Manton House Care Home Ltd

Manton House

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Manton House is a residential care home providing personal and nursing care to 19 people aged 65 and over at the time of the inspection. The service can support up to 22 people. The building has been extended and adapted over time and provides both single and double accommodation on both ground floor and first floor levels with a passenger lift.

People's experience of using this service and what we found:
Our inspection was brought forward due to changes in the providers registration and a number of concerns received about the service and the care people were receiving. During our inspection we were met by the manager who had been in post for approximately four months. They had been employed without delay following the departure of the previous manager. They had started to implement a lot of changes within the service to improve the quality of care people receive and had faced some challenge by specific members of staff who were resistant to change. At the time of our inspection these changes and processes were not firmly embedded within the service and we were not assured of the confidence and competence of the senior team some new to their role.

Although the manager demonstrated a person centred approach to care we found the service was not consistently proving individualised care to people. In our decision making processes when deciding a rating for this service we took into account the history of the service and the role of the provider in ensuring people received continuity of care which met good standards. Safeguarding incidents and incidents were recorded in different places and did not include clear outcomes, or lessons learnt to ensure improvements in care.

During our inspection we were not provided with all the information requested and therefore relied on information provided. An action plan had been implemented and provided but this did not give timescales for each action, or how each action would be clearly achieved and embedded within the service.

New staff had been employed, some at senior level, with no previous experience in care. Although all staff were supported through induction and shadowing existing members of staff, not all staff had the necessary skills in line with their job role. Some staff spoken with had weak knowledge and did not know where to find the relevant support and guidance. Staff training in using electronic recording systems for people's notes was not fully embedded on the day of inspection.

People's health care and behavioural needs were not fully understood by staff. This was in part due to the inexperience of some staff and the uptake of training in relation to people's specific health care needs and impact. Concerns had been raised by other agencies in terms of people's care and this was being addressed.

People's health care needs were recorded but not always clearly escalated when there was a change or unmet need. For example, staff were unclear how much an average person should be drinking or what signs to consider should a person become dehydrated and the impact this might have on other aspects of the

person's health. We have made a recommendation about this.

Medicines were administered by trained staff who had been assessed as competent. We have made a recommendation about using a tool to assess people's pain threshold where people might not be able to verbalise this.

We observed some positive engagement from staff which was appropriate and meaningful but not inclusive of everyone. Some people were observed as having regular engagement with staff whilst the activity levels for other was minimal. People's lunchtime experience could have been significantly enhanced if staff had sat with people and supported and encouraged them to eat and drink.

Two relatives spoken with did not feel the service was inclusive or had kept them in touch with changes in the service. However, the provider had kept families informed of the situation regarding visits during COVID - 19. The provider's quality assurance systems which involved seeking independent annual feedback from people and their families had not happened for two years which meant relatives and health care professionals had not had an opportunity to have their say or influence what the service improvements and priorities should be. The next survey was to be issued in August 2021 and had not taken place before because of the impact of COVID-19.

Environmentally lots of positive changes had been made and any issues identified at the time of inspection were rectified immediately.

We were not fully assured that people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not fully support this practice.

Rating at last inspection
Since the last inspection there has been a change to the provider's registration from a partnership to a limited company. This is the first inspection under their new registration.

The last rating for the service under the previous provider was requires improvement (published on 16/04/2019).

Why we inspected
The inspection was prompted in part due to concerns received about a wide range of issues affecting the health and safety of people using the service. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements across the service. However, the manager provided us with some immediate assurances of the actions they have taken to improve the service following our feedback.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Manton

House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified a breach in regard to the management and overall governance and safety of this service. These concerns relate to the management and oversight of this service.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good

We will request an action plan. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

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Details are in our well-Led findings below.

Manton House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Manton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had an acting manager who is not yet registered with the Care Quality Commission. This means that the provider is solely legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and used this as part of our planning. We also contacted the local authority for their feedback. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We carried out observations throughout the day of our visit, spoke with the manager, the area manager and three staff, which included a senior, deputy manager, and cook. We also briefly spoke with care staff about their interactions with people. We spoke with six people using the service.

