

Sammi Care Homes Limited

Himley Manor Care Home

Inspection report

133 Himley Road
Himley
Dudley
West Midlands
DY1 2QF

Tel: 01384238588

Date of inspection visit:
05 January 2017
06 January 2017

Date of publication:
16 March 2017

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

Himley Manor Care Home is registered to provide accommodation, personal and nursing care to a maximum of 51 people. At the time of our inspection there were 40 people living at the home. People who live there have health issues related to old age and/or dementia.

This inspection took place on 5 and 6 January 2017 and was unannounced. At our last inspection in April 2016 we found a breach of the legal requirements of the Health and Social Care Act and issued an overall rating of requires improvement. The breaches found 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 April 2016 the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. At this our most recent inspection we found they had not fully completed the necessary improvements in a timely manner.

The service had a 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.

Medicines within the service required more comprehensive checks to be completed and guidance for staff in their administration to be implemented. Risks to people's health and ongoing wellbeing were not consistently assessed, reviewed and updated; although staff were able to describe how they supported people to keep them safe from harm. Records in relation to incidents that occurred did not always clearly demonstrate the outcome or outline any learning or changes to practice as a result. Recruitment processes in place were not robust and some gaps and omissions in the necessary checks required before staff began working at the service were evident. Staff protected people from abuse and harm and knew how to recognise signs of abuse and raise an alert if they had any concerns. Staffing levels were adequate in order to meet and support people's needs.

Training provision was inconsistent and was lacking in terms of variety and availability for all staff, particularly new starters, who were commencing work without any up to date training being provided. Deprivation of Liberty Safeguard's [DoLS] was not clearly understood by all staff and most had not received the training necessary to improve their knowledge in this area. People's consent was sought by staff before supporting them and some consideration was given to their mental capacity to make informed choices. Staff accessed input from health care professionals for people when they needed it. Meal times lacked a sense of occasion and people were not supported as effectively as possible in relation to making food choices. Staff were provided with supervision and had access to the support they needed when they needed it.

People were most complimentary about the caring nature of staff; however the areas requiring improvement outlined in this report demonstrated that the provider did not always show caring for the

welfare of the people using the service. Staff were patient, reassuring and gave people the encouragement they needed when supporting them. Information about local advocacy services was displayed and staff we spoke with were aware of how to access advocacy support for people. Staff treated people with dignity and respect and were discreet in relation to assisting people with their personal care needs.

People's cultural needs were not always understood by staff or met. Assessments and reviews of people's individual care needs lacked their involvement or that of their representative in their development. People had some planned activities made available to them, for example visiting singers and film days, but more personalised activities were not in place. People were encouraged by staff to maintain relationships with their friends and families. Information about how people could make their views or concerns known, including information about how to make a complaint were available.

Issues identified at our last inspection in April 2016 had not been fully addressed, in the timely manner expected. The provider's quality assurance systems were not always effective in identifying and addressing issues of concern and that may affect people's safety. People's feedback in relation to the quality of the service was sought through a variety of meetings and surveys. People were positive about how effectively the service was managed. The provider promoted an open and inclusive culture within the service with people and staff able to freely raise any concerns they had. The registered manager understood their responsibilities for reporting certain incidents and events to us that had occurred at the service or affected people who used the service.

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?

The service was not consistently safe.

Medicines management required more comprehensive checks to be completed and the further development of guidance for staff in their administration.

Records and checks in relation to recruitment and safety of equipment in use were lacking.

Staffing levels allowed staff to meet people's needs and provide the care they needed in a timely manner.

Requires Improvement ●

Is the service effective?

The service was not consistently effective.

Staff were not adequately supported, as the provider failed to supply them with a comprehensive induction and ongoing training and/or updates.

DoLS was not clearly understood by all staff and they had not received the training necessary to ensure they were supporting people in line with principles of the Mental Capacity Act.

People's dietary requirements were known by the staff supporting them although the monitoring of risks in relation to malnutrition were not robust.

Requires Improvement ●

Is the service caring?

The service was not consistently caring.

The areas requiring improvement outlined in this report demonstrated that the provider did not always show caring for the welfare of the people using the service.

People were treated with dignity and staff respected people's right to privacy.

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

The service was not consistently responsive.

Care reviews lacked involvement of people or their representative in their development and review.

People's cultural needs were not always fully understood or met effectively.

People were clear about how to make their views known and information was available about how to make a complaint.

Is the service well-led?

