Mr Olu Femiola

Manor Park Care Home

Inspection report

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Keighley
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on the 15 September 2016 and was unannounced. Our last inspection took place in May 2014 and at that time we found the service was meeting the regulations we looked.

The service provides accommodation and support for up to twenty two people who have complex mental health needs. There were eighteen people living at the home at the time of our inspection. The home is located close to Keighley Town centre and within easy walking distance of the local park and other facilities in the area.

The service had 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 2008 and associated Regulations about how the service is run.

We saw records relating to people's care and support were regularly updated and staff were provided with the information they needed to meet people's needs. People's care and treatment was planned and delivered in a way that was intended to ensure their safety and welfare. People were cared for by staff that had been recruited and employed after appropriate checks were completed. There were enough staff available to support people.

We found staff received appropriate levels of training and supervision to carry out their roles effectively and in people's best interest.

We saw staff were kind and caring toward the people they supported and people were able to participate in social and leisure activities both within the home and the wider community. However, we found more could be done to provide people with a wider range of social, leisure and recreational activities.

We saw the registered manager and staff worked well with other community based professionals to ensure that people's health needs were met and people had access to the full range of NHS services. This included GPs, hospital consultants, community health nurses, opticians, chiropodists and dentists.

We saw medicines were administered by competent and trained staff and people received their medicines as prescribed and in a timely manner. Minor shortfalls in the system were addressed by the registered manager on the day of inspection.

We found the service was meeting the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).This legislation is used to protect people who might not be able to make informed decisions on their own.

We saw the complaints policy was available to everyone who used the service. The policy detailed the

arrangements for raising complaints, responding to complaints and the expected timescales within which a response would be received.

We found there were quality assurance monitoring systems in place which were designed to identify any shortfalls in the service and non-compliance with current legislation. We found the systems were robust which helped to ensure the service was managed effectively.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of the procedures for safeguarding vulnerable adults.

Assessments were undertaken in relation to potential risks to people who used the service and staff. Written plans were in place to manage these risks.

The staff recruitment and selection procedure was robust and there were adequate staffing levels to keep people safe.

Is the service effective?

Good

The service was effective.

The service was working in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This helped to make sure people's rights were protected.

People were supported to have an adequate dietary intake and their preferences were catered for.

We saw people had access to the full range of NHS services and staff worked closely with community based healthcare professionals in specific areas of people's care.

Staff received the training and support they required to fulfil their roles and meet people's needs.

Is the service caring?

Good

The service was caring.

Care and support was provided in a caring and respectful way.

People's right to privacy, dignity and independence was respected and valued.

Wherever possible people were involved in reviewing their care needs and were able to express their views about they wanted their care and support to be delivered.

Is the service responsive?

Good

The service was responsive.

People who used the service and their families were involved in the planning of their care and support.

Each person had their own detailed care plan.

The staff worked with people, relatives and other healthcare professionals to recognise and respond to people's needs.

There was a complaints procedure in place and people we spoke with knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The service was well managed and there were clear lines of communication and accountability within the staff team.

Effective procedures were in place to monitor and review the safety and quality of people's support.

There were systems in place to seek the views of people who used the service and to use their feedback to make improvements.

Manor Park 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 15 September 2016 and was unannounced. This meant the registered provider did not know we would be visiting.

We used a number of different methods to help us understand the experiences of people who used the service. We spent time observing care and support being delivered. We looked at three people's care records, medicines administration records (MAR) and other records which related to the management of the service such as training records, staff recruitment records and policies and procedures.

We spoke with eight people who were living at the home, the registered manager, four care staff, the chef and the housekeeper. We also spoke with three healthcare professionals who were visiting the home at the time of inspection.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also 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. The registered provider returned the PIR and we took this into account when we made judgements in this report.

Following the inspection we spoke with the Local Authority Commissioning team and Safeguarding Unit.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe living in the home. One person told us how staff helped them overcome feelings of low mood when they experienced auditory hallucinations which were telling them to place themselves in harm's way. Another person told us staff had supported them to regain confidence in going out into the community. They told us they now felt safe to go into the community alone.