We reviewed a range of records. This included three people's care records and medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one health care professional, four further staff and four relatives. We also spoke with the provider.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for a service previously registered which since the last inspection has changed its legal entity This key question has been rated Requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse: Learning lessons when things go wrong

● Some people had behaviours which could cause them or others harm. Staff recognised this and tried to support people in the least restrictive way. A previous safeguarding incident had led to staffs' dismissal and a review of the incident suggested staff had received appropriate training. We however found evidence that not all staff were suitably trained.

● A recent safeguarding incident was still open to the safeguarding team. No supporting evidence was provided by the service as they had not regarded it as a safeguarding episode but were able to provide a reasonable explanation. It should have however be recorded in the safeguarding log and allegations investigated.

● Safeguarding incidents were not always clearly recorded or show what actions were taken to reduce the likelihood of another incident. For example, one incident recorded one person pushing another out of their chair. The record stated for staff to monitor, and report to the safeguarding team. We did not see a corresponding body map, or reference or if the other person sustained any injury or if risk assessments and care plans were updated. Following the inspection the provider sent us additional information to show this had been done..

●Another involved an allegation made by a person using the service. It was not clear what the specific allegation was or how it was investigated. This alleged incident occurred before the new manager came into post, but we would expect the provider to have oversight of any safeguarding allegation and ensure actions were signed off.

● Staff received safeguarding training and supervision to help them identify and recognise what actions they needed to take to keep people safe. Staff had regular opportunity to discuss any concerns and reflect on the care provided within the home. Staff were aware how to escalate incidents of alleged abuse and inform management and the local authorities. Staff told us current management were responsive to their concerns.

Assessing risk, safety monitoring and management

● People had room risk assessments and there were good processes in place to ensure the premises were clean and maintained to a high level of safety. We sampled a number of health and safety records and these were in order.

● A number of staff had key roles which were interchangeable for example the activity person also assisted with catering and other staff supported maintenance. We were not assured all staff had received role specific training for tasks they were asked to undertake.

● During our observations we did identify a number of deficits such as a cracked sink and pipework which

had not been covered. This had not been identified by the service or included on the action plan.
● During our inspection we found individual risks to people were assessed, and steps identified to mitigate the risk. We found however risk assessments and care plans we might expect to see for a person admitted to the service five days earlier were not in place. This meant we could not see a clear plan of care for the person and how risks associated with their declining needs would be addressed in a timely way. There was no admission checklist and baseline information in regard to their eating, drinking, skin care and psychological needs were not clearly documented.'

● Logged incidents were very low and we found examples of incidents that had occurred within the service which were documented in the handover record and, or within the service user record but these were not logged centrally to ensure there could be clear provider oversight and analysis of these. Handover records did not indicate actions taken such as care plan updated. Cross referencing documentation would help provide a clear audit trail.

Using medicines safely

● Prescribed when necessary medicines like pain relief contained some generic guidance which was not specific to the needs of the individual. Not everyone would be able to express their needs and the service did not use a recognised pain assessment tool. The manager said information would be included in the person's communication plan, but this document did not explicitly say how a person might communicate pain.

We recommend the provider consider current guidance on administering medicines required occasionally for both pain relief and ensure instruction for staff are clear as to when it might be necessary for people who might not be able to verbalise their needs.

● Although staff were trained. recent changes to the staff team meant there was not always a staff member trained to give medicines throughout the night should someone require medicines. On call procedures were in place but could result in a delay in someone getting their medicines. This needed to be addressed.
● People were administered their medicines by staff who were adequately trained and assessed as competent to give medicines. Audits helped ensure medicines were given as prescribed. There was guidance in place about medicines and any additional information such as allergies.

Staffing and recruitment

●Recruitment processes were sufficiently robust which ensured staff employed had the necessary skills. A recruitment tracker had been introduced which provided evidence that all prerequisite employment checks were in place.
● Staffing levels were adapted in line with people's needs and a dependency tool was used to ascertain how much time each person required with certain aspects of their care. Recent concerns about staffing raised by a health care professional had been addressed.
● Two out of three planned admissions occurred five days before our inspection. The manager told us additional staff were rostered on to ensure people's needs could be met. The staffing allocation sheet showed staff fluctuations and at times reduced staffing. The manager told us they and the deputy manager both worked on a care shift. This was not included on the staff allocation sheet and should be to give a clear picture of who was working.
● There were some staffing vacancies and recruitment was ongoing. Agency staff were not being used which helped ensure people received continuity.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections. The service however had not communicated clearly to all relatives about visiting arrangements and changing

