Sammi Care Homes Limited

Himley Manor Care Home

Inspection report

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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

We carried out an unannounced responsive focussed inspection of this service on 24 January 2018.

Himley Manor Care Home is a home for people who receive accommodation and nursing care. A maximum of 51 people can live at the home. There were 32 people living at home on the day of the inspection.

We carried out an unannounced comprehensive inspection of this service on 13 November 2017. After that inspection we received whistleblowing concerns about a number of key care aspects, including staffing and a high number of incidents between people living at the home. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice or wrongdoing; staff should be supported to raise their concerns within the organisation without fear of reprisal. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Himley Manor Care Home on our website at www.cqc.org.uk.

Following this focussed inspection the overall rating for this service is 'Requires improvement'. However, the service will remain 'special measures' until the next comprehensive inspection where all Key Questions will be reviewed.

Whilst steps had been taken to improve people's safety there was a continuing breach of legal requirements due to the limited timescales since our last inspection. People's incidents were now being recorded by staff and a new reporting process had been implemented. This new process will take time to implement and we will continue to monitor and check these improvements on the next comprehensive inspection.

People living in the home, their friends and relatives told us that staff support and guidance had improved. People told us that recently staffs assistance maintained their safety and staff understood how they were able to minimise the risk to people's safety. We saw staff helped people and supported them by offering guidance or care that reduced their risks of harm. Care staff now had a clearer understanding of their responsibilities in reporting any suspected risk of abuse to the management team. Whilst staff were now confident that reported incidents were reviewed to improve care, continued evidence of this practice was needed. Staff were available for people and had their care needs met in a timely way. People told us their medicines were managed safely and administered for them by staff.

The manager had a range of audits ready to implement to demonstrate how they monitored the quality and safety of people's care and support. The provider's planned improvements will need to be fully implemented and demonstrate continued improvements are sustainable over time.

The manager had started to make improvements to the overall leadership of the home and both people and the staff team told us there were now opportunities to raise concerns and issue which were listened to.

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

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

Whilst there had been some improvement, sufficient action had not been taken and we identified ongoing breaches.

People benefited from increased staffing levels, and more knowledgeable staff. Staff were given clear guidance on how to mitigate people's risks. People lived in an environment where risks were identified and action taken to mitigate them.

We will check these improvements during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

Action had not been taken sufficiently; we identified an ongoing breach.

The management team investigated and took action about accidents and incidents which improved people's safety. The management team had reviewed staffing levels and increased staffing to ensure people had support when they needed it. Systems to ensure people were supported by trained staff had improved.

We will check these improvements during our next planned comprehensive inspection.

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.

We undertook an unannounced focused inspection of Himley Manor Care Home on 24 January 2018. This inspection was done as concerns had been received after our comprehensive inspection on 13 November 2017. The team inspected the service against two of the five questions we ask about services: is the service well led and safe. This is because the service was not meeting some legal requirements.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection. Following this focussed inspection the overall rating for this service is 'Requires improvement'. However, the service will remain 'special measures' until the next comprehensive inspection where all Key Questions will be reviewed.

Himley Manor Care Home 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 inspection team consisted of one inspector and two nurse specialist advisors. We reviewed the information we held about the home and looked at the notifications they had sent us. Statutory notifications include information about important events which the provider is required to send us by law. The inspection considered information that was shared from the local authority who are responsible for commissioning care.

During the inspection, we spoke with 10 people who lived at the home and three visiting friends and relatives. We 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 three night care staff, five day care staff, the deputy manager and the manager. We reviewed the risk assessments and plans of care for seven people and their medicine records. We also looked at provider audits for environment and maintenance checks, Deprivation of Liberty authorisations, two complaints, the last two months incident and accident forms, the home improvement plan, staff meeting minutes and 'residents' meeting minutes.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in November 2017 we identified a breach of the Regulation 12, the Regulation 13 and the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not actively supported to remain safe at the home through effective admissions assessments, incident management, risk management, staffing levels and safeguarding processes. The provider had a condition placed on their registration to restrict admission to the home unless agreed with the CQC. This was to ensure people living at the home remained safe while improvements were made.