The service was not consistently well-led

The provider lacked the necessary oversight of the service and had not fully addressed the breach of the regulations outlined following our last inspection in the timely manner expected.

The provider's quality assurance systems were not always effective in identifying and addressing issues of concern and that may affect people's safety.

Requires Improvement 

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 5 and 6 January 2017 and was unannounced. The inspection was undertaken by two inspectors.

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.

The provider completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about their service, what the service does well and what improvements they plan to make.

We liaised with the local authority and Clinical Commissioning Group (CCG) to identify areas we may wish to focus upon in the planning of this inspection. The CCG is responsible for buying local health services and checking that services are delivering the best possible care to meet the needs of people.

We spoke with two people who used the service. A large proportion of the people using the service had dementia type conditions and so 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 spoke with three relatives, a visitor, seven members of staff, the cook, the deputy manager, the registered manager and the provider.

We reviewed a range of records about people's care and how the service was managed. These included five people's care records, four staff recruitment records and ten medication records. We also examined a range of records used in the day to day management and monitoring of the quality of the service.

Is the service safe?

Our findings

At our previous inspection in April 2016 we saw gaps and incorrect recording in some people's Medication Administration Record [MAR] and we could not be sure that medication had been given as prescribed. We saw that the errors in recording had been identified previously by the registered manager, but these errors had continued occurring. We also found that guidance was not in place for staff in relation to 'as required' medicines they were prescribed, which meant that people were at risk of receiving these medications in an inconsistent manner. On this our most recent inspection we found that the necessary improvements had not been fully implemented.

Temperature records we reviewed for the medicines refrigerator showed that temperatures were being monitored incorrectly. This meant that the temperature some medicines had been stored at may have affected their effectiveness, for example insulin. The provider had put guidance for staff for those people receiving as required medication but this had not been done consistently. Some of the reasons seen for administration of 'as required' medicines stated 'for pain' or 'for agitation' and included in one record 'for behaviours'. This meant that the guidance was not personalised to the individual and as such there is a risk that staff may give the medicines inconsistently in the absence of clear guidance. Audits had failed to identify these issues.

We saw people prescribed medicinal skin patches for pain relief were having these provided at the correct intervals. However the patch was being alternated between two areas on the body and this was not in line with the manufacturer's guidance, which could result in unnecessary side effects. We found several gaps on one person's MAR but as no stock count had been undertaken when these medicines had been received this meant that the provider was unable to tell if people had or had not received their medicines as prescribed. Additionally we found discrepancies between the inhaler doses said to have been provided to two people according to their MAR and the doses still left in the inhaler. Weekly and monthly audits were being undertaken, including checks on stock levels and we saw that remedial action had been taken when omissions had been identified. However as not all medicines had not been counted when they were received, this may mean that such audits may be ineffective.

The provider told us in their Provider Information Return [PIR] that risk assessments for individual service users were in place and these are to manage the risks that have been identified. We found that records in relation to the potential risks to people had not been consistently assessed, reviewed and/or updated in a timely manner. For example, one person admitted over a month before our inspection had not had any assessment of potential risks and in another care record no review of the person's risks had taken place for several months. We found that in some instances people's needs had changed, so required updating. Other findings in relation to risk were that information in people's risk assessments and care plans were contradictory; for example differing information about the levels of support needed by a person to mobilise. Staff spoken with told us they had the information they needed about risks to the people they supported and any changes to people's risk management plans were communicated to them verbally at handover or recorded in the 'communications book'. We found staff clearly understood the level of risk to people and they were able to describe how they supported people safely, for example, by using moving and handling

equipment most suited to the person needs as outlined in their care plan. A staff member said, "I would check the care plan if I was unaware of people's risks".

The provider had a fire safety risk assessment in place with clear procedures in the event of an emergency evacuation. Personal emergency evacuation plans had been completed for each person, although these were not easily accessible in an emergency and contained limited information. We saw that the instructions they contained to guide staff in the event or need for urgent evacuation was not always appropriate, for example, using the hoist to transfer a person into their wheelchair. Staff we spoke with gave varied accounts of what they believed the procedures were for evacuation in the event of an emergency, such as a fire. We found that half of the staff had not received any fire training. Equipment in place was not consistently serviced or reviewed by the provider; we found that a hoist had not been serviced at the correct interval and the testing of the safety of portable electrical appliances/equipment was also overdue. This meant that checks of the safety of the environment were not comprehensive.

