Sammi Care Homes Limited

Himley Manor Care Home

Inspection report

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 13 and 14 November 2017 and was unannounced.

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. Care Quality Commission [CQC] regulates both the premises and the care provided, and both were looked at during this inspection.

Himley Manor Care Home accommodates 51 people in one building. At the time of our inspection there were 43 people living at the home who were receiving support with their care needs relating to old age and/or dementia.

At our last inspection in January 2017, we found that the provider was not always meeting the legal requirements set out by the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014 and were rated as Requires Improvement overall. The provider was failing to meet regulation 17 of the HSCA which related to the governance of the service and included a lack of effective quality assurance, inconsistent record keeping and a lack of training for staff.

After our inspection in January 2017 the provider met with us and provided us with an action plan outlining what they would do to meet legal requirements in relation to the breaches. We revisited the home and conducted a focussed inspection in July 2017 and found that the provider had adhered to their action plan and improvements had been made in order to meet the legal requirements. . At this inspection we found that areas previously improved had in the main not been sustained, with further breaches of the regulations identified and repeated.

The service did not have a registered manager. The provider had been managing the service with support from a deputy since the previous registered manager left in early September 2017. A new manager had been appointed and commenced in post on 23 October 2017, but had not yet registered with us. 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.

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.

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 or 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 in special measures.

The provider was failing to keep people safe. Admissions decisions including risk assessments that balanced and considered the needs and safety of people using the service were not in place. Staff were reactive not proactive to people's needs as a result of being rushed due to the high levels of dependency of people at the home. This meant they did not always prevent incidents that had the potential to cause harm to people, despite knowing the risks associated with their care needs. The provider was not reviewing the levels of staffing in relation to the complexity of people's actual needs. Recruitment practices were not robust and did not fully assure the provider that staff were safe to work with people at the home.

The provider had failed to take appropriate action without delay to investigate and/or refer to the appropriate body when concerns were reported to them. Incidents that affect the health, safety and welfare of people using services were not reviewed effectively or reported to relevant external bodies. On the whole, people received their medicines as prescribed. This meant that systems and processes implemented for medicines management were effective.

Peoples care was not always well coordinated and delivered in line with their needs and choices, as these were not consistently established. The mealtime experience lacked structure, choices and a sense of event, with insufficient staff to support people to eat and drink safely and in a timely manner.

Assessment and/or reviews required of people's physical well-being were sought appropriately; however people's mental well-being was not as well supported by referral to appropriate healthcare professionals. A number of people using the service were identified as having needs that required staff to have specialist training. Staff had not received training at a level that supported them to deal with people at the home with behaviours that challenge. Many staff had not received adequate supervision for a considerable period of time and in some instances none had been received since joining the service. Checks in relation to staff practices and competency were not completed.

Staff lacked knowledge about which people at the home were subject to a Deprivation of Liberty Safeguards [DoLS] and the application of DoLS by the provider was not effectively maintained.

Whilst most staff were seen to positively interact with people and actively support them within the restrictions of time constraints, there were isolated instances where language used to describe people was disrespectful. The provider failed to demonstrate a caring approach as they had not ensured the safety and quality of the service being provided to people.

Needs in relation to people's diverse needs, such as their cultural, sexuality and spiritual needs were not routinely explored and or care planned around therefore went potentially unmet.
Activities were limited and people were under stimulated due to lack of staff available to provide support to people to be meaningfully occupied. A lack of knowledge about some people as individuals and their lives

due to lack of holistic assessment was apparent. Complaints and concerns raised were not always effectively dealt with or taken seriously.

Involvement of people or their relatives in the development of care plans and reviews was variable. Care records were not updated in a meaningful way and so were not fully reflective of people's needs, particularly in relation to their dementia needs.

The service has been rated as Requires Improvement for the past three comprehensive inspections has not been fully compliant in all areas since August 2014. Following the previous 'requires improvement' rating, a minimum 'good' overall rating would be expected, but this had not been the case as we found the quality and safety of care that people received had deteriorated.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate

The service was not safe.

Staffing levels were not sufficient to meet people's needs in a timely manner and staff recruitment processes were not robust.

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

Safeguarding incidents were not recognised, dealt with and reported appropriately.

Medicines were overall effectively administered and managed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not supported by staff who received sufficient levels of specialised training and supervision to ensure they were competent to
meet people's complex needs.

Staff would benefit from a greater understanding of the Mental Capacity
Act 2005 [MCA] and the provider's application of the Deprivation of Liberties Safeguards [DoLS] required review.

People's dietary requirements were known by the staff although the support and monitoring of people at meal times was ineffective.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The areas relating to the safety and quality of the home outlined in this and previous reports demonstrated that the provider did not have a caring approach towards the welfare of the people using the service.

People did not always receive care that was respectful.

Staff were not always able to support people in the way they wanted because of constraints on their time.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always have their concerns dealt with effectively or receive care that was centred on them as an individual.

Care records did not reflect people's current needs and were not always accurate or up to date.

People were not always supported to be involved in activity or to engage in activities that they found meaningful.

Is the service well-led?

Inadequate

The service was not well-led.