This question was rated Inadequate and we have improved the rating to Requires Improvement. Whilst steps had been taken to improve people's safety there was a continuing breach of legal requirements due to the limited timescales since our last inspection. We could not be assured that the improvements we found during this inspection were sustainable or sufficiently embedded into practice.

At our last comprehensive inspection in November 2017 we found that the systems and processes to prevent abuse to people were not effective and incidents of abuse had not been reported as required.

At this inspection we looked at the improvements that the provider told us they had been made. We found that systems had been implemented to recognise and report allegations of abuse. However, we identified some incidents where appropriate action had not been taken. During this inspection we continued to identify further incidents to the management team where the process had not been followed consistently. These related to potential safeguarding matters that would need further investigation. These were rectified immediately by the manager. Whilst systems had been implemented by the management team to report and investigate allegations of abuse appropriately; these were newly developed and not yet embedded into practice. The provider had not yet fully demonstrated they had acted upon all safeguarding incidents and notified the local authority and CQC as needed.

This is a continued Breach Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities).

Where other potential safeguarding incidents had occurred staff had recorded the details, each incident had been seen by the management team. The management team had then reported these to the required external agencies, such as the police, local authority and CQC. Staff we spoke with were clear on their responsibilities to record and report any incidents. Staff we spoke with told us they would report any concerns about people's well-being and would not leave a person if they suspected or saw something of concern. The staff told us about some of the improvements since the last inspection which included clearer documentation to complete and an accessible and supportive management team who now reviewed incidents in support of people.

At our last comprehensive inspection in November 2017 we found that staff had not been deployed in sufficient numbers to minimise the risk of harm and emotional distress to people living at the home. The provider's history showed a lack of sustaining appropriate levels of staff to meet people's needs.

At this inspection people told us the numbers of staff on duty had improved and that staff supported them without delays and were available to respond to their request and monitor their safety. Relatives told us they had seen an improvement in how staff were able to look after people and were available when needed. We saw that when people were in the communal lounges there were staff present who responded to people or recognised a potentially unsafe situation, such as a two people becoming upset with each other.

We spoke with staff who told us they were confident they had time to look after the needs of people and were more able to promote and protect people's safety. The manager had implemented a system that reviewed people's needs and projected how many staff would be needed to fully support people. The manager confirmed this would be used alongside observations and feedback from others in the home.

All staff we spoke with had now received a supervision in which details of their roles, expectations and conversations about people at the home had been discussed. The manager had also progressed to making observed practice checks of staff to see how the staff work in practice. Mandatory staff training had been reviewed and all staff had now completed these courses. In addition, further courses in subjects on Mental Capacity and dementia care had been planned and were in progress.

Whilst the new systems are in place, and the provider has met the requirements of this regulation we will continue to monitor the provider and review the number of admissions to the home to ensure the regulation is not breached. We will also consider this regulation at our next inspection to check that the improvements have been maintained.

Although we found improvements in the staffing levels in the home these were recently introduced. We could not be assured that the provider had implemented systems to review the number of staff working in the home and to make changes to the staffing levels in the home to meet people's needs as required.

At our last comprehensive inspection in November 2017 we found that risk assessments for people were not consistently assessed, reviewed and/or updated in a timely manner. Guidance for staff about how to manage risks that have been identified was lacking. We found when people's needs changed, the required updates had not occurred and records in relation to risk were often contradictory. At this our most recent inspection we observed that some steps had been taken to review care planning documents and changes were being made to review and update people's care plans and risk assessments.

Where a person's needs had changed as a result of an incident the information had been documented and reported to the management team to make the required changes and update the person's care plan. However, not all care plans that linked to an incident had been fully updated. The deputy manager agreed that this work was ongoing. The provider needs to ensure that new information regarding a person's care is recorded and made available to staff to demonstrate how they are preventing or reducing a repeat of the incident.

A health professional we spoke confirmed that previously there had been no concerns raised by the provider in relation to a person's care. However, steps had been taken to ensure the care was reviewed and an alternative home sought to better support the person. Whilst these systems and process are being embedded and information shared with the appropriate health professionals, the provider had not yet fully demonstrated they had been proactive in these referrals.

This is a continued Breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities).

