Sammi Care Homes Limited

Himley Manor Care Home

Inspection report

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16 January 2019

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This service has a history of not meeting the regulations for several previous inspections. At our last inspection in April 2018 we found the provider and management team had made improvements and were no longer in breach of the regulations. However, some improvements were still required and the overall rating remained as 'requires improvement'. Following that inspection, the home also came out of special measures and the condition that we had put on the providers registration to not admit new people was removed.

Prior to this inspection we received an escalation of Information of concern about the service. These were relating to the attitude of the registered manager, poor care and staffing issues. We reviewed the information we received and made a decision to bring forward our comprehensive inspection.

This inspection took place on 15 and 16 January 2019 and was unannounced.

Himley Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. A maximum of 51 people can live at Himley Manor. On the day of the inspection there were 35 People living at the home.

At this most recent inspection we found that the improvements reported on following our last inspection had not been sustained. We found multiple breaches of the regulations.

A registered manager had been appointed in November 2017 and was registered with CQC in April 2018. However, they were dismissed by the provider in December 2018. At the time of our inspection the provider had employed the services of an interim manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People were not always protected from the risk of abuse. Where lessons could be learned to improve the service, and make the care people received safer; these were not always identified and addressed.

There were significant staff changes that had impacted negatively on people's care. Staff were not supported in a way that ensured they were effective in their role.

People's dignity was not always maintained and respected. Staff did not have time to spend quality time with people. Staff did not have information about people's social history or interests and were task focused with their approaches and engagement with people.

People did not always receive care and treatment that was responsive to their needs or provided in a

person-centred way. People were not supported to be involved in the planning or review of the care they received. Care plans had not always been updated to reflect changes in the support people received. People had limited opportunities for social stimulation.

People told us they felt confident to raise a complaint and arrangements were in place for complaints to be investigated. Staff who gave people their prescribed medicines demonstrated a good knowledge and understanding of how to do this safely although the managements of external creams and ointments needed improvement. People had food and drink that they liked, but if they needed support with this it was not always provided to people in a way that met their needs.

People who lived at the home did not benefit from a service which was well-led. There had been a failure in the leadership and governance of the service. The systems in place to monitor or improve the quality of care had not been effective. Ineffective leadership in the home had impacted
on the people who lived at the home and the staff team. The ethos of honesty, learning from mistakes and admitting when things had gone wrong was lacking. The provider had not always met their legal responsibilities to inform the Care Quality Commission of significant events which had occurred in the home.

The overall rating for this service is 'Inadequate' and the service is therefore in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question of overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be inadequate.

We found that the provider was not meeting all of the requirements of the law. We found multiple breaches in regulations. You can see what action we told the provider to take at the back of the full version of the report. 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health, safety and welfare were not assessed, monitored and mitigated.

People were not always protected from the risk of harm or abuse.

Infection control systems were not always being effective.

People received their medicines as prescribed. However, improvement was needed to the administration of prescribed creams.

There was enough staff to support people. However, staff were not always deployed effectively.

Is the service effective?

Requires Improvement

The service was not effective

The training and support staff received to carry out their role was not effective.

Where people's rights were restricted staff were not always aware of why these restrictions were in place, although they had been authorised lawfully.

People did not always receive consistent support to meet their eating and drinking needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The culture of the home was one that was not always caring.

People were supported by staff who did not always know and understand people's care needs.

People told us staff were caring.

Is the service responsive?

Requires Improvement

The service is not responsive

People did not receive care and treatment that was responsive to their needs or provided in a person-centred way.

People's views were not considered when planning and reviewing the care, they received. Care records were not accurate or up to date and did not reflect people's preferences.

People were not supported to take part in meaningful activities.

There were systems in place for the management of complaints.

Is the service well-led?

Inadequate

The service was not well-led.

People did not benefit from a service that was well-led. There Had been poor leadership and managerial oversight impacting on the safe running of the service.

The provider failed to notify the Care Quality Commission of significant events which occurred in the home.

