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Manchester House Nursing Home

Inspection report

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

Manchester House 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. Manchester House is registered to provide accommodation and nursing care for up to 67 older people and younger adults with a physical disability. There were 65 people accommodated at the time of the inspection.
This was an unannounced inspection which took place over two days on 25 and 26 June 2018.

The last comprehensive inspection was carried out in May 2017 when we found some breaches of regulations relating to safe care and treatment and Governance of the service. We followed up in November 2017 and found improvements had been made and the breaches of regulations were met. We rated the services as 'Requires improvement' because we needed to ensure the service could maintain consistent standards over a more prolonged period of time.

At this inspection we found improvements had been sustained. The service accommodates people with a wide range of diverse and complex care needs. Although we highlighted some areas for improvement we found that people living at Manchester House were receiving safe care which also enhanced their quality of life. The management and leadership of the service was more established and consistent.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the management structure supported the service with clear lines of accountability and responsibility. The auditing and monitoring systems in place had been developed over a period of time and were now fully embedded. This level of monitoring helped identify and reduce risks around safe care and treatment.

At the last inspection in November 2017 we made a recommendation for improvement because we found people were not always being supported in good time with their personal care needs; people told us they had to wait for extended periods of time when using their call bells to call for support. At this inspection we found some improvements had been made but feedback from people remained mixed and we saw that some people continued to present challenges for staff with respect to supporting their personal care needs.

We found people's risks regarding their health was assessed and monitored. There was improved clinical leadership in the service and there was evidence of effective referral and liaison with supporting health care professionals. Feedback from a visiting health care professional was positive about staff approach and competence in relation to wound care and pressure ulcer monitoring.

We found people were protected against the risks associated with medicines because the provider's arrangements to manage medicines were consistently followed.

We found the home was operating in accordance with the principles of the Mental Capacity Act 2005 (MCA). People were being supported to make key decisions regarding their care and treatment. The supporting care plans and assessments evidenced people being consulted and involved in their care. Care plans we saw were clearly written, agreed by people and were being regularly reviewed.

There were ten people who were being supported on a Deprivation of Liberty [DoLS] authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom and ensures that any restrictions are appropriate and in the person's best interests. We found these were being monitored by the registered manager of the home.

People told us they enjoyed the food. We saw that there were sufficient food and drinks and anybody at risk of malnutrition was appropriately supported.

People we spoke with said they were satisfied living at Manchester House. They spoke about the nursing and care staff positively. When we observed staff interacting with people living at the home they showed a caring nature.

Activities were organised in the home. The activities team were motivated to provide meaningful activities and these continued to be developed.

At the time of our inspection we found enough staff were provided to carry out people's care. Staff numbers were matched to the dependency levels of people living in the home. We found the staffing levels overall were consistent.

We looked at how staff were recruited and the processes in place to ensure staff were suitable to work with vulnerable people. We saw checks had been made to help ensure that staff employed were 'fit' to work with vulnerable people.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training. All the staff we spoke with were clear about the need to report any concerns they had.

Prior to the inspection, we were informed of a number of safeguarding matters, where concerns had been raised. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. There had been four such safeguarding investigations. The themes for these were clinical care of wounds, call bells not being answered and lack of adequate personal care. The homes management had liaised with the safeguarding authorities and responded to any recommendations made to help reduce any future concerns and risks.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed. Planned development and maintenance was assessed so that people were living in a comfortable environment.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of

how they could raise a complaint or concern. We saw there were good records of complaints made and the registered manager had provided a response to these.

The registered manager was aware of their responsibility to notify the Care Quality Commission of any notifiable incidents in the home.

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.

People's risks regarding their health care were assessed and monitored.

Medicines were administered safely. The provider's policies and procedures were followed.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

There were enough staff on duty to help ensure people's care needs were met.

Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

There was good monitoring of the environment to ensure it was safe and well maintained.

Is the service effective?

Good

The service was effective.

We saw people's dietary needs were managed with reference to people's individual preferences and choice.

When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed.

We found the home supported people to access support for their health care needs.

Staff said they were supported through induction, appraisal and the home's training programme.