Leadership and provider oversight of the service was disorganised and ineffective. The provider had failed to continuously improve the service provided to people over time and/or sustain any previous improvements made.

Quality assurance systems were not effective in assessing, monitoring and improving the quality of the service.

Incidents that occurred at the service were poorly managed, investigated, reported or learnt from.

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.

This inspection took place on 13 and 14 November 2017 and was unannounced. The inspection was conducted by two inspectors, a specialist advisor 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. A Specialist Advisor is a person who has specialist skills, knowledge and clinical experience in an area of practice relevant to the service being inspected; they are deployed by the Care Quality Commission to support the inspection process. The Specialist Advisor involved in this inspection was a registered nurse with specialist knowledge and skills of nursing people with general and dementia care needs.

We carried out this inspection because we had received six whistleblowing concerns about a number of key care aspects, including staffing and people not receiving personal care in a timely manner. 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.

In addition we received information from the provider relating to incidents that had occurred in September 2017 and October 2017 as a result of poor admissions processes and were under investigation. We also identified at that time that there was a potential lack of incident and safeguarding reporting by the provider.

We reviewed the information we held about the service including notifications of incidents that the provider had sent us. Notifications are reports that the provider is required to send to us to inform us about incidents that have happened at the service, such as accidents or a serious injury.

We contacted the local authority and commissioning services to request their views about the service provided to people at the home, and also consulted Healthwatch. Healthwatch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health

and social care services.

We spoke with eight people using the service. A large proportion of the people using the service had conditions, such as dementia which meant some of them could not clearly tell us their experiences of the care they received. 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 with us. We also spoke to five people who visited the service, ten members of care staff, the deputy manager, the manager and the provider.

We looked at care records relating to the care of four people using the service, six medication administration records [MAR] and four staff recruitment records. Management records we looked at included incident reports and a variety of audits that the provider used to monitor the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

People were not actively supported to remain safe at the home through effective admissions assessments, incident management, staffing levels and safeguarding processes. One person we spoke with told us that they preferred to stay in their room because they felt unsafe in the communal areas. A relative said, "Some people here are aggressive and often get upset although it has not bothered [person's name]". Another relative told us, "When I am here the residents [people using the service] are pushing and shoving each other and you [relatives] think is [person's name] safe?"

Staff were able to describe to us what 'abuse' meant, the harm people may be exposed to and what action they would take if they suspected someone was at risk, including the reporting procedures. Staff told us reporting procedures were to escalate incidents or concerns to the senior on duty. However it was clear from our inspection findings that this procedure was not always effective in safeguarding people, as reporting abuse or harm people had experienced to external bodies or taking appropriate action to minimise further risks to people's safety was not always evident. A staff member said, "The seniors don't follow things through when carers alert them". Another staff member said, "People being admitted here are more complex than before and need more support than we can provide; there are more risks to people living here now of getting hurt". A third staff member told us, "They [managers] should not accept these people if we can't meet their needs".

We reviewed the records of incidents that had occurred at the service and also behaviour charts completed by staff describing the behaviour displayed by people that was challenging. Incidents recorded included serious physical assaults on people using the service. We found that when two people using the service had raised specific concerns alleged verbal and/or physical abuse they had been subjected to by staff, this had not been taken seriously and/or reported to the local safeguarding authority or to us at the Care Quality Commission. The provider had failed to take appropriate action without delay of investigation and/or referral to the appropriate body when abuse was suspected, occurred/discovered or reported.

During our inspection we observed that a number of people using the service had a high level of complex needs and frequently displayed behaviour that is often described as 'challenging' to other people using the service and staff. Prior to our inspection we received reports of the police being called to two separate incidents at the home in September 2017 and October 2017; this was due to high risk behaviours including violence towards staff and threats made to people by someone who had recently moved in to the home. As a result of our concerns we wrote to the provider asking them to give us a detailed account of their assessment process and risk assessment in relation to potential admissions. They told us that as a result of these incidents requiring police attendance they had reviewed their assessment processes to make them more robust. However a decision to move a person on a respite basis onto a permanent stay on the first day of our inspection showed no evidence to support the improvements the provider had written to us about. We found the decision had not taken into account the level of risk that some of this person's actions, including episodes of physical and verbal aggression that had been displayed both prior to and during the persons respite stay at the home. This demonstrated that a lack of robust assessment around admissions to the home remained apparent and continued to place people and staff at risk of harm and abuse.

This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last comprehensive inspection in January 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 the necessary improvements had not been made and risks in relation to people using the service were not consistently managed, assessed and/or mitigated effectively.

We explored with staff how well they understood and managed people's needs in relation to their care needs and any associated risks. They described how the level of peoples complex needs had increased in recent weeks but staffing levels had not and they described how this impacted negatively upon peoples safety within the home; for example through altercations between people when there were insufficient staff to monitor and support people in the lounge areas. Many of the staff told us they did not have the guidance, training or skills necessary to manage the complexity of risks presented by people's behaviour that may be challenging. A staff member said "We can't cater to the needs for a lot of the people here". Another staff member said, "I have no idea what these people have got [health conditions] as I've never seen their care plans, I don't have time to look".

