Asprey Healthcare Limited

Smallbrook Care Home

Inspection report

Suffolk Close
Horley
Surrey
RH6 7DU

Tel: 01293772576

Date of inspection visit:
12 April 2017

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26 May 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

Smallbrook Care Home is a care home that provides support to up to 41 people who are living with dementia. The home is located in Horley. The service specialises in supporting people living with dementia and also has a specialist unit specifically to support younger people with dementia. On the day of the inspection 37 people were being supported. The people at the home have a range of needs and are supported with a full range of tasks, including maintaining their health and well-being, personal care, support with nutrition and social activities.

On the day of inspection we met the registered manager. 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 inspection was unannounced and took place on 12 April 2017.

People felt safe living at Smallbrook Care Home. Despite this staff had not acted to protect people in a timely manner when a safeguarding concern was raised and put people at risk.

Recruitment checks on agency staff had not been followed appropriately. This also meant that agency staff had not been given information about people they were supporting..

Since concerns were raised the registered manager had implemented an action plan that focused on the reporting of safeguarding and the employment of agency staff.

Staff had received training and had the knowledge to spot signs of abuse and act appropriately to report it. The registered manager has implemented a robust agency checklist and induction. This measure safeguards people as the registered manager is now checking that agency workers recruited safely. It also ensures agency staff have the knowledge needed to support people appropriately.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

.The service was not always safe.

The service did not always respond appropriately to safeguarding concerns.

The service did not ensure that agency staff were recruited safely or had an induction before they commenced employment.

The registered manager had implemented an action plan and improvements had been made with regards to the reporting of concerns and the employment of agency staff.

Smallbrook 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 was 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 took place on the 12 April 2017. This was a focused inspection as we had received information of concern about staff understanding of safeguarding and recruitment checks for agency staff. We also focused on whether the service gave agency staff appropriate information to fulfil their roles. The inspection was unannounced and was undertaken by two inspectors who had experience in adult social care.

Prior to the inspection we reviewed all the information we held about the provider. This included any information sent to us by the provider in the form of notifications. Statutory notifications are information about important events which the provider is required to send us by law. We spoke to the safeguarding team and the quality assurance team at the local authority.

We did not ask the provider to complete a provider Information Return (PIR) because we were responding to concerns raised at short notice. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection spoke to two people, one relative, nine members of staff and the registered manager.

During the inspection we spent time observing the care and support provided to people. We also read other records which related to the management of the service for example training records, employment files, and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe living at Smallbrook Care Home. One person said, "I feel safe here and the staff take good care of me." Another person said, "It is safe and I don't think anything worries me." A relative said, "I feel X is safe."

Despite this staff did not always respond appropriately when safeguarding concerns were raised. Staff had not reported an allegation of abuse in a timely manner to appropriate authorities.

Failure to have established systems in place to safeguard people from abuse was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we spoke to the registered manager about what she had put in place to ensure staff reported allegations of abuse appropriately. The lessons learnt action plan focused on the reporting of concerns. The registered manager said she had worked on, "Senior staff being more confident in reporting concerns." The registered manager had spoken about reporting abuse in a recent senior meeting. We saw that safeguarding was also on the agenda for the next care staff meeting. The local safeguarding and accident policy and procedure had been updated so that staff had clear guidance on their roles and responsibilities in supporting people if concerns were raised. The registered manager had also introduced a flow chart for staff with step by step guidance on how to manage an incident of abuse. This included contact numbers for the local authority, Police and CQC. The registered manager said this was implemented to give staff the confidence to report abuse. Staff were aware of these updated policies and flow chart. One member of staff said, "We know where the procedures are kept and where the phone numbers are kept." People were supported by staff who had received safeguarding training. This included an induction to safeguarding when they started employment as well as a class-based course, which was regularly refreshed. The registered manager made sure all staff received safeguarding training. A member of staff, who delivers some of the training, said it was important that domestic staff understood what safeguarding was because, "They are the ones in and out of people's rooms all day and have the eyes and ears to be able to tell if there is something wrong."

We were reassured during the inspection that staff understood how to spot the signs of abuse and report allegations of abuse appropriately. One member of staff said, "You know your residents and can tell when they want to tell you something. It's a matter of being patient and listening to people. You know when someone is upset." Another member of staff said, "I would report any abuse to senior staff or the manager and I am sure she would manage this well. If nothing was done about this I would report it to CQC or the Local Authority."

As part of the inspection we looked at notifications the registered manager had sent to CQC. We have no other concerns with how the service had reported concerns. Appropriate action had been taken to safeguard people following these incidents. Feedback had been received from the local authority who told us the service was, 'Transparent,' when reporting concerns.

People were sometimes supported by staff employed through an agency. Before the inspection we received specific concerns relating to the recruitment checks carried out on agency staff employed at the service.. The registered manager informed us that before the concerns were raised there was no system in place to ensure agency staff were appropriately employed and . This included a lack of systems for checking agency staff identification before employment commenced. This put people at risk as agency staff identification and training were not being verified adequately.

The registered manager also informed us that agency staff had not received appropriate support to carry out their duties while working at Smallbrook Care Home. This included a lack of induction before their employment commenced. The registered manager informed us that, "There was not any agency induction," before they started. This put people at risk as they were being supported by agency staff who did not know how to keep them safe. For example, agency staff were not shown the fire exits so would not be able to support people safely in the event of a fire.

The registered manager had implemented a lessons learnt action plan which covered areas of agency staff employment. The registered manager said, "The lack of agency induction was a lesson learnt." During the inspection we saw the registered manager had implemented an agency checklist and induction. The checklist looked at checking the identification of the agency member of staff and looking through their agency profile. The induction covered areas such as health and safety, professional conduct and people's support needs. A member of staff said, "We have now introduced flow charts so we all know what to do. We check agency staff now".

On the day of inspection the service was using two agency staff. They both confirmed that they had been recruited using the new procedure and had received a robust induction. We saw the supporting evidence for this. They both said they were confident in fulfilling their role and responsibility at Smallbrook Care Home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff failed to proactively protect people following a safeguarding concern.