COVID 19 guidance. Some relatives expressed concern about the minimal contact they had from the service about this and had not all found window visits to be acceptable. The manager told us relatives were provided a choice of visiting arrangements and they would communicate this.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service. We found people admitted were not always immediately isolated from others but there were mitigating factors around this and control measures put in place to reduce the risk.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.
This is the first inspection for a service previously registered which since the last inspection has changed its legal entity This key question has been rated Requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● The admission process to the home had changed to take into account the presence of COVID_19 and the service relied on assessments of the trusted assessors. New admissions were planned but although these were meant to be spaced out two service users arrived at the same time and we found a delay in some of the documentation we might expect to see being implemented for one service user. Their daily notes did not provide a clear overview of how they were settling, or risks being managed. Pre -admission information was found to be inaccurate and this was addressed with the relevant agencies. Additional staffing were provided and the manager felt the admissions were appropriately managed and there was no impact on other people using the service. We felt however there had been a lot of recent changes in the staff team and skills mix and it would be advisable to space out admissions to ensure there was no impact on the care of other service users.

Staff support: induction, training, skills and experience

●The manager was prioritising training and ensuring all staff were upskilled to enable them to meet people's needs. The provider has recently changed to a new online training provider which staff were getting familiar with. Staff were being supported to develop their knowledge and confidence in providing care to people but we found gaps in their knowledge particularly in relation to people's specific health care needs .

● We found when speaking to staff that their knowledge was variable particularly in relation to long term health conditions, end of life care and dementia and its impact. Not all staff had completed training in these key areas. Some staff were new to care and had limited experience in providing dementia care or understanding the impact this could have on people.

●The staff training record which was recently moved onto a digital platform showed gaps in online training and staff had been given six weeks to complete these. Some staff had completed advanced qualifications in care whilst others new to care were completing the care certificate, a recognised certificate across the care sector which gave staff a foundation of knowledge across a range of topics.

●Staff development was key to moving this service forward and empowering staff with knowledge. Supervisions and annual appraisals were in place, and the manager had introduced more regular weekly staff meetings and reflective supervisions.

Supporting people to eat and drink enough to maintain a balanced diet

● We had concerns about the lunch time experience for people using the service. The manager told us they would usually be on the floor but was not on the day of inspection, both inspectors observed lunch in different areas of the home.

● We found people were not offered food choices in a way appropriate to their needs. A menu on the wall

was not changed until later in the morning and people were asked what they wanted for breakfast the next day whilst eating lunch.

● People sat waiting for their meal in some instances for more than half an hour and when the meals were served, staff interaction was minimal. There was no explanation and food was just put in front of people. In the dining room, staff were not always present to assist people, where required. In the lounge, the television remained on throughout and where one person was being assisted, there was no staff engagement. Some people chose to remain in their room and several people did not eat their meal and encouragement was not provided to support people to do so.,

● We had a concern about one person who was not eating and drinking and although this was recorded, and staff were seen to offer alternatives this had not been escalated appropriately at the time of inspection. Their fluid intake was dangerously low, and they have subsequently been seen regularly by the nurse and doctor.

● Staff spoken with did not know how much fluid people should have. People's care plans stated that people should be drinking 2000 mls a day but no base line had been established or individual targets. If staff failed to recognise 'low fluid intake' people would be at risk from dehydration. The hydration and fluid policy did not give specific information about fluid targets or preventing hydration, and this was raised with the manager to ensure training and guidance were updated. Care plans showed low fluid intake on some days with no actions recorded within their notes.

● We reviewed people's weights and saw that where unplanned weight loss had occurred staff had continued to weigh them regularly and referred people to the GP. Weight loss was reversed. We observed staff providing snacks throughout the day including chocolate, crisps, and finger foods. Drinks were provided throughout the day, but people were not always given encouragement to drink them.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support

●Engagement was improving and there was evidence of meetings taking place between different agencies to support and improve the lives of people using the service.

●Guidance was sought from relevant health care professionals and the service worked closely with the matron from the local GP practice. Some care issues had been raised in April 2021 and these were discussed to ensure improvements could be identified and made.