Himley Manor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

The inspection was prompted in part by an escalation in concerns that we received in relation to the registered managers attitude, poor care and staffing levels. We reviewed the information we received and decided to bring forward our comprehensive inspection.

The inspection team consisted of one inspector, an assistant inspector, a specialist advisor who was a nurse with experience of dementia care and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service. We looked at information received from the local authority commissioners, Healthwatch and the statutory notifications the registered manager had sent us. Commissioners are people who work to find appropriate care and
support services which are paid for by the local authority. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan what areas we were going to focus on during our inspection visit. The local authority had told us that they had concerns about this service.

We spoke with 15 people who used the service, six relatives and two healthcare professionals. We also spoke with 12 members of staff including care staff, domestic, catering and senior care staff, the interim Manager and the nominated individual. We also contacted the local authority who commission the service to gather their feedback and they had told us that they were concerned about the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time.

We sampled care documentation for eight people, medicines records, four staff files, staff supervision,

appraisal and training records. We also looked at other records relating to the management of the service including audits, quality monitoring systems and action plans; accident and incident records; surveys; meeting minutes and complaint records.

Inadequate

Is the service safe?

Our findings

At our last inspection in April 2018 we rated this key question, is the service safe? as requires improvement. We found that the provider had made improvements and was no longer in breach of regulation 12. However, we found that systems in place to promote people's safety needed to be embedded.

At this inspection we found that the improvements we found at the previous inspection had not been sustained and again people were exposed to risk because of the ineffective systems in place.

We saw that some people who needed support to move were not always supported to do so safely. For example, we saw that one person who was sitting in a chair was pulled forward by their hand prior to being assisted with their moving and handling. We saw that a person was held under their arm by a staff member during a transfer. Holding a person under the arm could cause an injury such as a dislocated shoulder and or a skin tear. We saw that brakes were not always applied to people's wheelchairs when they were supported with a hoist to transfer. We saw that a number of skin tears had been recorded for people in recent weeks although these had been referred to the district nurses for their attention. The new manager in post told us that they had needed to order new hoist slings so that there was adequate equipment available for people who required a hoist. Before our inspection we were also made aware that health care professionals had raised their concerns about moving and handling practice at the home with the local authority.

We saw that at meal times people did not always get the support they needed, to keep them safe. A person's care records said they should be supported by staff throughout their meal because they would leave their meal without finishing it and also, they would take other people's food. We saw at the start of the meal the person was not supported by staff and some of their food fell on the floor. Staff had not noticed this so we alerted staff to this. Staff then sat and supported the person for part of the meal. However, they then left the person again to eat unsupervised we saw the person took food from another person and we again alerted staff to this so they could take action. We saw another person who was on a soft diet was served cooked bacon and began to eat the breakfast and started to cough. It was only when another staff member realised what had happened that the meal was promptly removed.

Staff we spoke with were not always knowledable about the needs and risks to people under their care. For example, we asked two staff members about a person who had a health condition and they were not aware of this condition. One of the staff members told us, "I haven't had much time to look at people's care records". The health condition the person had meant that staff should know about the person's needs so that they could support the person effectively to minimise any risks to their safety to their day to day care.

We saw that prescribed creams were not always given to people consistently. We saw prescribed creams had been left in a communal bathroom within the reach of other people who had access to the bathroom. We saw records were not always maintained when creams had been given to people and it was difficult to establish if people were receiving the prescribed creams they needed. We saw creams were dated several months old and there was no system for tracking when the creams had been opened so the timescale for

their effectiveness could be monitored. Staff we spoke with told us that creams were kept locked in the medicine trolley. However, we saw prescribed creams were also kept in people's bedrooms. We saw that where people were able to manage their own creams there was no risk assessment in place to ensure the person could do this safely. For example, to include an assessment of their capacity and the dexterity and physical ability to apply the creams. The cream used by one person who was self- administering their cream could not be located. Staff spoken with and records looked at were unable to tell us how long this had been the case.