We looked at people's risk assessment and care planning documents. Where people had risks associated

with their care the required equipment had been identified, for example, the aid of hoists. Staff we spoke with knew the type and level of assistance each person required, for example two staff assisting a person to walk. We spoke with staff about the type of support people needed to remain safe and free from the risks of potential harm. Staff were able to tell us people who were at high risk and how they support them, for example having offering a chat and a cup of tea.

All people were supported by senior care staff to take their medicines every day. We saw people were supported to take their medicine when they needed it with the nurse taking time to explain the medicines and staying with the person whilst they took them.

Staff who administered medicines told us how they ensured people received their medicines at particular times of the day or when required to manage their health. Senior care staff told us they knew when people needed medicines 'when required' and the information had been available to them alongside the medicine administration records (MAR) folder. Where people required a short term course of medicines we saw that these had been ordered and administered. People's medicines records were checked frequently to ensure people had their medicines as prescribed.

The home was clean, maintained and odour free and staff were seen to use protective equipment, such as gloves and aprons where appropriate to reduce the risk of cross infection. There was an on-going programme to re-decorate people's rooms and make other upgrades to the premises when needed. Housekeeping staff were employed to work every day and had clear routines to follow. Staff received suitable training about infection control, and records showed all staff had received this.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in November 2017 we identified a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to ensure systems and processes were place to assess monitor and mitigate risk to people living in the home. The provider had a condition placed on their registration to restrict admission to the home unless agreed with the CQC. This was to ensure people living at the home remained safe while improvements were made. This condition of registration remains in place.

This question was rated Inadequate and we have improved the rating to Requires Improvement. At this inspection we looked at the improvement that had been made. Whilst steps had been taken to improve the overall governance there was a continuing breach of legal requirements due in part to the limited timescales since our last inspection.

There was manager in post who had been in post since our last inspection in November 2017. The manager had applied to register with CQC and their application was in progress. 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.

Since the last inspection the manager had developed quality assurance systems to monitor and assess the standard of care people received. Audits had not yet been fully implemented to identify and record the required ongoing improvements. The manager told us they were working through the actions from our last report and were prioritising the concerns. However, the manager and deputy manager had not completed a written record of these and confirmed they had verbally agreed these.

The manager had a new process in place for staff to record any accidents and incidents were which included management oversight. The management team oversight provided the opportunity to investigate the incident to ensure that any risks to people were identified and reduced or eliminated where possible. This included referrals to the GP, mental health teams and social workers in support of people's care. However, the manager had yet to introduce a falls audit to demonstrate how they were identifying trends or themes, such as certain times of the day or a particular area of the home. As the process was new to staff we noted that not every incident had been reported and recorded. The provider will need to demonstrate going forward that all incidents and accidents reported show learning and updated in people's care plans.

We found that whilst some staff knew how to provide care to people, not all records were accurately maintained to show this. These had not always demonstrated how changes to people's needs were being managed. There was a risk that any new staff working at the service could provide ineffective and inappropriate care, by following inadequate care plans. The management team were in the process of reviewing and updating all care files and where agreed meeting with the families but this had not been completed.

The provider will need to evidence that the implemented changes are sustainable and demonstrate how effective they are at assessing, monitoring and identifying improvement in people's care and treatment.

This is a continued Breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities).

Staff meetings were held and had been planned going forward and staff told us they were encouraged to make suggestions and were listened to. The staff team was led by the manager and deputy manager and the staff team told us they were now enjoying working at the home. One staff member told us, "Things have changed for the better since the new manager has started". All staff we spoke with said there had been improvements in paper records and team morale which had started to have a positive impact on people living the home.

The manager had held residents and staff meetings to inform and update on the providers most recent inspection and areas for improvements. The actions from these meeting demonstrated that steps had been taken to in relation to staff training, safety of people's care and mealtime experiences.

People and their relatives were complimentary about the new management team at the home and the relationships that were being developed. We were told by one person, "There's always someone [staff] about, they are darn good workers". One relative told us, "We have seen such a difference since [manager name] started". Another relative said, "There seems to be enough staff now".

The manager was now submitting notifications of events had to be submitted to CQC. A notification is information about important events that have happened in the service and which the service is required by law to tell us about. This meant we were able to monitor how the service managed these events and would be able to take any action where necessary.