Adapting service, design, decoration to meet people's needs

● The service had been adapted in line with people's specific needs. There was good signage and different colours used to distinguish different rooms. Rooms were individualised and well maintained. There were areas of interest and sensory objects on the walls.

● Communal facilities were adequate but on the day of our visit the dining room was underutilised.

● Improvements to the garden had been made which was now a nice, safe space for people to use.

● Improvements to the laundry room were necessary as tiles were stained, the room was cluttered and there were inadequate arrangements for waste disposal. This has been added to the service's action plan.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take 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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

● We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Staff received training to help them support people in the least restrictive way and in the context of whether people had mental capacity or not. Staff told us how they offered people choices and if people were resistant this would be escalated. Staff tried different strategies to help ensure people received the care that they needed.
● We did not review any best interest decisions, but staff told us when these would be put in place and what for. For example, they gave an example of when a person swapped rooms and what was put in place.
● Some people had DoLS in place and these were kept under review.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.
This is the first inspection for a service previously registered which since the last inspection has changed its legal entity This key question has been rated Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity: Respecting and promoting people's privacy, dignity and independence

- The atmosphere at the home was relaxed on the day of inspection, and we did not identify any tension. However there had been some recent and continuing concerns about staff conduct. This was being addressed by the manager and had resulted in staff leaving or being dismissed. Staff were being supported to improve their practice, but we were not assured that all staff were working to the same high standards and levels of competency. Some staff were new to post and were still being supported to develop themselves in their role.
- We identified some blurring of professional and personal boundaries and discussed this with the provider in terms of recent concerns raised. Unrest within the service would have an impact on people using it. Most people were not able to tell us about their experiences but from the information we reviewed about the service people had not always received safe care which was consistent with a good caring service.
- Based on our observations during the day we observed some kind interactions and saw staff speaking with people in an empathetic way. Staff told us people's routines were flexible and there were no set times to get people up. They said people could choose when to take a bath or shower, but this was usually completed in the afternoons. We found however when reviewing people's records that there was limited recording of people being offered baths and, or showers and the care notes did not give a clear overview of people's day and the care and support they had been offered. The terminology used did not support a holistic culture.
- Comments from staff were mixed but most felt the new manager was approachable and visible and would address issues within the service.

Supporting people to express their views and be involved in making decisions about their care

- The manager had incorporated people's views in the overall day to day running of the service. Weekly meetings were not currently being attended by anyone using the service. The manager however felt it important to continue these. The manager actively asked people for their feedback and completed daily walkarounds and spot checks on staff which identified if people's needs were being met.
- Feedback about the service had not been sought from relatives, health care professionals or other key stakeholders so their views were not represented or incorporated into the service action plan.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.
This is the first inspection for a service previously registered which since the last inspection has changed its legal entity This key question has been rated Requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

●The culture in the service was changing and the manager demonstrated a person-centred approach. 'An all about me' gave an introduction of people's main needs and risks associated with the care.

● Care plans were being updated to include more specific information. Care plans we viewed contained generic information and did not clearly tell us what actions staff needed to take to ensure people's needs were met and people's independence upheld. For example, "Needs assistance," is not sufficiently descriptive about what assistance was needed by a person and might result in people receiving differential care.

● We reviewed three care plans and looked the care summaries for people. Night notes were extremely limited and did not show how people's night needs were being met. Some people did not sleep at night and were up from early morning. This was being reviewed and the manager had stated medicines might promote a better night's sleep. There was limited information about how staff could promote a good night's sleep and what other strategies they could try to support people to develop good day and night routines. Some people had been moved from room to room in line with their needs, but also due to others entering their room. A holistic approach had not been adopted.

● In addition, we found risks had not been fully explored or actions clearly recorded. For example, of the two recent admissions we reviewed one person's paperwork did not include weight on admission, and no baseline was established in regard to their food/fluid intake which was recorded as extremely low. Their skin integrity could be impacted from their immobility and poor hydration and nutrition, but this had not been risk assessed. The risk of them falling out of bed had also not been assessed. These issues were immediately rectified. When we spoke with the person, they were experiencing low mood and had ill-fitting dentures and sore gums, this had not been recorded as part of their plan of care.

