake up about 6am I don't have a hot drink until I come down. I'm parched". We saw on the day of our inspection this person did not come downstairs till after 10am. Another person told us, "The staffing levels are reasonable, some days are better than others, no complaints though". During our inspection we saw that staff were busy and interaction with people were often task focused. For example, when people needed support with meals or personal care. We observed in both communal areas there were times where staff were not present and people slept for long periods. We saw that staff other than care staff were available in communal areas for people however, people and relatives commented that this was something that did not usually happen. One relative said, "There's not normally a disco gang on, this doesn't normally happen". Staff felt there were enough of them available and felt the registered manager had made positive changes to staffing levels when they had raised concerns. The registered manager told us they used a dependency tool to work out staffing levels within the home and were confident there were enough staff available for people. However discussions with people and our observations demonstrated that the staffing levels in place did not always ensure people's social needs and preferences regarding their daily routine were met.

We looked at four recruitment files and saw pre-employment checks were completed before staff could start working in the home. This demonstrated the provider completed checks to ensure the staff were suitable to work with people in their home.

Staff were able to tell us about how to recognise abuse and the actions they would take if they were concerned about people. One member of staff said, "It's keeping vulnerable people safe". Another staff member told us, "It's reporting abuse if you have concerns". They went on to say, "I would report it to whoever is in charge". Staff were confident any concerns they raised would be dealt with appropriately and action taken when needed. The registered manager told us and records confirmed that when concerns were identified they had been reported in line with safeguarding procedures. This showed us the registered manager and staff understood how to keep people safe from potential harm.

There were infection control procedures in place and the home was clean and well presented. We saw an audit was completed by the provider in this area and schedules were in place to ensure the environment

was cleaned. Staff told us and we saw protective equipment including aprons and gloves were used within the home. We also saw the provider had been rated as five stars by the food standards agency; this is the highest rating awarded. The food standards agency is responsible for protecting public health in relation to food.

## Is the service effective?

### Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so or themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked to see if the provider was working within the principles of MCA. We saw when needed that some capacity assessments had been completed, these were not always individual to the area that was being assessed. We saw that one capacity assessment covered three areas including, constant supervision, personal care and administration of medicines. For some other area's capacity assessments were not always in place. For example, when people were using bedrails or sensors. When capacity assessments had been completed we did not always see how the decisions had been made. Although the capacity assessments demonstrated who had been involved with the decision making process there was no evidence that decisions had been made in people's best interests and why the decisions had been reached. Furthermore, we saw that some relatives had consented on behalf of their relation when they did not have the legal power to do so. This meant we could not be assured the principles of MCA were always followed.

We recommend that the provider seek advice and guidance from a reputable source, to assess the capacity in relation to specific decisions for people living at the home.

Staff demonstrated an understanding in this area and were able to tell us how they gained consent from people. One staff member said, "It's when people lack capacity to make decisions for themselves and need support from people close to them to keep them safe". Another staff member said, "Even though someone might not have capacity they can still be involved with decisions and we encourage them to make choices such as if they want to get up or where they want to sit".

When people had restrictions placed upon them we saw the provider had considered this and made referrals to the local authority. Although there were no authorisations in place the registered manager told us three people had been recently assessed and they were awaiting this information. There was no guidance in place for staff to follow while these applications were considered and some staff did not always demonstrate an understanding in this area. One staff member said, "I would have to check to see who this applies to". And another staff member told us, "I think it's everyone here".

Although staff spoke positively about the induction and training they received, we saw some staff supported people without having the relevant training. For example at lunchtime we observed a staff members handling food who had not had training in this area. On the day of inspection an agency worker was completing their first shift in the home. Although they had received a walk round induction that related to the environment, they had not received an induction that related to people who used the service. We saw

this staff member supporting someone who was at risk of falls, when asked they did not have the necessary information to support this person in a safe way. We asked the registered manager to show us inductions that were completed for other agency workers within the home; they did not offer us this information during our inspection.