We reviewed the provider recruitment practices. We saw that appropriate checks were undertaken for people with the Disclosure and Barring Service (DBS) check. A DBS check helps employers make safer recruiting decisions and minimises the risk of unsuitable people being employed. However, the four recruitment files we looked at did not contain a full employment history, with gaps not accounted for. We also found that one staff member recently recruited had commenced employment without any references, although we were told that the provider had made numerous efforts to acquire these. No risk assessment had been undertaken in relation to this staff member working without references. Another file we reviewed contained only one reference instead of the two required by law. This meant that the provider had not completed all the necessary checks as was required by law when recruiting staff to work with people using the service.

People we spoke with were unable to tell us if they felt safe, but their relatives and visitors spoke positively about the staff's ability to protect those living at the home. They told us, "They keep [relative's name] safe" and "I never need to worry about [relative's name], it's all safe here". Throughout the inspection we observed staff supporting people appropriately to ensure their safety. A relative told us how their family member had fallen and described how the staff dealt with this, they told us, "[Relative's name] sits in the lounge much of the day now so they [staff] can watch her and reduce her risk of falls. Everything was put in place after [relative's name] fell; they put an alarm mat in place and did all they could to make sure she would be okay in the future".

Staff spoken with were clear about their responsibilities for keeping people safe and protecting them from avoidable harm. They told us, "There are different types of abuse, like physical abuse which I would look for unexplained bruising and there is financial abuse, in order to prevent this we have a safe that only the management have access to" and "I would explain my concerns to the individual where possible, explain to the manager about it and report any safeguarding issues accordingly". They were able to describe to us what 'abuse' meant and the harm people may be exposed to and what action they would take if they suspected someone was at risk, including the reporting procedures.

People we spoke with were unable to tell us their thoughts about the level of staff available to support them, but their relatives and visitors told us they felt staffing at the home was adequate. Their comments included, "They watch [relative's name] constantly, they are always around" and "Generally speaking there seem to be enough staff". We observed that there were enough staff available to meet people's needs in a timely manner during our inspection. The registered manager told us that staffing levels were regularly reviewed based upon people's needs and level of complexity or as more admissions were taken. Staff we spoke with told us that staffing levels allowed them to meet people's needs and provide the care when they needed it.

Staff told us, "Oh yes, the home is divided into wings now which gives us more structure so that we know where we are all are working and our responsibilities" and "If we are short of staff, we try to get cover from other staff, we help each other out to get everything done".

Relatives told us they were satisfied with how the staff supported their family member with their medication. One relative said, "I am more than happy with how they support [relative's name]". We observed staff support people to take their medication, with patience and staying with them until they were sure they had taken them appropriately. Staff competency in relation to medicines administration was periodically completed. Medicines were stored securely and disposed of correctly.

Staff were able to describe how they would deal with and report any incidents or accidents that occurred. Staff told us that they did receive information and updates about incidents that had occurred, in meetings and daily handovers. This meant that staff were informed of any learning from incidents or changes to practice.

Is the service effective?

Our findings

At our last inspection in April 2016 we found that staff had not all received training relevant to their role and those who had undertaken training in some subjects had not had an update of these areas in a timely manner. At this inspection, staff told us they were due to undertake training, telling us, "I am due to do some refresher training at the end of the month. I don't know what it is off the top of my head but the office tells me what I need to do" and "I have three lots of training to go on in the next three weeks". Two members of staff who had both worked at the service for a number of weeks told us, "They [provider] asked me for my certificates, but most of my training I did several years ago" and "I haven't had any training, it's on its way I think. I have never worked in care before, no". We saw that a number of training sessions were planned in for staff to attend in the next few weeks to address this issue and we saw a small number of staff had received training in November 2016. However, records we reviewed demonstrated to us that the provider's efforts were not sufficient in making the improvement required in a timely manner. The provider told us in their Provider Information Return [PIR] that training in their mandatory areas for staff had been organised to keep all staff up to date. Evidence of future planned training was provided to us by the registered manager during this inspection.

Staff told us they received an induction where they reviewed the provider's policies and procedures and spent shifts shadowing longer standing staff before working more independently. However we found that the provider's induction was failing to provide staff with the basic level of training and information required in order for them to commence work with people with the knowledge required, in line with the Care Certificate.

People we spoke with were not able to comment on the competency of staff supporting them, but their relatives and visitors were complimentary about their skills. They told us, "I can relax knowing [relative's name] is well looked after by the staff here, they know what she needs and are good at what they do", "The staff here are very good with [relative's name], I can't fault them" and "The staff here are great, very competent".