Is the service caring?

Good

The service was caring.

When interacting with people staff showed a caring nature with appropriate interventions to support people.

People told us their privacy and dignity was respected.

There were opportunities for people to provide feedback and get involved in their care and the running of the home.

Is the service responsive?

Requires Improvement

Some people and their relatives told us there were long waiting times for staff to respond to people when they asked for help and assistance. This had potential to affect some people's well-being.

Peoples care plans showed good detail and evidenced they had been regularly reviewed. For two people the care plan goals regarding personal care needed further review.

There were activities planned and agreed for people living in the home. These continued to be developed.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain. Complaints made had been addressed.
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Is the service well-led?

Good

The service was well led.

There was a registered manager in post to provide a lead for the home. There was a consistency of management and leadership which had provided improved stability for the service.

We found the senior management structure was now clearly defined and provided better support for the home. The provider had clear lines of accountability and responsibility.

The systems for auditing the quality of the service had been embedded and were consistently carried out.

There were some systems in place to get feedback from people so that the service could be developed with respect to their needs and wishes.

Manchester House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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 was an unannounced inspection which took place over two days on 25 and 26 June 2018. The inspection team consisted of two adult social care inspectors.

We were able to access and review some provisional information we held about the service and this included feedback from health and social care professionals.

During the visit we were able to meet and speak with nine of the people who were staying at the home. We spoke with two visiting family members.

We spoke with the registered manager and 17 of the staff working at Manchester House including nursing staff, care/support staff, kitchen staff, domestic staff, maintenance staff and senior managers. We also spoke briefly with the providers [owners] of the home.

We looked at the care records for five of the people staying at the home as well as medication records, three staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits including feedback from people living at the home and relatives.

We undertook general observations and looked round the home, including people's bedrooms, bathrooms and the dining/lounge areas.

Good

Is the service safe?

Our findings

At our last comprehensive inspection in May 2017 we found the home in breach of regulations regarding people's safe care and treatment. This was because some people's risks regarding their health care were not being adequately assessed and monitored. At the time we assessed these concerns as a 'major' risk. We followed up with a 'focussed' inspection in November 2017 and found improvements had been made and the risk to people's health had decreased.

On this inspection we found that the improvements had been maintained.

Prior to this inspection we had received concerns regarding the health care of two people living at the home. These had been referred through the local authorities safeguarding processes. The concerns included the management of one person's pressure ulcers and the care of another person who was at risk of falls. We looked at both of these areas of concern on our inspection and found that they were being adequately monitored with some good practice noted.

For example, following a recent safeguarding investigation for a person living in the home, we saw that the service had responded promptly to initiate the recommendations made by the local authority to improve the care provision. Care documents recorded these changes and staff were continuing to monitor these changes to ensure they were effective.

Care planning documentation we reviewed included management of risks associated with people's health and well-being. Risk assessments had been completed in areas such as, falls risk, diet, weight and nutrition, medication, skin, bed rails and personal safety. These were monitored, reviewed and linked with people's plan of care to support them safely.

Another person had been admitted to the service with ongoing risk of pressure sores including wound care that required continued assessment and monitoring. We found clear records which detailed the nursing input and the improvement in the condition of the wounds. This included appropriate liaison with external health care professionals; in this instance the Tissue Viability Nurse [TVN].

People we spoke with told us they felt safe at Manchester House. They trusted the staff to monitor their care. One person said, "Since I've been here they [staff] have done a good job and I'm safe." A relative commented, "I've no real issues, the place is spotless and the care is good." We spoke with two people who regularly go out into the local community by themselves. They told us, "It's very relaxed here and we can come and go but the staff always make sure we get back safely."

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the local contact numbers for the local authority safeguarding team were available.

We found the management of medicines was safe and the systems in place helped ensure people's medication was being administered effectively. We reviewed people being given their medicines over the breakfast time. Nurses administered medicines in a safe and respectful way. We found that people did get their medicines at the right times.