Other staff spoke positively about the training they received and told us that their competencies were checked by the quality team. One staff member said, "We have observation, we don't know when they are doing them. They will check anything, how we speak with people, how we record things and if we are moving people correctly". Another staff member told us, "It's good we have feedback after so it makes you think". We saw that staff carried cards that could be used as prompts in areas they had received training in.

People enjoyed the food and were offered a choice. One person said, "The food is excellent". Another person told us, "I have no concerns with the food, always a choice, very hot and very enjoyable". At breakfast and lunchtime we saw people were offered a choice and had a range of different meals. There were pictorial menus available for people in the home to support them to make choices. When needed staff spent time with people and offered them support. We observed that people were supported in line with their care plans and when people needed specialist diets this was provided for them. If people had individual preferences, such as vegetarian diets we saw this was provided for them. Throughout the day people had cold drinks available to them and hot drinks and snacks were offered. Records we looked at included an assessment of people nutritional risks.

People received support from health professionals when needed. During the inspection we saw professionals were in the home including the district nurses and one person was having an assessment from a speech and language therapist following a referral that had been made by the home. The registered manager told us they work jointly with health professionals to ensure they delivered effective care and support. One visiting health professional commented, "We find the home good, they follow our recommendations".

We saw the home was clean and decorated in accordance with people's preferences. People's personal belongings were in their room, including photographs of people who were important to them. The registered manager told us how people were involved with decorating the home and how this was discussed in the resident and relative forums. One of the rooms had been transformed into a reminiscence room and there were objects and equipment available for people to use to help them reminisce, during our inspection we saw staff supporting people with this. There was a large garden area that was suitable for people to use and in the summer people confirmed to us they liked to go outside.

## Is the service caring?

### Our findings

People and relatives we spoke with told us they were happy with the staff. One person said, "I get on well with them all, there isn't a bad one at all" A relative told us, "The staff are very friendly and will go out of their way if you ask them to do something". We saw positive interactions from staff throughout the day. When staff had time they spoke with people in a caring way and offered them support. For example, we saw when staff were transferring people using equipment they offered reassurance and one staff member held the persons hand. During lunchtime people received support when needed and staff spoke with people during the duration of their meal. This meant people were supported in a kind and caring way.

People's privacy and dignity was promoted. One person said, "I find they are good with my dignity, they treat me with respect". Staff gave examples of how they treated people with respect and promoted their privacy and dignity. One staff member said, "We close doors and just consider people's privacy. I always think what I would like in those situations". Another staff member explained that people liked to look nice and clean and have their hair nice so they felt more dignified. When people were supported with specialist equipment we saw people's clothes were adjusted to maintain their dignity.

People were involved with making choices. One person said, "I like to pick my clothes and beads each morning, they know I like to look glam". We saw staff offering people choices about what they would like to do and where they would like to sit. One staff member explained why this was important, "When people live in groups its essential they keep what's important to them. We should remember they are all still individuals and like different things, that's why I always ask people, even if they always sit in the same chair I ask". Records we looked at reflected how people made choices and what was important to them.

People's independence was promoted. One person said, "I do as much as I can for myself and if needed they staff step in". Staff gave examples of how they encouraged people to be independent. One staff member said, "It is just giving people the power back to do it for themselves". The care plans we looked at showed information about the levels of support people needed for example with meals. This demonstrated people were supported to maintain their independence.

Relatives and visitors we spoke with told us the staff were welcoming and they could visit anytime. A relative said, "They are all very friendly, I come whenever I like. My relation sometimes pops in later during the evening and it's not a problem". We saw relatives and friends visited throughout the day and they were welcomed by staff.

## Is the service responsive?

### Our findings

At our last inspection we found improvements were needed as people felt there could be more to do in the home. We could not be sure the needs of people living with dementia had fully been considered. At this inspection we found the provider had made the necessary improvements.

People had the opportunity to participate in activities they enjoyed. One person said, "Much better now more to do". Another person told us, "We have the opportunity to take part in events". Since the last inspection an activity coordinator had been appointed and was working within the home. They told us, "We decide what activities we are doing based on what people tell us they like. In the summer we go outside a lot. Some people like balls games where as other just like to have a chat. We try to have a mixture of group and individual activities for people". During the inspection we saw people were involved with exercise classes, some people were having their nails done and others were reminiscing with staff. A hairdresser was also employed by the home and people could have their hair done if they wished. The registered manager told us that they had been in contact with an external wellbeing and activity programme that had offered ideas how to support people. We saw that an activity took place each morning which encourage people and staff to get motivated.