Our discussions with staff demonstrated people's well-being and how to recognise possible abuse were clearly understood. Staff described what they would look for, what action they would take and how they would make sure people were kept safe. Staff were able to describe to us how they would make a safeguarding referral and how to contact the Care Quality Commission (CQC). Staff had confidence any concerns they raised would be taken seriously and action taken by the manager.

People who used the service told us there were always sufficient staff on duty to meet their needs and this was confirmed by the rota's we looked at. We saw there was a recruitment and selection policy in place. The registered manager told us as part of the recruitment process they obtained two references and carried out Disclosure and Barring Service (DBS) checks for all staff before they commenced work. These checks identified whether staff had any convictions or cautions which may have prevented them from working with vulnerable people. We saw there was a staff disciplinary procedure in place to ensure where poor practice was identified it was dealt with appropriately. The registered manager told us if they found a member of staff was no longer suitable to work in a health or social care setting they would make a referral to the appropriate agency, for example, the Disclosure and Barring Service. We looked at three employment files and found all the appropriate checks had been made prior to employment.

Medicines were administered to people by trained care staff. We were told people were assessed as to their capability to self-medicate. Whilst no people had been found capable of self-medicating oral medicines we saw some people had been assessed as being capable and willing to apply their own creams and lotions and use their inhalers. The process demonstrated the provider was attempting to maximise people's independence.

We looked at people's medicine administration record (MAR) and reviewed records for the receipt, administration and disposal of medicines and conducted a sample audit of medicines to account for them. We found administration records were complete.

The staff maintained records for medication which was not taken and the reasons why, for example, if the person had refused to take it, or had dropped it on the floor.

We looked at MAR sheets which along with our observations of the administration of medicines demonstrated medicines prescribed to be administered before or after food were given as prescribed.

Arrangements for the administration of 'as necessary' (PRN) medicines were available but were not universally applied therefore not always protecting people from the unnecessary use of medicines. For

example, we saw one person was prescribed Ibuprofen 400mgs PRN and Paracetamol 1g PRN yet no protocol existed to describe which medicine should be administered for what presentation nor was the carer able to describe how they would make a safe and effective judgement. We brought this to the attention of the registered manager who took immediate action to construct PRN protocols where none existed. We saw evidence people were referred to their doctor when issues in relation to their medication arose. Allergies or know drug intolerances were clearly recorded on each person's MAR sheets.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. At the time of our inspection no-one was receiving controlled medicines. However the facilities existed to correctly store and record any prescribed controlled medicines. Drug refrigerator and storage temperatures were checked and recorded daily to ensure medicines were being stored at the required temperatures.

We saw liquid medicines supplied in bottles were not always managed in a safe way. Medicine spillage down the side of the bottle was wiped clean, however this process was over time removing the label which effectively removed the identification of who the medicine was prescribed for. The carer told us they would discuss the issue with their colleagues and wipe the bottles clean without damage to the label.

We saw evidence of effective auditing of medicines. Daily and weekly audits ensured the availability of medicines. Any discrepancies were addressed which resulted in the safe system of administration we witnessed.

We saw from care records risk assessments highlighted the effects of potential hazards and how they were to be mitigated. Risks assessments were completed for each person in respect of the likelihood of falls, use of bed rails, nutrition, moving and handling tasks, continence and the likelihood of developing pressure ulcers. Some people presented risks to both themselves and others. For example some people with enduring mental illness were unable to identify the risks of smoking in their rooms and unsafely disposing of lit cigarettes. We saw these people were restricted in their access to lighters and matches and had their smoking closely monitored. We judged the restriction to be proportionate to the harm the service was seeking to prevent.

We completed a tour of the premises and inspected five people's bedrooms, toilets, bathrooms and various communal living spaces. We found some areas of the home would benefit from refurbishment and the registered manager told us there was a rolling programme of refurbishment and renewal in place. We also found attention was needed to the garden to the front of the property which was becoming a little overgrown.