From our observations, speaking to people and staff, reviewing care records and behaviour charts it was clear that a number of people using the service required an urgent review of their care needs by the appropriate health and social care professionals. We were unable to evidence from liaising with staff or reviewing records whether this had been recognised or proactively sought. Records reviewed particularly in relation to people on a respite stay were disorganised and not fully completed. We found that when incidents had occurred these had not been explored for any learning and failed to outline how future risks would be minimised. We also found that these had not always been reported to the safeguarding authority or to us at the Care Quality Commission. Charts in place in relation to recording peoples 'challenging' behaviour were not understood by staff and were poorly completed. Checks of the safety of the environment and equipment were regularly completed but personal evacuation plans in case of emergency, had not been completed for all of the people using the service. The provider was failing to consistently assess and mitigate risks to support people to stay safe through effective monitoring and management.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and their relatives if they felt there were enough staff on duty to safely provide care, one person said, "You have to make allowances if it takes them [staff] some time, they have got other people to see to". Another person stated, "There is a shortage of staff during the day time and night time", they went on to say, "There are not quite as many staff on at a weekend. It's an absolutely horrendous shortage at times. I have to wait between one to two hours for the toilet. I have to wait for two people and they are not always available". A relative said, "I don't think there are enough staff". Another relative said, "I worry about staffing when I am not around, I visit four days a week and there's a real shortage of staff. If you ask them [staff] to change [provide personal care to] [person's name] you have to wait, then remind them [staff] again, it's easier to do it ourselves sometimes, which we have done".

We observed care throughout the days of inspection and found staff were rushed and were unable to spend any significant amount of time with people in the lounge or communal areas. This also meant at times people were left unsupervised in lounges and dining areas which left them at risk of harm, such as falling or

without the care and support they required. On several occasions members of the inspection team had to intervene to prevent harm occurring to people and/or to provide support/comfort to people who were experiencing distress; for example to prevent people from undressing, to avoid falls and also from being verbally and physically attacked. We observed call bells ringing for long periods of time and/or people having to wait longer than was acceptable when they asked staff for help and/or their attention. Staff were seen to be asked by the manager on both days to delay and to cut short their planned breaks as peoples care needs had not been fully met. A staff member said, "We were actually told that we couldn't have any breaks today because you [inspectors] are in. They have offered to pay us the difference''.

We observed people were at risk of harm through failure of the provider to regularly assess and review levels of people's dependency on staff and the complexity of their needs to ensure an adequate number of staff were deployed. We saw that when new admissions or people's health needs deteriorated, for example requiring end of life care, no additional staffing had been considered. One person told us "They [provider] need more staff here. I can hear the other residents shouting in the middle of the night, sometimes it is really bad and one lady keeps coming into my room and she is quite aggressive". All of the staff spoken with reported to us they were unable to complete tasks in a caring way as they were so rushed due to peoples increasing needs. A staff member told us, "We [staff] just can't get people up as we should; we don't have the man power because some people who are really aggressive need three staff to support them. We are often here after shift doing paperwork because there is no time to do it beforehand. They [management] don't seem to have a clue how dependent some of these people are and how long it takes to complete personal care properly". Another staff member told us, "There are not enough staff to meet their [peoples] needs. Sometimes there is no one on the floor and this lack of staff makes it unsafe. The staff work so hard, some of them don't even get a break". A third staff member told us, "It's very disorganised here. You have to be in ten places at once. There have been a lot of staff who have come and gone here". The manager told us that staff turnover had been high in the past few months. We spoke with the provider about how they assessed the level of people's dependency and what tool was used to then establish adequate staffing. The provider had not completed the dependency tool available for some time; however, as care records seen were often not an accurate reflection of the level of needs people had, the tool would be unlikely to be effective.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last comprehensive inspection in January 2017 we reviewed the provider's recruitment practices; we found a full employment history had not always been sought or gaps accounted for and appropriate references were not consistently in place before staff began working with people. On this our most recent inspection we found the necessary improvements had not been made.

We saw that the Disclosure and Barring Service (DBS) check had not been undertaken in a timely manner for one member of staff that we looked at with. A DBS check helps employers make safer recruiting decisions and minimises the risk of unsuitable people being employed. Another member of staff working at the home had insufficient references on file and three out of the four files we looked at did not provide a full employment history.

At our last comprehensive inspection in January 2017 we found a number of issues relating to how medicines were managed. We found incorrect temperature recording for the medicines refrigerator. Guidance for staff for how to administer medicines to people prescribed to be given on an 'as required' basis medication was not always available and/or was not personalised to the individual. Medicinal patches applied for pain relief were not being alternated between areas on people's bodies in line with the manufacturer's guidance. Some gaps were found in administration charts and a stock count had not been

recorded when medicines had been received, this meant that we were unable to tell if people had or had not received their medicines as prescribed. On this our most recent inspection we found that the necessary improvements had been implemented and sustained.

People who were able to talk with us were on the whole satisfied with how staff supported them with their medicines. One person told us, "I am still on the tablets I was on before, there have been no changes", and another person said, "The doctor here cut my tablets down to one and there was a change in my blood pressure tablet. They [staff] put cream on my legs three times a day. They give my tablets to me". A relative said, "I have not heard anything from them so I am assuming they give [person's name] them [medication] what I was giving them [person] at home".