Since the last inspection we saw that people's dementia had been considered and some improvements had been made. For example we saw bathrooms had signs on so they were easier for people to identify. The home was using coloured plates at mealtimes and more pictures were used around the home to help support for people. For example, there was a pictorial activity planner in place.

Although the home wasn't currently supporting anyone with cultural needs this had been considered. The registered manager told us how they had started to consider how information was presented to people and to ensure it was accessible for them. For example, when people had visual impairments discussions had taken place between the registered manager and the person as to how information could be best presented. We saw some people used equipment that offered them support, for example one person had a talking watch. The home was working on implementing protected characteristic and information was displayed around the home in relation to this. The registered manager told us this was an area that they were currently developing.

When people were receiving end of life care we saw that plans were in place to offer support to people with this. These plans were individual to people's needs and choice, and there was clear guidance in place for staff to follow. For example, how people wanted their environment. When people needed medicines, plans were in place for this and these were available for when needed.

People knew how to complain. One person said, "I would raise my concerns with the manager". A relative told us, "I would speak with the manager first, I know how to make a formal complaint if needed, I am sure action would be taken". There had been no complaints made since our last inspection and no one we spoke with had made a complaint so could not comment of how this had been dealt with by the provider. The provider had a complaints policy in place and the registered manager told us how they would respond to

any that were made. This demonstrated there were systems in place to deal with concerns or complaints.

## Is the service well-led?

### Our findings

Quality checks were completed within the home, however as these were not consistently completed the provider could not always demonstrate how these were used to drive improvements. For example the registered manager told us they completed a twelve week audit of incidents and accidents within the home. As the previous audit had not been completed the last audit had taken place in August 2017. Although some action had been taken following each incident, no trends or analysis were being completed or action plans produced to drive improvements or make changes to the service. We saw that other monthly audits had not been completed since September or October 2017, this included nutrition and complaints audits.

People and relatives had the opportunity to attend a resident and family forum. We saw that in May 2017 following this an action plan had been produced. However following the forum in October 2017 where family members had identified areas of improvement we could not see what action had been taken and how this information had been used to make changes within the service. We spoke with the registered manager who identified this was an area that needed improvement.

We saw and the registered manager confirmed that areas of improvement were needed with the system that were currently in place within the home. For example in relation to how medicines were managed and the systems that were used to learn lessons when things went wrong.

This is a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

There was a registered manager in post. The registered manager understood their responsibility around registration with us and we had received notifications when significant events had occurred within the home. This meant we could check appropriate action had been taken. The current rating for the home was displayed visibly when entering the home in line with our requirements. The provider does not currently have their own website to display their rating.

All the staff we spoke with felt the registered manager was approachable and would be happy to raise any concerns. One staff member said, "She always listens, they have a walk round where they can see what's happening. We have the opportunity to raise any concerns, action is taken following this". Staff told us they had the opportunity to raise concerns and all the staff we spoke with told us they had the opportunity to attend staff meetings and individual supervisions with the registered manager or quality team. Staff knew about the whistle blowing process. Whistle blowing is the process for raising concerns about poor practices. One member of staff said, "It's raising concerns if you see something that isn't right". We saw there was a whistle blowing procedure in place. This showed us that staff were happy to raise concerns and were confident they would be supported and the concern addressed.

The registered manager told us how they worked in partnership with other agencies. They told us how they were part of groups for wellbeing and activity programmes along with specialist groups which offered support for people with dementia. The registered manager explained how they joined web seminars to



gather ideas and share information. They told us in the future they would use this information within the home.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Quality monitoring systems were in place however this information was not consistently completed or used to drive improvements within the home. Feedback was sought from people and relatives however this was not always used to bring about changes. This is the second time the provider has been rated requires improvement.</p>