We saw that records in place for staff to monitor that people were receiving the care that met their assessed needs and to monitor risk's in relation to their care were not always maintained. For example, one person's food and fluid intake needed to be monitored daily to minimise the risk of dehydration. There were inconsistent records kept with gaps or no records kept for several days. The records would ensure that staff were monitoring this aspect of the person's care. Another person was being cared for in bed and had been assessed by the home as needing hourly checks. There were inconsistent records kept with gaps or no records kept for several days. Failure to maintain the records meant staff were unable to check if people were receiving the care that met their needs and ensure risks in relation to people's care were being monitored.

We looked at people's care records and saw that an assessment of people's needs had taken place prior to them moving in to the home. However, we saw that the pre- assessment of their needs was incomplete and lacked detail. Some staff that we asked told us that they had not had the opportunity to look at people's care records. The home offered people a respite service following a hospital stay. However, although the hospital had identified key risks in their discharge documentation the home had failed to implement a care plan and risk assessments to inform staff how they should support the person effectively to meet their needs.

The evidence above supports a breach of regulation 12 Breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities).

At our last inspection we found the management team had continued to develop and embed the system to recognise and report incidents of abuse and had done so as required. At this inspection we found that the provider was not consistently recognising and reporting safeguarding incidents. We saw that some incidents requiring reporting had not been acted on. For example, we saw that an incident between two people had taken place in November 2018. Staff had recorded in the care records that they had reported the incident to the registered manager. However, the information shared by staff had failed to be acted on and was not reported as a safeguarding to the local authority. This placed people at further risk of harm. Discussions with staff and reading of records confirmed that following this incident further incidents took place that may have been avoided if appropriate action to mitigate risk had been taken after the initial incident.

We saw two further incidents of unexplained injury to people that had not been reported. Some staff we spoke with were unsure about their responsibility regarding to reporting and escalation of concerns in relation to people's safety. One staff told us, "I wouldn't know what to do if the concerns weren't taken by the senior or the manager". We saw that following specific incidents people's care records had not always been reviewed to see if any preventative measures needed to be put in place to prevent reoccurrence.

The evidence above supports a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities).

People had mixed views about whether they felt safe or not. Our observations during our inspection visit

varied. At times the home was hectic and not organised and staff were reactive to what was taking place. At other times the home was calmer and where people presented with anxieties, staff reacted quickly and calmly to reassure people. One person told us," I do feel safe." Another person said, "I feel safe, but sometimes they [pointing to another resident can be noisy. I don't like that]." A relative told us, "There has been a lot of changes, which isn't good for people. But I would say something if I need to."

We received mixed views from people about the number of staff available to meet their care and support needs. One person told us, "There is staff around, well most of the time." Another person told us, "The staff respond as quickly as they can when you call out or use your buzzer." A third person told us, "I don't always get what I want when I want it but they try their best." A person being cared for in their bedroom told us that although they do see staff it is only to do a quick check and they always seem to be rushing. A relative told us, "There seems to be enough staff but I am not here all the time….". Some relatives expressed concern about the amount of staff changes and the negative impact that this could have on their relative's care. Some staff told us that they did not think there was enough staff on duty. A staff member told us, "We need more staff to keep people safe". We saw that how staff were deployed across the home was a concern. We saw that there was not always a visible staff presence in communal areas of the home to respond to request from people and we needed to alert the manager at times about this. For example, we saw that some people were left in the dining area still eating their meal and there were no staff in the area to respond to any emergency situation that may of occurred. The manager told us that they were reviewing the current dependency tool which was used to ensure there were enough staff available to meet people's needs. Until this was completed and as an interim measure the provider had agreed to increase the senior staff level from one to two senior staff each day.

We noticed a strong odour in some areas of the home. The interim manager told us that this had been identified by them and they had actioned some high-level cleaning to address this. We saw personal protective equipment (PPE) was available throughout home. However, we observed that a few staff members when wearing PPE had tucked the neck loop into the waist which meant the protection provided by PPE was compromised. Cleaning was underway throughout our inspection visit and communal areas were observed to be clean. The provider told us that they had increased the domestic staff team since our last inspection.