Medicines were stored and disposed of safely and records available demonstrated that people were supported to take their medicines as prescribed. Stock checks were completed throughout the day by staff to ensure people had received their medicines. We found that when gaps were identified in the medicines charts during the weekly audits undertaken, remedial action stated these omissions would be addressed with staff through supervision and competency checks; no evidence was found or provided to support these actions having been completed. The provider confirmed that competency checks had not been completed for all senior care staff administering medicines to people.

People were supported in an environment that was clean and hygienic. Bedrooms and communal areas were clean and comfortably furnished, with well-maintained decoration. Staff told us that they had received training in how to protect people from the spread of infection, for example through hand washing and the use of personal protective equipment. We observed that staff followed appropriate infection control and prevention practice, for example using personal protection equipment (PPE) when providing support to people and at meal times. We saw that staff washed their hands and used gloves and/or aprons at appropriate times. A staff member said, "There are always enough gloves and aprons for us to use and hand gel". Regular audits were completed and cleaning schedules were in place to ensure the cleanliness and suitability of the home.

Requires Improvement

Is the service effective?

Our findings

People's needs were not consistently assessed and staff had limited knowledge about people who had more recently joined the service. We asked staff about one person who had joined the service several weeks before and they were unable to tell us about the person and their particular needs. No individual assessment, care plans or risk assessments were completed for this person. The provider was registered to provide care to people with dementia in a home without nursing care. However we found that when people's needs had deteriorated in relation to their mental well-being and behaviour, the provider had not actively sought the specialist care and support that people needed. This meant that peoples care was not always well coordinated and delivered in line with their needs and choices, as these had not been established.

We asked people and their relatives if they felt the service effectively met their needs and we received varied comments about their skills. One person said, "They [staff] know what they are doing. They make sure that I am fed and washed". A relative told us that they felt staff were not sufficiently skilled to support people with dementia or to 'manage people when they got worked-up'. They said, "They [staff] try their best but I worry about [person's name] safety".

At this inspection staff spoke positively about the induction they had received. A staff member told, "I had a great induction, lots of shadowing and I did online training and had a tour of the building". Staff told us they had some updates from the newly appointed deputy manager as it was identified that staff had not received all their necessary updates they required.

The provider told us at our focussed inspection in July 2017 that they had identified that staff needed training in relation to behaviours that challenged. Staff told us they had recently been signed up to a distance learning course; staff spoken with were at varying stages of this, with some having completed it. The majority of the staff we spoke told us they felt ill equipped to support people with some of their more complex behaviours. The special advisor who supported this inspection identified a number of people using the service that did not have needs in line with those of a care home without nursing staff; with evidence seen that some people required support from staff with a specialist range of training. One staff member told us, "The challenging behaviour training we have here is not really geared to people with dementia who are often frail; it's really more for children and young adults". Staff received a range of mandatory training which they completed on line as part of their induction. Staff told us were given the opportunity to access and enrol for some accredited national vocational training that would cover a number of subject areas that related to the people using the service.

Staff told us they rarely had one to one supervision or appraisals which would have given them time to discuss any concerns or learning needs they may have. Staff told us they felt unsupported in their role; both through formal and informal methods. Feedback we received was that recent changes to the management of the service had impacted negatively upon staff morale and they felt unable to speak to management when they required support. We found and staff confirmed to us that they had not received supervision for considerable periods of time and in some instances none had been received since joining the service. A staff

member said, "I haven't had any supervision since I have been here". The majority of staff spoken with felt unable to access informal support from the provider or manager as they felt they 'wouldn't be listened to' and that they 'don't understand'. Another staff member said, "You can't really speak to [providers name] and [managers name]". Ineffective systems for supporting staff were clearly impacting upon staff morale and a high staff turnover was also evident. Checks in relation to staff practices and competency were not completed to provide the necessary support and feedback they needed about their performance and ensure they were sufficiently skilled to work with people.

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 application 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.

At our comprehensive inspection of the service in April 2016 we found that staff had a basic understanding of the MCA and DoLS, although they had not received any training in DoLS. During our inspection in January 2017 we found that over half of the staff had still not received any training in relation to MCA or DoLS and staff we spoke with did not understand what Deprivation of Liberty Safeguards (DoLS) meant or what this may mean for the people they were supporting. At this our most recent inspection we found that although the provider had sought additional online training as part of their staff induction and mandatory training, we found staff knowledge remained poor and the application of DoLS at the service was lacking.

Records did not consistently demonstrate that people's mental capacity had always been assessed or considered in a decision and time specific manner. Those applications made by the provider that had been authorised by the supervisory body had not been notified to us at the Care Quality Commission as was required. Staff were unable to identify who was currently subject to a DoLS authorisation and some struggled to give even a basic description of what DoLS would mean for a person subject to one. This meant that Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were not implemented or fully understood despite staff attending training.