All other medicines had been checked upon receipt from the pharmacy and the recording of medication on medication administration records [MAR] were complete. We checked peoples topical cream charts, where carers recorded the application of moisturising and barrier creams. These records were up to date and showed peoples creams were being used as prescribed. There was one record that was confusing as the MAR did not match the information on the carers monitoring chart; this was addressed during the inspection.

Some people were prescribed one or more medicines to be taken only 'when required'. With one exception, extra information on how nurses should give these medicines (in the form of a protocol) was kept with the person's MAR. Most protocols described a person's individual needs well but some were written in a more general way. For example, people who were prescribed pain relief [paracetomol] when required had only brief records regarding this. A nurse updated these records to include more detail, this helps ensure medicines are given for consistent reasons.

Some people required a prescribed thickening agent adding to their drinks to enable them to swallow safely. We saw thickening agents were recorded however these records did not include details around the consistency that the food needed to be. This is good practice as their use differs depending on the person and the type of thickener used. We brought this to the attention of the staff and they told us the records would be updated to reflect this. Talking with staff confirmed their knowledge regarding their use.

One person was administering their own medicines. This had been assessed to ensure they were kept safely in the person's bedroom. The person was in for a brief period of 'respite' care and had a care plan outlining control measures in place; this did not include detail of medication storage which was addressed when we fed this back to the nurse administering medicines.

Medicines were stored safely and kept at the right temperature. Both the temperature of the clinic room and the fridge temperatures were recorded and safely monitored. If medicines are not kept at the temperature advised by the manufacturer they may become less effective or even harmful.

Medicines that are controlled drugs (medicines subject to stricter legal requirements as they can be misused) were stored and handled safely. The stock balances of the controlled drugs we checked were correct.

The home had an up to date medicine policy describing how staff should manage medicines in the home. We saw that regular audits (checks) were carried out to see if staff followed the policy.

During the two-day inspection there was a sufficient staff presence to provide support to people in accordance with individual needs. To care for 67 people accommodated at the time of the inspection there were three nursing staff, a senior care staff member and 13 other care staff. There was also a deputy manager and a nurse 'clinical lead' to provide extra input and support. The registered manager was supernumerary. The provider operated a dependency assessment tool linked to staffing numbers to help ensure these numbers were maintained.

People we spoke with told us that staffing was maintained and they received most of their care in a

reasonable time frame although this did vary at sometimes.

Staff spoken with were overall happier than previous inspections and told us the staffing levels and consistency of staff was better maintained. There was now a settled team of nursing staff. Senior care staff had been developed to carry out daily management of units and staff allocation as well as trained to administer medicines. This gave more flexibility to manage the daily routines.

Staff were recruited safely with processes followed to ensure staff were suitable to work with vulnerable people. We looked at three staff files and asked the acting manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people.

Safety checks and service contracts were in place to ensure the premises and equipment were safe and well maintained. We looked at a number of these including, fire safety checks and electrical safety certificates. These were current. Information on how to support people in an emergency was available in the home. This included a fire evacuation plan and individual personal emergency evacuation plans [PEEPS]. These were located in people's care. Key pads helped to keep the home secure and visitors were asked to sign in when they arrived and left the premises.

We reviewed some incidents and accidents on the inspection as well as 'lessons learnt' for any safeguarding incidents. We found changes had been made to people's care in light of any findings from these incidents and investigations.

On inspection visitors and people we spoke with had no concerns about the cleanliness of the home. We observed staff had access to personal protective clothing, such as gloves and aprons, and these were changed at appropriate times such as when servicing food. All areas seen were clean and serviceable. The management team completed infection control audits, as part of monitoring safe standards in the control of infection.

Good

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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals 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.

An assessment tool was used to assess people's capacity to make 'key' decisions such as, use of bed rails, care and treatment. Where appropriate, people had signed to indicate their consent and it was clear to see people had been involved in the day to day decisions in relation to the care being provided.

We saw evidence of 'best interest' meetings which had been held and any decision made in a person's best interest were recorded; consent had been sought in line with good practice and guidance. There were examples of supporting documentation around relatives having lasting Power of Attorney (LPA) to show they could make decisions for the person concerned. Overall, there was evidence that families were consulted with regarding any best interest decisions including the initial admission to the home. During the inspection we observed staff seeking people's consent before supporting them. For example, when taking part in the social arrangements which had been organised and where people would like to sit.