Systems were in place to manage emergency situations such as fire. Some staff told us that they were not familiar with the fire safety arrangements in the home. Immediately following our inspection, the manager confirmed that staff had not been provided with the appropriate training on fire safety which placed people at the risk of harm. They gave us reassurance that this would be addressed without delay.

We observed part of the medicine round and also reviewed Medication Administration Records (MAR) for four people. We found that records were completed to reflect when people received their medicines. The staff member carefully and politely explained to people what they were doing and demonstrated good knowledge about the medicines that were being administered. We checked records of the administration of 'as required' medicines, which can be used to support people with pain or anxiety. The records in place to offer guidance to staff around the use of PRN medication to ensure staff acted consistently lacked detail. For example, there was no clear instruction for why a medicine would be given and what the signs of agitation would be for the person requiring the medicine. Also, staff were not recording of the back of the MAR record the reason and outcome of administering the PRN medicine.

We looked at four staff recruitment files and found the provider had completed pre-employment checks to ensure staff were suitable to work with people. These recruitment checks included requesting references from previous employers, identity checks and Disclosure and Barring Service (DBS) checks. DBS checks help

providers reduce the risk of employing staff who are potentially unsafe to work with vulnerable people. Staff we spoke with also confirmed these checks took place. This demonstrated the provider had systems in place to ensure people received support from staff who were safe to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in April 2018 we rated this key question, is the service effective? As requires improvement. We found that although some improvements had been made further improvement was required to ensure people received effective support from a well-trained and knowledgeable staff team particularly in relation to moving and handling and Deprivation of Liberty Safeguards (DoLS). As a result, we rated this key question as 'Requires Improvement'.

At the time of our inspection there had been a significant turnover of staff and this had impacted on the effectiveness of the care people had received from staff. People we spoke with expressed mixed views about whether they felt staff had the skills required to support them. Our observations and discussions with staff throughout the inspection visit showed that not all staff had a good knowledge of people's needs, or knew people's likes and dislikes or what action to take to ensure people received the support they needed. For example, we saw some poor moving and handling practice and not all staff were aware of specific health conditions that people required support with.

The manager told us and we saw records to confirm that staff have received training. However, this had not always been effective. The manager told us that they had identified concerns in key areas of care practice including safe moving and handling, safeguarding and mental capacity. They told us that they had arranged for a programme of staff training to take place at the end of January and the beginning of February 2019. They told us that staff would be observed and supported in their day to day practice by senior staff members to ensure people were supported effectively.

We observed interactions between people and staff and saw people were at times offered choices and asked to consent to their care and support but this was not consistent. For example, we saw a staff member ask a person's permission before putting on a clothes protector and we saw staff explaining what they were doing before supporting people to move. However, we also saw staff carrying out the same or similar care tasks without communication with people about what they were doing and without asking people's consent. Also, one person told us that staff would adjust their bed positioning without asking them or telling them what they were doing.

Where people used non- verbal communication, we observed some staff offered focused choices to support the person to make their own decision. For example, by showing people different drink or food options so they could point to what they wanted.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with demonstrated a limited understanding of the mental capacity act and DoLS. Many staff were not able to identify which people living at the home were subject to an authorised DoLS or the reasons for this. Staff lacking in knowledge about DoLS may place people at risk of being restricted unlawfully. At the time of our inspection we saw that the manager was in the process of implementing a system so they were clear about what applications had been made by the previous registered manager. They were also reviewing people's care to assess whether any additional applications needed to be made.

We found that people's mealtime experience was not always a positive one. We saw that people who required support from staff did not always receive this consistently. For example, staff did not always support the person throughout the meal but left to do something else. We also saw that not all staff knew what people's eating and drinking needs were and who was on a special diet. However, we could see that work was taking place to improve this and ensure that people's records clearly stated what their needs were and any related risks. The manager had made referrals for a number of people to have their eating and drinking needs formally assessed by the speech and language team. Most people we spoke with were happy with the food and drink provided. One person told us, "We get two choices." Another person told us, "I can always ask for some more food". We saw that menus were available giving details of available meals and options; however, these were in written form and also written on a chalk board which was difficult to read. A pictorial menu may benefit some people to enable them to make choices. Where people were cared for in bed we saw that staff supported them to eat their meal in their bedroom.