Staff told us they received supervision periodically but could also access the support they needed at any time. A staff member said, "Supervisions take place every three months, they are a two way conversation, so I can say whether I am happy or unhappy, whether I have any concerns and what I need help with". We saw that the supervision structure for staff was clear and checks were completed to ensure it was working effectively.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. At our last inspection 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 this inspection we found that over half of the staff had still had not received any training in relation to MCA or DoLS and at least three of the 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. One staff member told us, "DoLS? No I don't know what it means and have no idea if anyone is on one". This meant that the provider had not equipped staff with the knowledge or training they required to support people in line with the principles of the MCA and DoLS.

The provider had made applications to the supervisory body to deprive people of their liberty, but none had been authorised at the time of our inspection. A visitor told us, "The staff always asks [person's name] what he wants they don't make him do anything he doesn't want to". A relative said, "They [staff] always try to get [relative's name] permission and talk her through everything they need to do". We observed that people were not unlawfully restricted and that attempts to gain their consent were actively sought by staff before assisting or supporting them. A staff member said, "We have to apply if we want to deprive somebody of their liberties, like if they wanted to leave and it would be unsafe for them to do so". Records showed that people's mental capacity was overall considered and assessed when necessary and 'do not actively resuscitate' orders seen, followed current guidance.

People were unable to tell us their thoughts on the food on offer to them, but their relatives and visitors told us, "The food looks nice he seems to enjoy it", "We had an issue with [relative's name] eating, but they [staff] made changes and now she is eating much better" and "I think the food is excellent". We saw that people were supported through staff verbally asking them the day before about what they would like to eat the following day. However, most of the people using the service would not be able to make clear verbal choices and no pictorial prompts were used to support people to make these choices. The cook confirmed that no pictorial menus were available. People were not openly given the opportunity to make other food choices on the day, through providing visual and sensory prompts of plated up food choices for them to view, but were provided only with what they had chosen the day before.

We observed lunch and saw that people needing assistance or in their rooms received their meal and were assisted where required in good time. We saw that people had drinks within their reach or offered to them regularly. 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 cook was knowledgeable about people's individual dietary requirements, such as those people requiring soft or pureed meals and kept records in the kitchen for all staff to refer to. The cook described how she prepared food in relation to one person's cultural preferences. Staff demonstrated they knew those people who needed additional support and monitoring to ensure their nutritional needs were met; however records reviewed showed that people's weight and risk of malnutrition were not consistently monitored and/or recorded.

Relatives spoken to said they were confident that all their family member's health needs were well catered for. People's health and well-being was supported by staff who knew how to support them should they become unwell. Records we reviewed demonstrated that assessment and/or reviews required of people's health by external healthcare professionals, for example by district nurses was appropriately sought routinely and in more urgent circumstances.

Is the service caring?

Our findings

People who were able told us the staff were 'good' and 'nice'. Relatives and visitors were mostly complimentary about the staffs caring nature. Their comments included, "The staff treat him so very well, they are very kind from what I have seen", "The staff are excellent and yes very caring" and "They [staff] are absolutely brilliant, their strength is caring. They speak to people kindly and support them with genuine care". Although people spoke positively about the caring nature of staff, the areas requiring improvement outlined in this report demonstrated that the provider's systems and processes did not always show care for the welfare of the people using the service.

During our visit we saw a lot of positive interactions with people and observed staff supporting and comforting people without hesitation. Relatives and visitors we spoke with told us that staff were comforting towards people and provided them with the reassurance they needed. They said, "They [staff] are comforting towards [friends name], they never rush him" and "It's a family type home and they [staff] always listen to [relatives name], they are so patient with her". We saw that the staff showed patience and gave encouragement when supporting people. For example we saw staff comforting one person who was anxious by using specific distraction techniques that the person clearly responded to whilst ensuring their dignity was maintained. A staff member who had only worked at the home for a short time shared their observations with us, saying, "The staff here really do care and the people living here are very much loved".

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. Relatives we spoke with told us they were satisfied with the level of communication and information they received. They said, "The communication here is perfect, if there are any changes in [relative's name] needs, they [staff] contact me immediately" and "They [staff] keep us informed and let us know if anything happens".