Staff had made applications for people to be supported on Deprivation of Liberty (DoLS) authorisations. The applications were being monitored by the registered manager and ten of these had been authorised by the Local Authority.

We observed staff providing support at key times and the interactions we saw showed how staff communicated and supported people appropriately. When we spoke with staff they were able to explain each person's care needs and how they communicated these needs.

People were supported to maintain their health and well-being with the support of a range of community health professionals. This included local GPs, dietitians, tissue viability nurse (skin care) and opticians.

Where appropriate there had been adaptations made to the environment to assist people with disability. For example, the placement of dining tables heled ensure ease of access for people in wheel chairs and with mobility needs. Bathrooms were easy to access and use for people. Many people were observed to have equipment provided such as mobility aids and beds / mattresses to assist with skin integrity.

Appointments were recorded in the care files we looked at and staff were following treatment plans where applicable. We spoke with a visiting health care professional who was involved in the support of five people living at Manchester House. We were told that people were monitored well by staff who liaised effectively to support people's health care needs. Each person's care file included evidence of input by a full range of health care professionals. If people had specific medical needs we saw these were documented and followed through.

People we spoke with, relatives and health care professionals told us that staff had the skills and approach needed to ensure people were receiving the right care with respect to maintaining their health. One person said, "The staff are excellent, they are always there for you." A relative commented, "Staff are good and seem very competent – they know what they are doing."

Staff received training and support which provided a good knowledge base to look after people well. The training program was ongoing and overseen by one of the provider's in-house trainers. Courses undertaken, included, infection control, mental capacity, moving and handling, equality and diversity, safeguarding, fire safety, first aid and food hygiene. Other training gave staff specialist knowledge in the service's care delivery, such as male catheterisation, wound care, 'end of life' care including updates for the management of syringe drivers for administration of medicines at the end of people's life.

New staff received an in-house induction and worked alongside more experienced staff when they commenced employment. New staff were enrolled on the Care Certificate. The Care Certificate is the government's recommended blue print for induction standards. The manager enhanced staff learning with supervision and an annual appraisal. Supervision sessions between staff and their manager give the opportunity for both parties to discuss performance, issues or concerns along with developmental needs. Staff told us they completed training and obtained qualifications in social care and nursing staff maintained and updated their professional development. 58% of care staff had NVQ / Diploma qualifications [although this was noted to lower than the previous inspection] and a further 16 staff were currently undertaking them. We spoke with a visiting NVQ assessor who told us the service promoted training in all areas and the approach by care staff they witnessed was "excellent."

People's nutritional needs were assessed and staff were aware of people's dietary needs and preferences. A person told us the staff asked them each day what they would like from the menu though they felt the choice of sandwiches could be better.

The menus were displayed in the main dining area and were available in picture format to support people's understanding and choices.

Staff served people meals which were supplied by a catering company which provides meals for health and social care settings. We looked at the menus and these recorded the choices available. Staff told us alternatives would be prepared if people did not want the menu choices. The meals were served from a heated trolley to ensure they were served hot. A number of people sat at the dining room table for their meals whilst others preferred their meal in their room. Staff supported these choices.

Good

Is the service caring?

Our findings

Staff were observed demonstrating reassurance, kindness and patience towards people throughout our visit. We heard staff speaking in kind and friendly tones at all times. They appeared to be busy moving from person to person but not overly rushed. These interactions showed good interpersonal skills and understanding.

People's communication needs were considered throughout their care plans. This included details about any sensory loss and included clear guidance to staff about how to support each person's individual need. For example, the use of hearing aids, gestures and touch to support them.

Staff supported people's rights to independence. This we saw in respect of how people wished to spend their day. People told us they liked the freedom the home offered to them and this enabled them to continue with their lifestyle as much as possible and their preferred interests.
Two people we spoke with told us the home had a certain 'freedom' about it; "Staff are relaxed and kind, they take me out in my wheelchair sometimes" and "I love it here – you feel free. They've helped me get some independence back; I can walk with a [walking] frame now."