People told us they had the opportunity to see healthcare professionals such as their GP, dentist and optician to maintain their health and receive ongoing healthcare support. One person told us, "Yes I can see the GP when I am not very well." Another person told us, "I have seen the dentist and the optician." Prior to this inspection we had received some information about the relationship between the home and health care professionals, that had an impact on the effectiveness of the care. The manager told us that some work was taking place with healthcare professionals to improve the relationship between them and the home.

We saw that there was some signage in place which would benefit people living with dementia to navigate themselves around the building. However, some opportunities for reminiscence had been missed as areas for people to engage in while walking around the building were not available.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in April 2018 we rated this key question, is the service safe? As Good. At this inspection we found that some improvements were needed. As a result, we rated this key question as 'Requires Improvement'.

Observations carried out during the inspection showed some inconsistencies in the way staff provided care to people. For example, some staff did not respond to people's request for support, or the response was not timely. Some staff did not take time to explain to people what was happening, or what they were doing. When we spoke with staff we found that they did not always know information about people's social history or interests and were task focused with their approach and engagement with people. Some disagreements about staff performance took place in front of people. These were all examples of a culture that was not always caring.

Observations carried out during the inspection showed some inconsistencies in the way staff provided care to people. For example, One person told us, "They know me well I think and they [staff] are always polite and respectful." Another person told us, "They[staff] are kind to us". We did see some examples where staff would come down to the level of the person they were speaking with, their tone of voice was quiet and calm and there were lots of reassurances given to people. We also saw some examples when people appeared disorientated or anxious and staff were close by to offer the appropriate support.

We saw there was a lack of information about people's life histories, likes and dislikes which contributed to staff's lack of understanding about people's needs. The new manager was aware of this and we saw that that work was underway to improve people's care records so that they contained the information needed about people's diverse needs. The new care plan structure we looked at showed that it would include information about people's individual needs including their faith, religion, culture and sexuality. The manager told us that as well as people's life histories the new care plan documentation will include information about people's interests and experiences before moving to Himley Manor.

We saw staff respected people's privacy. One person told us, "As far as respect and privacy and dignity are concerned they [staff] respect us by making sure we are dignified when they support us with personal care. Another person told us, "Staff always knock before they enter my bedroom." A third person told us, "She [staff] treats us with respect and is cheerful." A relative told us, "My observation is that they do respect people." Another relative told us that although they don't go into their family members room when staff are supporting them with personal care. They had no concerns about how their family member was supported. We saw that some staff encouraged people to stay independent. For example, we saw staff encourage a person to help them prepare the dining room by putting table clothes on the tables.

We saw that relatives and friends were welcome to visit the home and we observed staff and the management team greeted visitors, took time to speak with them and made them welcome to the home.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in April 2018 we rated this key question, is the service effective? As Good. At this inspection we found that improvements made and reported on at our last inspection had not been sustained. Improvements were needed. As a result, we rated this key question as 'Requires Improvement'.

At our last inspection we found that part of the improvements being driven by the management team was to ensure information contained within care plans and risk assessments were current and reflective of people's needs. However, these improvements had not taken place. At this inspection care plans we sampled still lacked detail and had not always been reviewed when needs changed. In addition, we found that when people became anxious or agitated, there was a lack of detail to inform staff how to support them. More detailed information would assist staff in preventing the behaviour from occurring and guide their response if it did occur. We found that the new management team were aware that they needed to take action so that information was current and reflective of people's needs and provided staff with the information needed so they would know how to meet people's needs. Also with such a high turnover of staff it was pertinent that this information was available for staff to refer to so people would receive consistent support in line with their care needs.