● We reviewed other records which showed no assessment of risk when a person was not drinking enough for their needs and poor information around maintaining people's skin care and continence, for example no details of pad size to be used. We also had a discussion with the provider during feedback about monitoring people's bowels when staff supported people with personal care as constipation can have a devastating effect on people's health and can be life threatening.

We recommend the provider consider updating the nutritional policy and be clear how they expect staff to monitor people's fluid intake where this is considered necessary to safeguard people's health and reduce the risk of other health complications such as dehydration.

● We noted some people had sensor alarms as the least restrictive measure to keep them safe. Staff had all recently had manual handling training and each person requiring one had their own manual handling sling which is good practice.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Some people using the service had limited communication and this could increase their frustration and reduce their means of communicating their needs. We have suggested in this report that staff consider how to increase people's choice and support their communication by using different assessments such as a pain assessment tool where necessary. Communication plans were in place but did not give a good overview of people's needs.
●One person had one to one staff support due to their distress behaviours. We reviewed the behavioural charts which were used by the mental health team to help them understand what triggers were causing the person to become distressed and how these triggers could be reduced. We found however these charts did not tell us what was happening before an episode of distressed behaviour and just recorded 'no trigger'. There is always a trigger for behaviour and without this information the mental health team would not be able to analyse what was causing the persons distress and what changes could be introduced to support them.

● We met one person who had very limited social interaction due to hearing loss and visual disturbances. They had yet to be assessed for hearing aids and delays for an appointment had partly been created by COVID-19. Their care plan did not consider what impact their visual and hearing impairment had on their communication needs or how the person could be supported more effectively. We did observe staff writing information down for them, but their daily situation was very difficult for them.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● Photographic evidence was provided of social activities which had taken place. There was an activity planner and a designated member of staff came in daily. On the day of inspection there was bingo. The manager was unable to tell us if the activity coordinator had received any specific training in the provision of activities to ensure they were suitable and inclusive particularly for those living with dementia or sensory loss.
● Although we observed some good staff interaction which reduced people's anxiety, we were concerned that some people stayed in their room by choice and chose not to join in activities. One person told us, "I have never played bingo in my life and I am not going to start now." The range and scope of activities was limited, and we could not see how the service fully took into account people's needs and past interests as this was poorly recorded.
●The manager was clearly addressing the task-based approach to meeting people's needs and was ensuring staff were spending time with people. At 10am all staff stopped what they were doing to spend time and sit down with people. This could be introduced to different times of the day, afternoon and evening. We have taken into account the impact COVID-19 has had on services and a change in priority for care staff in ensuring people are protected from the virus. Some opportunities had been reduced by the pandemic for example the service use to have volunteers and family coming into the service. This had to stop and would have limited people's opportunities.

Improving care quality in response to complaints or concerns
● There was a complaints procedure in place, and this included the complaints procedure in picture format to make it more accessible. No complaints were received and there had been limited feedback about the service prior to this inspection.

End of life care and support

● People approaching the end of their life were supported by the district nursing team. Staff contacted them when appropriate to ensure people had adequate pain relief and physical symptoms relieved as far as possible to ensure people were made comfortable.

● Staff spoken with had not all had training in providing end of life care and when we asked the manager about what resources there were to ensure people had a good death they spoke about support for the staff. There were no links with the local hospice or accreditation for end of life care.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for a service previously registered which since the last inspection has changed its legal entity This key question has been rated Requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. We identified a breach of regulation 17 Good governance of The Health and Social Care Act 2008, (Amended in 2014.)

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: Continuous learning and improving care

● We inspected this service due to a change in the provider registration and also due to concerns expressed by a number of different agencies about the standards of care. A number of these concerns were raised by members of staff who the provider has since told us were raising concerns maliciously following termination of their employment. We were not aware of the high number of safeguarding concerns and were not provided with the supporting evidence that these had all been properly investigated. We cannot assume that these were malicious without the evidence.

●At our inspection we found the manager was working hard to improve the service and they had a clear ethos for developing a person-centred culture. In order to achieve this, they were putting systems in place to ensure staff were adequately supported to improve their professional practice and taking into account how people thought their care could improve. Some improvements were noted such as positive changes to the environment and good infection control procedures which helped protect people from infection including COVID-19.