All hot water taps were protected by thermostatic mixer valves to protect people from the risks associated with very hot water. Heating to the home was provided by radiators, however not all bedroom radiators were covered thus exposing people to the risk of a burn from a hot surface. The manager told us they would action the matter. We saw fire-fighting equipment was available and emergency lighting was in place. We saw fire escapes were unobstructed. We saw upstairs windows had opening restrictors in place to comply with the Health and Safety Executive guidance in relation to falls from windows, however in one upstairs room the restrictor was damaged which allowed the window to fully open. The manager assured us the damage would be repaired without delay. We found all floor coverings were appropriate to the environment in which they were used; were well fitted and as such did not pose a trip hazard. We inspected records of the lift, gas safety, electrical installations, water quality, pest control and fire detection systems and found all to be inspected by a competent person. We saw all portable electrical equipment had been tested and carried confirmation of the test and the date it was carried out.

Good

Is the service effective?

Our findings

We spoke with the cook who had a good understanding of people's dietary needs and provided people with a varied and balanced diet. People who used the service told us the food provided was good and an alternative was always offered if they did not like what was on the menu. One person said, "The meals are great and we get to choose what goes on the menu." Another person said, "The food is really good, it's always tasty and well cooked."

We found staff were knowledgeable about people's individual support and care needs. For example, we saw one person was prescribed Chlorpromazine. This medicine makes people sensitive to sunlight and the carer told us during the recent sunny weather they had to ensure the use of an effective sun-block cream.

The registered manager told us that all new staff completed an induction training programme and new employees with no previous experience in the caring profession would complete The Care Certificate within the first twelve weeks of employment. The Care certificate is an identified set of standards that health and social care workers adhere to in their daily working life. We looked at the training matrix and found staff had recently attended a range of training courses including health and nutrition, moving and handling, managing challenging behaviour and person centred care planning.

The registered manager told us the training and personal development needs of individual staff members were identified during their formal one to one supervision meetings and their annual appraisal. Staff spoke positively about the training provided by the service and confirmed they received regular updates in a range of mandatory topics.

As part of the assessment process of each person's care and support needs, an assessment of their mental capacity was carried out. The assessments were specific to people in respect of their daily living needs. We saw evidence these were reviewed when there were changes in the person's needs. Where people were assessed as lacking the capacity to make specific decisions, a process of best interest decision making was undertaken and recorded.

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 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 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager was knowledgeable about the MCA and DoLS and knew the CQC needed to be notified when the outcome of any applications were known. We saw ten standard authorisations had been

submitted to the supervisory body for current residents. Two authorisations were in place both with attached conditions. We saw care records translated the conditions into the care plan which were being met.

During our inspection of medicines we saw one person was receiving their medicines covertly. An examination of the person's care records showed correct procedures had been applied which should have ensured the medicines were administered within current guidelines. We saw meetings had occurred involving a psychiatrist GP, family members, a social worker, care staff with personal knowledge of the individual and a pharmacist. Documents demonstrated a clear treatment aim of covert medication along with the required benefits to the person's health. A qualified person had made a written statement regarding the person's lack of capacity. A review process was in place. However, the best interest meeting recorded only three medicines which were to be administered covertly. Our observation of the medicine round and MAR records showed six regular medicines were administered covertly and additionally the administration of Lorazepam 0.5mgs and Promethazine 25mgs on a PRN basis. The original decision to administer medicines covertly had been reviewed and no change made to the original decision. The registered manager assured us a review would be arranged as soon as possible and thereafter medicines would be administered correctly.

Consent to care and treatment was sought in line with legislation and guidance. People told us they felt involved in their care and staff always asked for their consent as a matter of routine. Staff told us people's consent was gained before assisting them with care and support.

Staff were able to talk about what would happen if a person lacked mental capacity and what they would do if a person did not consent to receive care and support. They knew how best interest decisions should be recorded and who should be involved in the process.

We observed staff gaining people's consent to support them. For example, during the medicine round we saw people were asked if they wished to have their medicines or would they prefer them a little later. We also witnessed staff asking people what they wished to wear, where they would like to sit and to give gentle persuasion to sit outside in the sunshine.

We spoke with one member of care staff about the use of restraint. They were able to describe de-escalation techniques to minimise the use of restraint or restrictions to people's liberty. They said, "We never use physical restraint here."