At our last inspection we reported that Improvements had been made to the activities available for people to take part in and a new activities coordinator had been appointed in the weeks prior to the inspection. At this inspection we found that the activities coordinator had left. We saw that there were limited opportunity for people to engage in and experience different and stimulating activities. Some people told us they were bored. One person told us, "There is nothing to do here, I do get bored." Another person told us, "No one has the time to even sit and have a chat with me. There is nothing for me to do." A staff member told us, "There is nothing for people to do they are bored."

Activities not only offered social engagement, but also support people's mental, physical and emotional wellbeing and we saw many missed opportunities for this to happen just through day to day activity. For example, involving people in day to day task around the home. Where people were cared for in bed, we did not see that there was anything in place to ensure people did not become socially isolated. However, we did see some staff taking part in activities on a one to one basis with people including just chatting about how people's day was. We also saw a person supported to look through a book with the staff supporting them and another playing a table top game. One person told us that they preferred to stay in their bedroom and occupy themselves. The manager told us plans were already underway to make improvements. This included employing a person in the role of activities coordinator.

Staff we spoke with confirmed that information about people needs and changing needs were shared during the shift handover meetings, where updates were provided by senior staff. The manager told us that the handover process was also being reviewed so that it provided an overview of people's current needs and gave a quick reference to any risk staff needed to be aware of. We found that a number of staff were in the

process of getting to know people and understand their needs. We saw some good examples where staff sat and spoke with people asked what they wanted, checked the information out and then proceeded to ensure that the person was supported with their request in a safe way that met their needs.

We saw that care plans were in place for people who were receiving end of life care and they included some basic information about people's care. However, they did not cover the social, spiritual and psychological aspects of the person's care. This information would ensure people were able to spend their final days as they wished to.

People told us they knew how to raise a complaint if they were unhappy about the care they received. One person told us," I have never needed to complain". A relative told us that they had raised some concerns with the previous manager and was not really satisfied with the way it was dealt with, they told us, "It wasn't a good response". Another relative told us that they felt very positive about the new manager, even though they had not been working that long in the home. They told us that they had raised an issue and their concern was dealt with immediately. They told us, "[managers name] seems to listen and act". We looked at the complaints record and found there was a system in place to record complaints made. We reviewed recent complaints and found these concerns had been investigated, actions taken and a written response provided to the complainant. This demonstrated the provider had dealt with people's views and complaints in accordance with their policies and procedures.

Inadequate

Is the service well-led?

Our findings

At our last inspection in April 2018 we rated this key question, is the service well-led? As Requires Improvement. At this inspection we found that improvements made and reported on at our last inspection had not been sustained and we found that the provider has breached a number of regulations. We found that the provider has repeatedly failed to improve the overall governance of this service. When improvements have been made the provider has failed to maintain the improvements over a period of time.

The service has failed to meet the regulations in seven inspections over five years. Himley Manor has been rated as requires improvement across six inspections and inadequate in one inspection since 2014.

The expectation would be that following the previous 'requires improvement' rating, the provider would have ensured the quality of care received had improved and attained a rating of either 'Good' or 'Outstanding' at this inspection. At this inspection the service had deteriorated significantly placing people at risk of exposure to harm and unsafe care and support. We found widespread and significant shortfalls in the way the service was led.

We found that the systems in place to monitor the service had not identified the shortfalls we found during our inspection. The systems in place had failed to ensure care records provided up-to-date and accurate information for staff about service users' conditions and how they were to be supported safely. The systems in place had failed to identify when additional support or action may be required to keep people safe. For example, the audits in place had failed to identify that records lacked specific details about people's health conditions and how staff were to mitigate against associated risks. We saw that pre-assessment was incomplete and lacked information about people's specific health care needs. Systems in place had failed to identify that the processes in place to protect people from the risk of avoidable harm and abuse were consistently effective. For example, processes were not consistently followed to ensure safeguarding procedures were being adhered to keep people safe from the risk of harm. As a result, potential safeguarding concerns had not been reported to the local authority or investigated. Systems in place had failed to identify people's safety in respect of moving and handling practice was being compromised. Monitoring arrangements had not recognised that people were not been supported to move in line with moving and handling practice and had not recognised that skin tear injuries to people may have been because of poor moving and handling practice. For example, upper arm injuries to service user's which resulted in the district nurse team reporting their concerns to the local authority. The systems in place had failed to identify that the administration of prescribed creams were given to people as directed by the prescribing officer or stored safely as required. For example, the system in place to ensure that creams were dated when opened so the timescale for their effectiveness could be monitored, had not identified that this was not being followed. We saw prescribed creams for were dated April 2018 and stored in a communal bathroom that was accessible to other people. There were insufficient and inadequate systems in place to monitor and improve the quality of the service.