Nevertheless, we observed that people were not restricted unnecessarily and that attempts to gain their consent were actively sought by staff before assisting or supporting them. A relative said, "They [staff] will come back and try again if [person's name] doesn't want to cooperate, they never force anything". A staff member said, "If people are not happy to come with us, say no to receiving personal care, then we try again later or gently encourage them".

At our last comprehensive inspection in January 2017 we found that the lunchtime experience lacked structure, and people were not supported to make or be offered choices. At this our most recent inspection our findings were similar, with lunch time being disorganised and no improvements were seen and/or had been sustained. People's thoughts and opinions of the food on offer and choices they had were varied. One person said, "Food is not as good as it was, I don't like the food on offer in the evening it's usually scotch eggs, pork pies, hotdogs or cheese on toast. They [staff] keep saying to me you can't keep having soup, they say you shouldn't have the same thing but I don't get the choices I like". Another person said, "I get food and its okay". A relative said, "[Persons name] gets smaller portions than they had been use to and has lost weight but they are still a good weight". Another relative said, "I have seen them [staff] coming around with

drinks during the day. The meals look quite good as well".

We saw that people were not openly given the opportunity to make food choices on the day, through providing visual and sensory prompts of plated up menu options for them to view. No menus were displayed. We observed that people using the dining room who needed assistance had significant delays in getting the support they needed to eat from staff. It was clear that there were not enough staff to ensure people who required assistance had individual attention when eating or were effectively supported to be independent. This meant that not all people had an enjoyable experience when being assisted to eat.

We observed lunch provision outside of the main dining room, in the lounge areas and found people who needed assistance and monitoring had been left unattended; for example one person was unable to reach the meal staff had put in front of them and another had spilled their plate into their lap. We found that the lunch time experience lacked a sense of being a social event, with tables not laid ready for people to be seated and no condiments offered. The provider said they had tried laying the tables before but people had pulled the table cloths off and took the condiments from the table, so they had stopped doing it. This further reflected that people were not supported by available staff appropriately during the lunchtime period. Staff demonstrated they knew those people who needed additional support and monitoring to ensure their nutritional needs were met; however records reviewed showed that although some people's weight and risk of malnutrition were reviewed regularly, others did not have assessments of the risks in relation to their nutritional needs completed. This meant that people's needs in relation to eating and drinking were not consistently considered with some people potentially not getting the support or choices that they needed or would like.

The home environment allowed people to walk around freely and with support people could access the garden area, which was secure. The home had signage that supported people with dementia to navigate independently to their room or the bathroom if they were able. However the environment was not ideal for people with dementia as it lacked the use of contrasting colour and items or areas within the home that would provide sensory stimulation. Restrictions were in place in relation to visitors, such as friends and relatives coming to see people at lunchtime, as the provider believed this was 'disruptive' for people.

Whilst we found that a number of people using the service required an urgent review of their care needs by the appropriate health and social care professionals, other people we spoke with told us they had access to a doctor when they needed one. A person said, "The chiropodist comes in to do my feet". Relatives spoken with said they were confident that all their family member's health needs were catered for as required. One relative said, "The district nurse has seen [person's name] about her pressure sores and the nurse practitioner came back out to her and she was very good". Staff spoken with knew how to support people and access support for them if they became physically unwell. Records we reviewed demonstrated that some assessment and/or reviews required of people's physical well-being were sought appropriately; however people's mental well-being was not as well supported by referral to appropriate healthcare professionals. When we discussed the complexity of people's needs with the staff and management, they frequently referred to 'medication reviews' being required or organised. No reference was made to other interventions that may be considered to support people, for example specialist support and guidance, particularly in relation to people's behaviours.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in January 2017 although people spoke positively about the caring nature of staff, the areas we identified that required improvement demonstrated that the provider's systems and processes did not always show care for the welfare of the people using the service. At this our most recent inspection we found the provider had not demonstrated a caring approach as they had failed to make or sustain required improvements.

During our visit we saw many positive interactions with people and observed staff actively supporting people, wherever possible within the constraints of their limited capacity. Staff were observed to stop and attend to people who appeared agitated or upset, but were not able to spend the time that would be favourable with these people, particularly in the mornings. For example we witnessed a staff member walking with her arm around a person who was tearful, guiding them to a seat and giving them a drink and sitting with this person for a little while until they were calmer. However, there were isolated instances where language used to describe people was disrespectful. We saw a member of staff point at a person they were assisting above their head and call out to other staff across the room 'can someone come and help me with thingy'. The manager told us about plans to try a new system at meal times and referred to people who needed assistance to eat as 'feeders'.

One person told us, "I stay in my room now, I don't like it downstairs. There are always arguments and fallouts". We observed occasions throughout the inspection days when the noise levels in the lounge areas particularly from people who required a high level of staff support but who were not being attended to, was overwhelming. We observed that people around this person appeared to be uncomfortable and troubled by the noise. Research shows that high levels of noise can trigger anxiety and agitation in people diagnosed with dementia, so unsurprisingly other people in the lounge may find such high levels of noise difficult to tolerate. We saw no efforts or consideration for other people seated in the area where the noise levels were raised and they were people who would be unable to mobilise independently or be unable to problem-solve independently due to their own dementia, so were reliant on staff to proactively think of their wellbeing. Records showed that one person's distress, including screaming and shouting out was frequent and had been increasing for many weeks. Staff told us and we observed that measures currently in place to support this person were ineffective but input from specialist healthcare professionals remained unsought. This meant that the person and people around them were being exposed to unnecessary distress and discomfort.