A relative said, "Staff are very good. We [family] are all pleased with the care."

People's records with stored securely to maintain the confidentiality. Records were stored within an office that was locked when not in use.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained. People told us that on the whole staff knocked on their bedroom door and waited before entering bedrooms. People said the staff were patient and careful when delivering personal care. A relative told us the staff were polite and helpful at all times.

We observed a large number of doors were kept open leading onto the corridor. This meant any person passing could see directly into the room, including people who maybe in bed. We discussed this with staff who told us that people preferred their doors to be left open as they felt more 'in touch' and this was reassuring. We spoke with three people who confirmed they preferred the door to be left open. The registered manager and regional manager both said they would continue to monitor this.

The registered manager advised us that people were involved in the running of the home through a series of forums including surveys and meetings. For example, a 'resident meeting' had been held in April 2018, organised by the activities staff. We were told that an future development would be the introduction of a residents committee to formulate more input and feedback form people living at Manchester House. A food survey had been undertaken involving 25 people living at the home resulting in the introduction of a new hot trolley to ensure food was served at the right temperature. The activities team informed us that there were more regular feedback meetings with people as part of the organised activities in the home.

There was some information available in the home for people via the 'service user guide'. We discussed the use of advocacy for people. There was some information available in the home regarding local advocacy services if people required these. The activities team were also responsible for linking in when needed and referring people through the advocacy service if needed.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2017 we reported on people's dissatisfaction with the time it took for care staff to be responsive when they called for assistance using their calls bells in bedrooms. This had been an ongoing concern since our previous inspection in May 2017.

Prior to this inspection we had received continued ongoing concerns that this issue had not been improved. We received a further two reports through safeguarding investigations which related to staff not responding to calls for personal assistance in a timely manner.

We followed this up on our inspection. We found a mixed response from people.

Our general observations and feedback from most people was that there had been improvement overall. People we spoke with over the two days of the inspection reported staff generally attended in a reasonable time frame. The provider had conducted ongoing audits of response times following the inspection in November 2017 which showed an average response, at peak times, between 8-14 mins with the slower response times in the morning when everyone was wanting to get up. Additional measures had been put in place including two designated staff to attend to call bells over meal time periods. We tested the repose time during the inspection with one person who needed help in their room and staff responded within a minute.

Although this evidenced improvement we still came across evidence of people continuing to be dissatisfied. For example, a residents meeting minutes dated 12 April 2018 recorded 'residents were unhappy with the length of time it took for buzzers to be answered. Unhappy with carers excuse that they were understaffed'. One person and their relative told us the staff were kind but so busy and could not always come when needing help. The relative stated "I'm not happy that [person] has to wait for the toilet or for other care."

One care staff told us, "The issue of the call bells is tricky – there are delays when we are busy; we do our best. We now have designated staff at meal times to answer call bells and its better."

We fed this back to the registered manager as an area of care that required further development.

People had a plan of care based on their individual needs and this considered their past medical history, personal choice and preferences. These covered areas such as mobility, skin care, personal care, sleep and mental health. Care plans and supporting documents were reviewed regularly and updated. We did however find conflicting information for one person in respect of the frequency of pressure relief they required. This had caused some confusion. Their care monitoring chart said this should be provided every two hours however their plan of care stated four hourly. We brought this to the registered manager's attention to review as there was a risk the person may not receive the care they required. The registered manager said they would review this with immediate effect.

There were two examples of people who presented challenges for staff to support adequate standards of

personal care. Although these care needs were identified in care plans, the goals of the care plans were not being met in that the level of personal care was observed to be insufficient. We fed this back to the registered manager so the care plan could be further reviewed.

In respect of preferences, we saw information recorded around people's preferred food, time of getting up and retiring at night. Staff told us about people's care and support and that they received a good handover at shift changes to facilitate this. We found examples of very good individualised care for people with very complex medical conditions. For example, a person with spinal injury had specific care around preferences for named staff to carry out aspects of personal care.