We looked at a sample of care plans for people who we saw had bed-rails attached to their beds. Assessments of people's needs demonstrated bed rails were used only to prevent people falling out of bed or where people were anxious about doing so. We saw families had been included in discussions prior to bed-rails been used. We saw risk assessments were carried out to ensure the potential risks of using bed rails were balanced against the anticipated benefits to the user.

The care records we looked at provided evidence people had access to a range of health professionals and their advice was recorded to assist staff provide appropriate care. During the course of the inspection we spoke with three healthcare professionals and they told us they had no concerns about the standard of care and support provided at the home and staff always followed their advice and guidance.

Good

Is the service caring?

Our findings

People told us the staff were 'smashing' and one person said, "There's always someone who I can talk to when I'm having a bad time." They said, "When I hear voices it's frightening but staff get me through it."

People were assisted by staff to be as independent as possible. We saw staff encouraged people to do as much for themselves as they were able to and prompt people when needed, in a respectful way. We were told by the registered manager they had plans to convert an area adjacent to the dining room into a kitchenette to enable people to prepare drinks and light snacks for themselves.

Staff spoke with people in a positive way and showed a person centred approach to the people they were supporting. For example we, observed staff discussing with people what they would like to do during the day and what plans they had for the weekend.

Staff knew people well and engaged with them at every opportunity. Staff were caring and considerate and listened to what people had to say. There was a warm and happy atmosphere and people looked relaxed and comfortable in the presence of staff.

The staff we spoke with were clear in their understanding of respecting people's privacy and informed us they always knock and seek permission before entering a person's room. Staff also informed us they ensured doors were closed when assisting people with personal care. This demonstrated to us that staff were conscious of maintaining people's privacy and dignity.

However, whilst our impression of staff interaction was overall positive we witnessed one action which displayed a less thoughtful and respectful approach. One person had difficulty drinking which caused fluid to dribble from their mouth. We witnessed care staff attending to the person's needs with a toilet roll rather than hand tissues. We brought this to the attention of care staff who said they did have access to suitable products. This was discussed with the registered manager who confirmed this matter would be addressed immediately.

The care records we looked at contained the information staff needed about people's significant relationships including maintaining contact with family. Staff told us about the arrangements made for people to keep in touch with their relatives. We also found care records contained specific information about people's likes and dislikes, their lifestyle and the social and leisure activities they enjoyed participating in. This showed that people who used the service and/or their relatives were able to express their views and were involved in making decisions about their care and treatment.

The registered manager told us no one who used the service required an advocate. However, we saw contact details were available about advocacy services that people could request to use if they so wished. An advocate would support a person who needed help in making decisions about important aspects of their life and make sure their individual rights were being upheld.

The registered manager told us visiting hours were not restricted and family and friends were encouraged to visit people as often as they liked.

Good

Is the service responsive?

Our findings

People who used the service told us they were happy living at the home and with the staff that supported them. One person who was staying at the home on a respite care basis told us they were relieved and very pleased they had been allowed to extend their stay as they did not yet feel ready to go back to live in the community. They told us they had stayed at the home before and always felt well supported by the registered manager and staff.

We saw prior to living at the home, people's health care and support needs were assessed, planned and evaluated to agree their personalised plan of health care and support. Care plans were informed from a range of health and social care professionals which ensured care staff had all the information they needed to construct a meaningful plan. We saw the pre-admission assessment included both a life history and medical history.

Care plans included people's likes and dislikes and what was important to that person. They also provided details about people's personal care needs, their mobility, the support they needed with eating and drinking, managing continence and in one case wound care management. The care plans we looked at were clear, appropriately detailed and filed in a logical order. Care plans evidenced the person and where possible their families were involved in the process and they were looked after in the way they liked.

Many people who were receiving care had a long history of mental ill-health and had received care from hospital services immediately prior to admission to the home. We saw four people had their care needs assessed regularly by a multi-disciplinary team which included psychiatrists, social workers, specialist nurses and staff from the care home. These meetings informed the care planning review process at the home. We saw evidence this close working relationship was benefitting people. For example, we saw care staff had observed one person with declining ill-health. The manager discussed the person's current medication with the mental health team who made changes to the prescription. Our discussion with care staff and our observations from daily records showed the intervention of the manager had improved the person's health.