People who were able told us that overall staff were kind to them. A person said, "They are very kind and helpful and would get me anything I want, if I want anything they would do their best for me". Another person said, "Compared to last year it is worse now. It's gone downhill regards the staff, there are one or two that are not as helpful as the others". A relative said, "I think they [staff] are very friendly, they do look after them [people using the service]. If they are bringing [person's name] a drink they will ask me if I want one, but they are usually rushed off their feet". A second relative said, "They [staff] are always friendly with [person's name]".

We saw personalised information in some people's care records and plans which outlined individual preferences such as times they liked to get up, interests and important relationships, working history and lifestyle. Whilst this is good practice and would support the staff to provide person-centred care, the reality seen by the inspection team was that staff were rushed and therefore task orientated. Staff also told us that they did not have the time to read peoples care records. One staff member said, "There is no time to give people the care and attention and support they need". The provider did not support their staff in practical terms to achieve a high level of care delivery, for example through adequate staffing in relation to people's needs.

Where people had specific needs, for example cultural beliefs these had been considered, including how the person wanted these needs to be met and was recorded in line with their stated wishes, such as their food preferences. But a number of people's care records did not contain these details and so not everyone's needs were explored or known. This meant that some people's diverse, cultural, gender and spiritual needs had not been explored and therefore could be potentially unmet.

Information about local advocacy services was displayed and staff we spoke with were aware of how to access advocacy support for people. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

On the whole people and their relatives said they were happy with the level information about their care. A relative said, "We have been involved in doing [person's name] care plans and they [staff] let us know if anything is wrong". There was some evidence in the care records that had been fully completed that people or their relatives had been involved in planning their care.

Inadequate

Is the service responsive?

Our findings

During our focussed inspection in July 2017 we followed up on a breach of the law identified at our comprehensive inspection in January 2017; the breach related to how people's needs were not always assessed and met, documentation was unclear and not up to date and activities provision was lacking. We found the breach had been met in July 2017 as improvements had been made. However our findings at this our most recent inspection showed that these improvements had not been sustained.

We asked people and their relatives if the service was responsive to their needs and the responses we received were varied. One person told us, "I am always having to wait for the toilet. When I press the buzzer I have to wait such a long time, an hour or more sometimes, it's painful. [Deputy managers name] told me there would be changes and she said the number of staff would be increasing. In the meantime I have to keep waiting". Staff told us that they did not always have time to ensure people received care that was responsive to their personal care needs. In particular they said they did not always have time to ensure people were taken to the toilet in a timely way. A staff member told us "There is one person who has reported that staff are not doing the correct checks at night or taking them to the toilet when they buzz, but nothing happens". We saw that the person referred to by staff had been put onto a behaviour chart in respect of their use of their buzzer; we discussed the reasoning behind the chart being implemented with the manager and provider, but neither were aware this was in place and could not account for why this would have been done or how the information would be used. This meant that people did not receive the care they needed when they needed it and their needs were not being met in a personalised or timely way.

People's care records did not include sufficient information on how to support people living with dementia or take full advantage of the skills and strengths they maintained, or how to manage or support them with distressed or risky behaviours. Some records had evidence of involvement of people and/or their relatives in the planning and review of their care with some personalisation evident. However, in others we found no involvement of people or their representatives, no plans of care or any assessment of needs having been undertaken since they came to live at the home. Care records were not updated in a meaningful way and so were not fully reflective of people's needs, particularly in relation to their dementia needs. This meant people would not get the care they wanted in the way they prefer because no one had taken the time to establish this information from them, or their relatives.

Where efforts had been made to assess people's needs in relation to their behaviour, these were not addressed in terms of how they should be supported by staff. For one person whose care plans stated 'experienced low mood and anxiety due to her changing dementia needs', there was no guidance about what form of support or reassurance should be provided in order to help the person. Our observations and findings were that this person was spending extended periods of time in distress, shouting and screaming but staff lacked the guidance, skills or time to support and reassure the person appropriately. We also found that the evaluation and review of care plans lacked any meaningful analysis. For example we saw a care plan evaluated by staff saying 'remains the same'; however daily reports, behaviour charts and staff we spoke with identified numerous recent changes for the person with a clear need to refer the person to a specialist service.

Behaviour charts were poorly completed and this information was not used to inform care planning around the individuals' specific needs. For example, entries on one person's chart stated 'shouting out 'help me' throughout the night' and 'very vocal tonight', but no reference to this was made in their night care plan. Records we reviewed for this person contained no analysis of what this person what trying to convey through this form of communication or had no evidence of any changes being made in an attempt to support this person to have their needs met differently during the night. Another person's behaviour chart detailed incidents of 'punching doors', 'trying to break locks and handles' 'unzipping trousers and showing penis' and 'grabbed [person's name] by the throat'. We reviewed the persons care file which stated at the front 'no behavioural problems' and contained no care plans or risk assessments in relation to these behaviours. Staff spoken with said they felt unable to support and/or protect people from such complex behaviours due to a lack of support, guidance and availability of staff. This meant people were at risk of not receiving care that was responsive to their needs and placed staff and other people at risk.

