Trident Reach The People Charity

Manor Park

Inspection report

24 Manor Park Grove
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: 24 Manor Park Grove is a residential care home that was providing personal and nursing care to five people with a learning disability. The care home accommodates people in a domestic style house with some adaptations.

People's experience of using this service:
Although staff knew people's needs and the risks people may present, people were not always supported effectively and consistently by staff.

Systems to monitor the quality and safety of the service had not been effective at monitoring and improving the quality of the service.

The home was clean, and people's rooms were personalised. However, some environmental risk were not well managed.

People were supported to receive their medication as prescribed and systems were in place to ensure only suitable staff were recruited.

The service applied some of the principles and values of Registering the Right Support and other best practice guidance. The care setting was domestic in style and layout providing a comfortable and homely environment for people to live in. However, we saw limited opportunities for people in terms of choice, control, and independence.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

The Secretary of State has asked the Care Quality Commission (CQC) to conduct a thematic review and to make recommendations about the use of restrictive interventions in settings that provide care for people with or who might have mental health problems, learning disabilities and/or autism. Thematic reviews look in-depth at specific issues concerning quality of care across the health and social care sectors. They expand our understanding of both good and poor practice and of the potential drivers of improvement.

As part of thematic review, we carried out a survey with the registered manager at this inspection. This considered whether the service used any restrictive intervention practices (restraint, seclusion and segregation) when supporting people. The service used some restrictive intervention practices as a last resort, in a person-centred way, in line with positive behaviour support principles.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection:

The last rating for this service was Good (report published February 2019)

Why we inspected

We received concerns that indicated people were not receiving safe care and treatment. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

Enforcement

We have identified breaches in relation to safe care and treatment and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded

Follow up:

We will continue to monitor the service through the information we receive until we return to visit as per our re-inspection programme. If any concerning information is received, 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 well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Manor Park

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.

Inspection team
This inspection was carried out by one inspector and an Expert by Experience; an Expert by experience is someone who has had experience of working with this type of service.

Service and service type
24 Manor Park Grove 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. This information helps support our inspections. We used all 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
Most people who were using the service at the time of our inspection could not talk to us about their experiences of the care provided. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with four members of care staff, the registered manager a relative and a health and social care professional.

We looked at two people's care records, three staff recruitment records and records relating to the governance of the service. This included quality assurance audits, records of accidents and incidents and complaints records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse

● Prior to our inspection there had been a safeguarding investigation into allegations of staff causing physical and psychological harm to service users. The local authority had asked the provider to investigate the allegations and to report back to them on their findings. The allegation of physical harm was unproven, but the allegation of psychological harm was upheld.
● During our inspection we observed staff practices that disregarded the needs of a person and did not follow the persons support plan.
● We raised our concerns as a safeguarding alert with the local authority.

The practices we observed were not necessary or proportionate, this is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● A relative told us, "We've been quite happy with [person's name] being here. They are looked after properly."
●The registered manager was unaware that the practices we observed were taking place. They took immediate action during the inspection to address the concerns and to ensure that the practice ceased, and that staff followed the persons behaviour support plan.
● Staff told us they were confident to report any concerns with people's safety or welfare to the management team or with external agencies. Staff said they were confident action would be taken. Staff told us the provider had a whistleblowing policy which could be used.

Learning lessons when things go wrong
● Lessons were not always learnt from incidents to reduce the risk of re-occurrence. Although the provider had systems in place to look at incidents; there was no overall management of the information to identify trends. For example, there was no analysis of what happened before an incident or any patterns identified regarding the circumstance of the incident.
● The registered manager was aware of their responsibility to report any concerns to the relevant external agencies.

Assessing risk, safety monitoring and management
● Staff knew people's risks however there were some inconsistencies in how risks would be managed. For example, some staff were not following a person's behaviour support plan.

● People's care records were not always reviewed following an incident. For example, there had been an incident of aggression between two people, but there was no evidence that a review of the measures in place to mitigate any risk had taken place.
● A work place fire risk assessment had been completed by the provider to asses fire safety measures. Areas of noncompliance had been identified in July 2018 but had not all corrective actions had been addressed.
● We saw that a cupboard containing potential harmful cleaning products was shut but not locked. We were told the key had just broken. The registered manager acted during the inspection to secure the items and action the repairs.

Staffing and recruitment
● Checks were carried out on staff before they started work in the home to make sure they were suitable to work with people.
● The registered manager told us that they had experienced some staffing difficulties recently because some staff had been on leave due to investigations taking place. Some agency staff were used to maintain safe staffing levels.

Using medicines safely
● People received the right medication at the right time and staff had been trained to give medication safely.

● Medicines were stored safely.

Preventing and controlling infection
● The home was clean and tidy.
● Staff had received training and followed infection control practices to reduce the risk of cross infection.

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. At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At this inspection we found the systems in place for oversight of the service were not robust. The audits undertaken had not identified or effectively prioritised where improvements needed to be made or improvements had not been made in a timely manner.
- For example, there were systems in place to monitor staff performance and competencies, however these had not identified the concerns we found during our inspection. Some staff failed to follow people's care plan and risk assessments, and this had not been identified by the registered manager or provider.
- There were systems in place to monitor health and safety and environmental risks to people. However, these systems had failed to identify the risk that we saw during our inspection. We saw 10 items of large furniture waiting for disposal, including a sofa, chairs and table had been placed on the patio area of the garden that was accessible and accessed by people. We were told that nine items had been placed there for over four weeks and one item had been there for a week. The location of these items presented a risk to people and restricted people from safely accessing the garden.
- The systems in place failed to identify that non – complaint actions highlighted in the fire risk assessment had not been actioned. The assessment identified that additional emergency lighting was required to an escape route but this had not been provided.
- Where the systems had identified areas for improvement, for example audits of care records; the action plans did not evidence that the improvements had been made.

The providers systems had not been effective at identifying risks and improving the quality of the service. This is a breach of regulation 17 'Good governance' of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider understood their responsibilities to notify us of certain events such as abuse, and serious incidents and we found these notifications had been received.

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

- The provider was aware of their responsibilities under the duty of candour and could tell us examples when relatives would be informed of any concerns or issues that had arisen. A relative we spoke with during the inspection confirmed this to us.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Many of our observations during the inspection did not uphold that a person – centred, open and inclusive environment was provided consistently at Manor Park Grove.

● Prior to our inspection the provider had carried out a safeguarding investigation in relation to allegations about staff practices, However, their investigation did not identify the issues that we found during this inspection. It was unclear what learning had taken place following the recent investigation.

● Following our feedback, the registered manager told us that they would be based full time at Manor Park Grove for a six month period to address the areas of concern that had been highlighted during the inspection. They told us that they would also be relocating their office to the ground floor so that they could observe and monitor staff practices more closely.

● The registered manager told us where they felt people's needs were not being met appropriately at the service they were working with the local authority to address this.

● Staff provided mixed feedback about the management of the service. Most staff felt supported in their role and some staff didn't.

● Relatives told us the service kept them informed about their relative and the registered manager was always available and approachable if they wanted to ask anything. A relative told us, "On the whole I'm very happy with the care and always feel [person's name] is well looked after."

Working in partnership with others; continuous learning and improving care

● The registered manager told us the service had good relationships with other partners which benefitted people and staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The systems in place to safeguard service users from abuse were not robust.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers systems had not been effective at identifying risks and improving the quality of the service.

The enforcement action we took:

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