The evidence above supports the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The ethos of honesty, learning from mistakes and admitting when things had gone wrong had not been embedded. The provider has a legal responsibility to inform the CQC of significant events which occur in the home. When notifiable incidents had occurred, these had not always been reported to the relevant authorities or to CQC. This was a breach of the Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 18: At the time of writing our report we are seeking advice from our legal colleagues regarding what action we take.

There was no clear vision and strategy for the service. At this inspection we found that despite concerns raised at our previous inspections the previous improvements to the overall provision of the service had not been sustained. This demonstrated the management systems at Himley Manor were inadequate.

Prior to our inspection there had been an escalation in information of concern that we had received. This related the attitude of the registered manager, poor care and staffing issues. We attended a meeting in December 2018 with the local authority and attended by other professionals and the provider. Following the meeting the provider told us that they had dismissed the registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. In early January 2019 we were informed that they had employed the service of an interim manager. When we carried out this inspection the interim manager had only been working at the service for just over a week.

Surveys had been carried out with people, staff and relatives by the previous management team. We saw that in a staff survey a comment had been made about the number of 'unknown marks' appearing on people. A residents survey had raised some issues about more activities being available to people. The action taken by the previous management team in relation to these surveys was not clear.

Most relatives expressed concern to us about the management changes and high turnover of staff. One relative told us that they had made an appointment with the manager [old manager]. They said, "When I arrived they would not see me. not even a hello…they just delegated someone else. Another person told us, "[Old managers name] was not responsive to our questions." People and relatives spoke very positively about the manager. They told us that they were approachable and supportive. A relative told us, "I can see good changes after just a few days with the new manager." A staff member told us, "I think [manager's name] will do a really good job at turning this home around. Another staff member told us, "[Managers name] is really approachable. I can see things improving each day now that [manager name] is here."

The manager since being in post had already contacted the Local Authority, safeguarding team, commissioners of the service and health professionals to support care provision. The manager told us that they had taken steps to improve relationships with other professionals to support service development. Conversations that we had with the local authority and health care professionals confirmed this and there was early indication that things were already starting to improve. The local authority had imposed a suspension on any new admissions to the service. The provider had also advised us that they intended to place a voluntary suspension on new admissions for three months until 08 April 2019. They told us that this would help them to embed the changes that they needed to make.

At the time of our inspection we discussed our findings with the provider and new management team and we saw evidence that they were taking steps to address all the issues that we raised above. At the time of our

inspection the interim manager was taking action on ensuring that systems in place were improved so that all incidents were reported as required. We saw in the few days that they had been working there they had already identified and taken action on incidents and shared information with the local authority about these. Some staff we spoke with understood their responsibility to report and escalate any concerns about people's safety. They told us that they were confident that the interim manager would act on any concerns they raised. A staff member told us, "[Manager's name] is very good. I feel confident that if I told them something it would be dealt with and reported as needed. Another staff member told us regarding safeguarding that it was, "Everyone's concern."

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 12 HSCA RA Regulations 2014 Safe care and treatment Risk's to peoples health, safety and welfare were not always assessed, monitored and mitigated.

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 Systems in place did not ensure that people were protected from the risk of harm.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify us of significant events

The enforcement action we took:

Fixed penalty notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess and monitor the service were not effective.

The enforcement action we took:

Notice of proposal positive conditions