Other people's care records we looked at had been completed more fully. For example, in one of the files we reviewed, we found that appropriate referrals had been made to the relevant health professionals in relation to other aspects of their health and wellbeing, such as skin health and nutrition. We spoke with a visiting district nurse who told us the senior staff on duty were good at letting them know if they had concerns about peoples skin health.

We asked people about activities in the home and they told us on occasion singers came in or they had their nails painted. One person said, "I watch TV and read a bit when I can". Another person said, "They [staff] do the best they can. They come in [into the person room] and go; it's not like they can stay very long. I get fed up with TV and I can't read now". Since our last focussed inspection in July 2017 a member of activities staff had left and so the remaining activities coordinator worked five, half days during the week. During our inspection days we saw that the activities coordinator had to step in numerous times to support people in the lounges and dining room with care needs, as allocated staff were frequently called away or not always apparent; we saw this limited the provision of any meaningful activities they were trying to engage in with people. Research shows that increased activity and engagement for people with dementia can have a positive effect on their quality of life and contribute to other important outcomes including mortality rates. This meant the people living at Himley Manor Care Home due to the low levels of engagement were at risk of social isolation, behavioural symptoms and poor quality of life.

There were three separate lounge areas and a large dining room on the ground floor. We saw that people frequently seated by staff without others near to them, often appearing isolated and looking bored. People were seen to experience long periods of time without any interaction or stimulation from staff or from other activity. We asked the provider what other support was available from staff to occupy, involve and stimulate people, other than the input provided by activities staff, they told us, "The care staff don't have any responsibilities to do activities at the moment". Staff spoken with told us they simply could not spend time doing any activities with people as they were too busy ensuring their personal care needs were met.

We reviewed how the provider dealt with complaints. A person told us, "I have been told off by the seniors [staff] for complaining". A relative told us, "I asked [manager's name] if she had done anything about a complaint I had made but she said she was busy. She was a bit short with me but I can deal with it, it's not a problem". Another relative said the provider was approachable and they could talk to them and that they hadn't got any complaints about the home.
The provider had a complaints procedure in an accessible format, that was displayed in communal areas informing people how to make a complaint and whom they should contact. The provider initially told us they had not received any complaints since our last inspection in July 2017, but two people we spoke with told us they had raised concerns and did not feel these were taken as complaints or properly investigated.

The provider then told us they had investigated the concerns raised but had not logged this as a complaint or incident as such. We asked them to provide the documentation in relation to their investigation but this was not forthcoming. By not recording all concerns and complaints made, the provider was missing an opportunity to put things right and to make improvements.

Inadequate

Is the service well-led?

Our findings

The service has been rated as Requires Improvement for the past three comprehensive inspections and has not been fully compliant in all areas since August 2014. The expectation would be that following the previous 'requires improvement' rating, a minimum 'good' overall rating would be awarded, but this had not been the case as we found the quality of care received had deteriorated. This meant that the quality of care and service provided to people living at the home was not continuously improving over time or sustaining any previous improvements.

The provider's systems to monitor and improve the quality of care had failed to identify and address the many issues we found. During the inspection we identified a number of concerns and four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because aspects of the service were not safe, were not well-led and did not provide effective, responsive care. Where audits and checks had been undertaken we found a lack of essential analysis and/or evidence of how issues when omissions or deficits found had been addressed. For example incident reports were poorly competed and no clear follow up action had been taken. Systems for audit and quality assurance of care records were not in place. Risks to people were not monitored due to the lack of on-going assessment of the dependency of people using the service, and ineffective admissions processes.

We carried out this inspection because we had received six whistleblowing concerns about a number of key care aspects, including staffing and people not receiving personal care in a timely manner. We had also received information from the provider relating to incidents that had occurred in September 2017 and October 2017 as a result of poor admissions processes, that were still been investigated. We identified at that time that a potential lack of incident and safeguarding reporting by the provider. The findings of the inspection team were that these concerns were justified. Throughout and at the conclusion of our on-site inspection we gave feedback about our findings to the provider, but they failed to fully acknowledge the failings we identified.

Providers are required by law to notify Care Quality Commission [CQC] of certain events which occur at the home. Records we reviewed indicated that the provider had failed to notify CQC of several notifiable events. We wrote to the provider in October 2017 asking them for a detailed account of their understanding of what incidents were reportable; they responded to us stating they, the deputy manager and senior care staff had a clear understanding of what was reportable. Despite these assurances during our inspection we saw that numerous notifiable incidents had not been reported to the appropriate external agencies and to us at CQC. We asked the manager to retrospectively submit all outstanding notifications to CQC.