People's plan of care recorded their decisions around end stages of life and final wishes. The service had links with a local hospice to provide appropriate support at the end of people's life. There were no people being supported for this care at the time of the inspection. The registered manager advised us that further training was planned for end of life care. Five staff had attended training and updates I the last year.

The service offered a varied activities programme. Social activities were organised by an activities team, seven days a week; this included activities 'in house' and also trips out from the home to local venues. For people who did not wish to take part in group sessions, the activity team provided some 'one to one' time. During the inspection we spoke with an activities organiser who told us the service's activities were being continually developed based on what people would like to take part in and this included bringing new items together for a newsletter. We were also told that the activities team are taking over a small patch at a local park which they can cultivate with flowers. The activities team had developed an activities folder and this provided information regarding people's' preferred interests, diets and other relevant information. We saw people taking part in dominoes which appeared to be very much enjoyed. Other social activities included, quizzes, shopping, gardening club, cards and reminiscence sessions. A relative said, "The activities staff are excellent."

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We saw there were good records of any complaints made. There had been two complaints received since April 2017. We looked at both of these and they had been responded to appropriately. We saw they had been investigated and addressed in terms of a response by the registered manager.

Good

Is the service well-led?

Our findings

The last two inspections of Manchester House have evidenced improvement and better consistency regarding the management and running of the home. Over this period the provider has been able to meet their action plans following Inspections and therefore meet regulatory requirements.

On this inspection we found continued overall improvement. The management of the home continued to be settled. The registered manager has been in post for a year and has gradually built a management team for the home including a deputy manager [recently employed] and a clinical lead to provide ongoing support for the nursing team; two senior carers also provided support for care staff on a daily basis.

The registered manager had a clear vision for future progress in the home and further cementing the existing positive culture. Key themes included the further development of training in the home and the development of senior carer roles as well as a continued development and focus on activities for people. The registered manager explained that some of these had been a result of feedback from people living in the home.

Although supernumerary to the number of staff on duty, the registered manager was still very 'hands on' in terms of being involved and supporting clinical input for people. The PIR submitted by the registered manager explained; 'The manager becomes involved in day to day care of clients ensuring that staff have feedback. The manager attends handover five days a week for continuity and to impart any knowledge, information staff need'. This approach was also evidenced when we spoke with staff who told us the registered manager was involved daily and provided a good lead in the home.

We found the senior management and organisational structure was clearly defined with a clear structure from provider, to regional managers, and supporting quality managers and training managers. The management audit tools used to regularly monitor the service to help negate clinical risk were being carried out regularly and had helped identify and reduced clinical risk. These processes had been developed steadily over the past two years by the provider and were used to monitor all aspects of the running of the home including clinical care. The 'bedding in' of the quality assurance processes had been instrumental in helping to ensure continued improvement ongoing.

Auditing was carried out internally by the registered manager and clinical support manager and these were supported by specific routine audits carried out by the regional manager on a monthly basis. The quality assurance manager carried out a full six-monthly audit looking at safety and quality across all areas. We saw examples of these audits which contained action plans and were monitored ongoing. We could see that the service continued to learn from the findings of the auditing process and any other feedback received. Over the past three inspections improvements in meal presentation, staffing and learning from safeguarding events as well as staff development evidenced a positive approach to service development.

We spoke with nurses who reported more stability overall. One nurse commented, "I've been here a short while but I can see the care is good. The manager listens and supports us well. We cope well with [people] who have very complex needs." Other staff said, "It's really improved, the manager is excellent and made so

many changes," and "Can't think of a better place to work."

We found the provider and managers open and constructive. Immediate feedback following our inspection was met openly and positively. Following the inspection, the provider responded positively to feedback about the concerns by some people regarding the effectiveness of the call system. We were told the provider had agreed plans to install a call system that would better monitor staff response times. In addition, we were advised, "We of course will continue to monitor our dependency and staffing guidance levels."

The Care Quality Commission (CQC) had been notified of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding Manchester House.

From April 2015 it is a legal requirement for providers to display their CQC rating. The rating from the previous inspection for Manchester House was displayed for people to see and was also included on the homes website.