●Appropriate monitoring and quality assurances systems had been introduced by the manager which included daily handovers, spot checks, weekly staff meetings and reflective supervisions with staff so they could discuss what was working well and what could be improved on. This was being completed in a supportive way and staff given opportunities to influence the service delivery.

● Despite these positive changes we still identified areas for improvement as detailed in the report and until systems and processes were firmly embedded in the service, we could not be assured people received a consistent and safe service.

● There were delays in the manager providing us information we had requested, and some information was not received such as provider audits and oversight. We therefore were unable to take this information into account when completing the report. We did take considerable time to give feedback and seek various opportunities for information to be provided.

● Some staff had been dismissed and there was some evidence that staff culture was poor and the service had not consistently achieved good outcomes for people. We were confident this had been recognised and was being addressed.

● The provider had responded to internal whistle blowing concerns. Although these had been investigated it was not clear how information gathered as part of the investigation was used to continue to address issues across the service. We had a conversation with the provider about the manager and the need for them to

establish firm boundaries and have clear parameters around time-off to ensure they got adequate rest and expectations of their role were made clear.
● Staff had not always maintained personal and professional boundaries. For example, the use of social media for the purpose of airing grievances which could be viewed as a breach of The Data Protection Act. Steps were being taken by the provider to address this.

All the above supports a breach of regulation 17 Good governance of The Health and Social Care Act 2008, (Amended in 2014.)

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● We found no evidence that people were being harmed but inconsistent management and a lack of robust oversight and governance processes placed people at risk of harm. Governance processes were being strengthened and staff being held accountable for their actions. Increased monitoring and supervision of staff was in place but not all staff had updated evidence of their mandatory training or role specific training.
● A number of senior staff were new to role and not all had relevant qualifications or experience. As an equal opportunity employer these staff were working under close supervision and being offered support to develop their role. Some senior staff lacked basic knowledge of people's underlying health care needs and conditions and were not aware of where to find the relevant guidance to support their decision-making processes and advice staff.
● Electronic records were in place to record people's daily needs. We identified some improvements were necessary in terms of using descriptive sentences to explain how staff were meeting people's needs in line with their care plan. This was particularly the case at night where there was minimal evidence of how people's needs were being met. Care plans were being reviewed and we found them quite task focused with some repetitive, sometimes contradictory information.
● Care records did not give a comprehensive overview of how people's needs should be met in a way that upheld their rights, dignity and independence. Distress behaviours that occurred from time to time were recorded but we were unable to see what occurred immediately before the behaviour or that staff knew people sufficiently well to understand what was causing the person distress and what could be done to reduce it.
The service had stringent cleaning processes in place, but these were recorded across multiple records which we suggested to the manager they might want to streamline, making it easier for auditing purposes. Electronic care plans and daily notes were accessed on handheld devices. Not all staff were yet familiar with using these and information was being inputted differently with some staff recording information contemporaneously and other staff inputting information at the end of the day. We spoke with the manager about having a consistent approach.
● Action plans were in place which showed a proactive response from the provider. We did find however that action plans did not give timescales for actions to be completed and by whom.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Working in partnership with others
● During COVID-19 restrictions were in place to ensure people were kept safe. Contact from family had been reduced and at times window visits or telephone calls encouraged. This did not suit everyone, and families told us alternative arrangements as restrictions were lessoned had not been suggested. Family members spoken with were frustrated about communication with the service. One family member told us, "Every-time I rang they just told me yes they are fine, so I eventually stopped ringing." Several relatives had no idea the previous manager had left or what was happening in the home in terms of their family members health.

Others were not aware of recent care reviews and had not been asked to give feedback on the service.

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●The provider confirmed that surveys had not been issued for two years, but this was because of extra demands on the service created by COVID-19. This however meant relatives, stakeholders and to a lesser extent staff had not had the opportunity to feedback their views and influence the service delivery.

● Most people using the service were living with dementia. The manager had a good understanding of dementia and providing individualised care. Not all staff however had undertaken dementia training to help them positively engage with people and reduce their distress. The manager had set up weekly resident meetings and acted on people's feedback. For example, one-person wanted to see the 'house dog,' and did not get the opportunity as did not go downstairs. The dog is now taken round to all parts of the home.

● The service worked well with other professionals and had started to set up meetings with other health care professionals to improve communication and relationships between the different health and social care professionals.