During our inspection we found a lack of co-ordinated leadership, which was impacting upon the quality of care provided. Between September 2017 and our inspection date the provider had been managing the service with support from a deputy manager. There was no registered manager in post at the time of our inspection but a newly appointed manager had been in post for three weeks. They had not applied as yet to be registered with the Care Quality Commission [CQC] and their future plans to register with us were not made clear at the inspection. They told us that when they had taken on their role they had not been aware

of 'the amount of work required to bring the place up to standard'. This did not give us the necessary assurances that the manager was fully aware and prepared to make the necessary improvements at the home.

The provider was not proactive and required direction in relation to the need for reporting to and liaison with other health professionals; for example failing to organise the reassessment of some people's support needs to protect the person and others around them. The provider was unwilling to accept the findings we outlined in our written and verbal feedback including the fact that their actions and omissions meant that a delay had occurred in people's needs being fully met and considered. The provider did not have a clear oversight of the current needs of people using the service and failed to work in partnership with other agencies to identify and deal effectively with risks as they arose.

We asked people and their relatives if they knew who the manager was and what their opinions of the home were, their feedback was varied. A person said, "I don't know about management as I don't know who the managers are now". Another person said, "[Providers name] has been to see me twice. The new manager hasn't been to see me, I have liked this place but it's gone downhill". One relative said "I haven't met the manager. I have seen her in the office. I am really happy with this place". Another relative said, "They [management] are very insular. They don't move far from the office. They don't have the same relationship with the family members or their relations as the carers". A third family member said, "I don't see them [managers] very often, I would say this place has gotten slightly worse. They need more staff since [previous manager's name] left". Two other relatives that we spoke with who visited at least four times a week during the daytime said they had not met and could not identify the manager, saying, "We don't even know what they [manager] looks like, we aren't entirely happy with [person's name] being here as we don't have confidence [person's name] is properly looked after here". This meant that people were unable to identify the manager clearly, and they were not as visible or accessible to people or their relatives as they needed to be in relation to the day to day management of the home.

We asked staff about their views of management, including whether they felt supported. Responses we received included, "I don't get any support really or supervision but the new manager seems nice and we are a close team so we are hoping that things will get better", "First time I met the new manager was when she came out the office and was rude, shouting at us whilst we were waiting to get lunches out for people, she hasn't actually introduced herself properly", "The managers don't listen to us, there is no point telling them, that's why we are glad you are here to help, so things can get better" and "They [manager] need to get out the office and meet people and get to know them and see what the issues are first hand". Records showed that staff were not suitably supervised, or having their competency or practice observed and assessed. We found the management team were not apparent around the home over both inspection days but were positioned mainly in the office. Feedback received and our observations further demonstrated that management arrangements were lacking and the new manager had failed to establish themselves with people, relatives and staff alike.

The provider gave people and their representatives the opportunity to provide feedback about the service in the form of meetings and surveys sent out to them. A survey had been sent out at the end of 2016 but no analysis or changes made as a result of this feedback was available. This meant the provider had not demonstrated how they had analysed and responded to the information gathered, including taking action to address issues where they are raised.

The provider failed to have effective governance, including assurance and auditing systems that effectively assessed, monitored and drove improvement relating to the quality and safety of the service provided. In addition the systems and processes in place did not fully mitigate any risks relating the health, safety and

welfare of people using services and others. Providers are required by law to continually evaluate and seek to improve their governance and auditing practice.

The above evidence constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was required to display this most recent assessment of their overall performance in relation to the regulated activities undertaken at the premises. The provider had displayed their most recent rating at the home that was given to them by the CQC as is required by law. However the report and rating displayed on their website was not their most recent report. This report from June 2016 was however also rated as requires improvement so did not differentiate from the on-going rating of the home and providers performance.

This is a breach of Regulation 20A HSCA 2008 (Regulated Activities) Regulations 2014.

A recent meeting had been organised to provide information to relatives about changes to management structure but these had been well attended. People and their relatives spoken with were not clear about the management structure or recent changes or developments within the home. The provider told us to date they had not used any other form of communication with people or their relatives to give them the necessary information and updates about the service.

The provider had failed to sustain any improvements made at the time of our previous inspection and the quality and safety of the service had significantly deteriorated, so much so that the provider has been rated as inadequate in three out of the five areas that we looked at. This means that the provider has been rated as inadequate overall and has been placed 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.

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 or 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 in special measures.

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 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had failed to display their rating received as part of their CQC performance assessment for their regulated activities.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of service users of receiving the care and treatment and doing all that is reasonably practicable to mitigate such risks were not managed

The enforcement action we took:

We imposed a condition on the Provider's registration preventing them from admitting any additional service user until risks to service users are addressed.

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 and processes were not established and operated effectively to prevent abuse of service users investigate, immediately upon becoming aware of any allegation or evidence of such abuse.

The enforcement action we took:

We imposed a condition on the Provider's registration preventing them from admitting any additional service user until risks to service users are addressed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was an on-going failure of the provider to maintain or sustain effective oversight and management of the service, putting people who use the service at risk of poor quality unsafe care

The enforcement action we took:

We imposed a condition on the Provider's registration preventing them from admitting any additional service user until risks to service users are addressed.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	Insufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed Staff were not receiving appropriate support, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform

The enforcement action we took:

We imposed a condition on the Provider's registration preventing them from admitting any additional service user until risks to service users are addressed.