We observed the handover between the morning and night staff. The handover was thorough and provided staff with up to date information on people's health and welfare and any changes in their needs. We saw the meeting was attended not only by the care staff but also by the cook and house keeper. This ensured everyone on duty were made aware of people's changing needs and helped staff to provide responsive and appropriate care.

We saw the service did not employ an activities co-ordinator and therefore it was the responsibility of the care staff to arrange social, leisure and recreational activities for people to participate in. We were told eight people had recently enjoyed a four day break at Skegness accompanied by three staff and there had been a recent day trip to Blackpool. However, while it was apparent some people were happy just to sit and watch televisions other people told us there was little to do and they were bored a lot of the time. One person said, "There is nothing really to do and every day is very much the same. We do sometimes go out in the minibus

but I would ideally like to get out more." We discussed this with the registered manager who told us they were aware more needed to be done to provide people with a stimulating environment and would take steps to address this matter although they told us some people refused or were reluctant to participate in any form of activities.

We looked at the complaints policy which was available to people who used the service, visitors and staff. The policy detailed how a complaint would be investigated and responded to and who they could contact if they felt their complaint had not been dealt with appropriately. The policy also detailed the timescales within which the complaint would be dealt with. The registered manager told us they were pro-active in managing complaints and encouraged people to air their views of the care and facilities provided.

We saw the registered manager had recently distributed a questionnaire to people who used the service specifically about their understanding of the complaints procedure. They told us they had done this to make sure everyone was aware of how to make a complaint and were clear about how to use it.

Good

Is the service well-led?

Our findings

People who used the service also told us they had confidence in the registered manager and staff team and the service was well managed. One person said, "I have lived here a number of years and would not want to live anywhere else, I like [Name of manager] and all the staff and they are used to me and my ways." Another person said, "I am happy living here people are friendly and I can go out whenever I want provided I let them know."

Throughout our inspection we observed the registered manager interacted with staff and people who lived at the home in a professional manner and had a visible presence throughout the day. We found the registered manager was open and transparent with the inspectors about where they recognised improvements were still required and encouraged both staff and people who used the service to raise concerns and ideas for improving the service.

The staff we spoke with told us the registered manager was approachable and encouraged and supported them to develop their skills and knowledge base. One person said, [Name of manager] is always around if you need them and keeps a close eye on what is going on." Another person said, "The home is well managed and all the staff know the standards of care [Name of manager] expects from them."

We saw the home had a quality assurance monitoring system that continually monitored and identified any shortfalls in the service and any non-compliance with current regulations. We looked at the audits completed by the registered manager and found they covered all aspects of service delivery.
There was evidence that learning from incidents took place. Records showed that any complaints, accidents and incidents were recorded and the registered manager monitored the frequency of such events and looked for common themes and trends.

A range of risk assessments and policies and procedures were in place, providing staff with information about specific areas, such as health and safety, infection control, environmental hazards and moving and handling. The registered manager told us they were in the process of reviewing all the policies and procedures in place to ensure they were in line with current legislation and good practice guidelines.

We saw the provider visited the service on a regular basis and checked the audits completed by the registered manager to ensure they provided accurate and up to date information. We also saw evidence the provider also took time to talk with people who used the service, their relatives and healthcare professionals during their visit.

The care records we looked at indicated the registered manager submitted timely notifications to the Care Quality Commission (CQC) indicating they understood their legal responsibility for submitting statutory notifications. We saw people's care records and staff personal records were stored securely which meant people could be assured their personal information remained confidential and only made available to external agencies on a need to know basis.

The registered manager told us as part of the quality assurance monitoring process the service sent out annual surveys questionnaires to people who used the service, their relatives and other healthcare professionals on an annual basis. They told us the results of the survey were collated and an action plan put in place to address any concerns raised. We looked at the results of the last survey and found people had made positive comments about the management of the service.

We also saw annual survey questionnaires were sent out to staff to seek their views and opinions of the care and support people received and the overall management of the service. This showed to us that the registered manager involved both people who lived, visited or worked at the home in the quality assurance process, valued their opinions and continually looked at ways of improving the service.