On the day of the inspection we observed staff treating people with dignity and respect and being discreet in relation to personal care needs. We saw that if people were in their rooms, staff knocked on the door and waited to be invited in before entering the room. Overall, people looked comfortable and well cared for, with evidence that personal care had been attended to and individual needs respected. Staff spoken with said, "I always try to treat people right as someday it could be my Mom or Dad, you work in care because you love it, not to get rich" and "When I am carrying out personal care I would cover people with a towel when I can and explain to them what I am going to do, I constantly explain what I am doing. If possible try to get them to do it themselves to give them their independence". We observed staff supporting people to be as independent as possible, for example taking a few steps where possible before using a wheelchair and also encouraging them to eat and drink as independently as they could before assisting them.

We saw visitors and relatives coming and going; they were all offered a warm welcome by staff. Those we spoke with all told us they could visit freely and were always made welcome. One relative said, "I can visit when I like, I am always offered a drink and made welcome".

Is the service responsive?

Our findings

At our last inspection in April 2016 we found that the care records did not have regular reviews with people or their representative's with some not being reviewed for long periods of time. At that time we spoke with the registered manager who said that the care records were being updated and were not up to date and that people were not involved in reviews. They told us and the Provider Information Return [PIR] stated they were planning to introduce reviews following feedback they had received from people requesting this. At this our most recent inspection we found that the work for completion had not been fully undertaken and the records we reviewed were inconsistent in relation to review, content and involvement of people in their development.

People we spoke with were unable to tell us if they had been involved in reviews of their care. Relatives told us they had been asked about their family member's care needs when they first came to the home but could not recall a review meeting since this time. We saw that people who were able were consulted about their care. The registered manager discussed their plans with us which they were developing a more systematic approach to reviewing people's care needs with their representative at regular intervals. This meant that people's care needs were not reviewed with their or their representative's involvement on a regular basis and not always updated when changes to their needs occurred.

We saw that records available to staff were not consistent in their content and level of information about people's care needs, likes and dislikes and personal history etc. Newer members of staff we spoke with who had worked at the service for a number of weeks told us they had learnt from other staff about people's needs and had some limited knowledge of people's preferences and life histories. This meant that staff did not always have all the information made available to them in order to ensure all aspects of people's lives were considered when supporting them.

The provider told us in their PIR that prior to admission the potential resident had a pre-assessment completed. This they told us this was to gain a good understanding of the person as a whole and to ensure that the setting could meet their needs. We found that people's cultural needs were not always understood by staff or being met consistently. We observed one person who used the service who had specific cultural needs, that staff were either not aware of or could not consistently cater for. We asked staff about this person's cultural needs and they told us, "Off the top of my head I don't know, it would be in the care plans" and "I am not totally sure. There is a person here who is of a different race but I am not sure if they have anything different".

We spoke with the registered manager about this person and they acknowledged that they could not always converse clearly with the person in their first language; they told us flash cards were being sought to communicate better with the person. They said that a small number of staff were able to communicate and/or understand this person, however they were not always on duty. We observed staff supporting this person who did not speak their language and it was clear that staff could not communicate how they wished to support the person and effectively gain their agreement. We reviewed the person's care records and found that although the person had been at the home for five weeks, no guidance was available for staff

about how to support this person such as care plans and risk assessments. This meant that the persons' preferences and needs could not be met effectively at all times.

This is a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014.

People had some planned activities made available to them, for example visiting singers and film days. Some efforts were seen in relation to gaining information about personalised activities that people may wish to do that reflected their hobbies and interests prior to coming to the home. For example, one visitor told us how their friend had a love of a particular singer and that staff would often play his records for them, which gave them a lot of pleasure. Relatives we spoke with said they were satisfied with the level of activity and entertainment the service provided to their family member. The home had been without a dedicated activities co-ordinator for three months and efforts to recruit to the post had so far been unsuccessful. The registered manager said that staff were being allocated on each shift to be responsible for organising activities; but they recognised that without a dedicated coordinator, an element of personalised activities for people was difficult. A staff member told us, "We [staff] do activities like bingo, film days and bake cakes. We have been to the local shopping centre and we have pub days and gone out for meals. An Elvis impersonator came in last week, the ladies loved his singing".

People were encouraged and supported by staff to personalise their rooms and display items that were of sentimental value or of interest to them. We saw a number of bedrooms and found a lot of personalisation such as people's own choice of furniture, pictures, personal effects and photographs. People were encouraged by staff to maintain relationships with their friends and families in a number of ways, including being welcoming towards their relatives and visitors during their visits to the home.

People's spiritual needs were established on their initial assessment. We saw in records that where a need was identified in relation to, for example religion, the provider ensured support was given to the person to follow this in line with their wishes. One local church sent volunteers along regularly to provide general support to people in line with their religious preferences and some people had attended the local church periodically.

People we spoke with were unable to tell us if they knew how to make a complaint, but their relatives were clear about how they would raise any concerns they had. A relative said, "They [management] don't mess about if you have got an issue, they act appropriately and sort it out".

We reviewed how the provider dealt with complaints. The provider had a complaints procedure which gave people the guidance they needed about how to make a complaint and whom they should contact. We found that the provider acknowledged, investigated and responded to each complaint received in a timely manner and in line with their own policy. Staff knew how to direct and support people to make a complaint. Complaints were logged and monitored for any trends. We saw that information was in an accessible format and was displayed in communal areas informing people of how they could make a complaint.

Is the service well-led?

Our findings

At our last inspection in April 2016 we found the provider to be in breach of the law in relation to the lack of good governance of the service. We found that quality assurance audits had not been completed to monitor the quality of the service, where medication issues had been identified these had not been addressed, staff had not received timely updates of their training and an accurate record of people's care needs had not been maintained. On this our most recent inspection we found that action in response to our previous findings in these areas, had not been fully achieved as outlined within this report. This meant that the provider had not taken the necessary action to make the improvements required as outlined at our last inspection.

The provider told us in their Provider Information Return [PIR] that they ensured regular audits of the home, health and safety, medication and care plans were undertaken regularly. We saw that the registered manager was undertaking a number of checks and audits with the aim of ensuring the quality of care and safety of the service provided. However, we found that the audits did not consistently identify the issues we found, for example with medicines management and safety of the environment. The provider told us they were aware of the deficits with training that we found and agreed that care records were not up to date at present, but were 'in progress'. Some of the records we reviewed showed evidence of the work that had been done to improve them, but we were told only around ten records had been completed so far. Evidence was provided to us and confirmed by staff relating to planned training in the weeks following our inspection. So although the provider had taken some action to address the issues we identified at our last inspection, this had not been done in a timely manner. Records of audits and checks being completed that we reviewed varied in the quality of their analysis and evidence of actions taken. This meant that the provider's quality assurance processes were not robust and/or fit for purpose.

The registered manager understood their responsibilities for reporting certain incidents and events to us that had occurred at the service or affected people who used the service. For example we saw that incidents that occurred were appropriately reported to the appropriate external agencies and us at the Care Quality Commission [CQC]. The registered manager and provider told us that they had not been aware that they were in breach of the regulations following our last inspection; they said they had read our last report but had not picked out this important information. However they had as was required submitted an action plan to us about how they would improve the service in the areas we had identified.

The signing off, review or action taken in relation to incidents by management was not always clear or complete. For example, the monthly analysis was a list of all the incidents that had occurred but no actual learning or changes to practice was outlined. This meant that any investigation or analysis of incidents may not be comprehensive, encourage learning or the identification of trends.

The provider did not carry out any formal audits at the home, but the registered manager told us they visited the home several times per month and was supportive towards them. The service had not been fully compliant with the regulations at any of our inspections since August 2014. We spoke with the provider during the inspection and they told us they needed to be more involved in the quality assurance of the

service and increase their oversight of the necessary improvements. We requested information from the provider about their service in the form of a PIR and this was fully completed and returned to us within the given timeframe. However the information provided on some aspects and key questions did not reflect when we found at our inspection.

This is a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014

People told us they were happy with how the home was run, with one person telling us, "It's pretty good and organised here". Relatives told us they were more than happy with how the service was run by the management team. They were complimentary about the skills of the registered manager saying, "The manager seems really good at what she does, she is around if you need to speak to her" and "I love [registered managers name] to pieces, she is always there for me and she's such a good manager and very much part of the place. You see her helping out the staff on the floor when needed".

Staff told us that there was an open culture within the service and they felt comfortable to raise any issues with the registered manager. They said that management and/or senior staff were supportive and that they were benefitting from regular supervision, meetings and a regular staff team. They said, "I am very happy working here and generally morale is very good here. We [staff] know that they can always talk to the manager if we have a problem or a concern" and "If I have any queries or questions, I can ask the seniors. They are always really helpful".

Staff told us they felt supported in their role through meetings and supervisions. They said, "I feel I am supported in everything I do here", "I attend staff meetings; they are usually held every month. This is a good forum for discussing concerns. I can bring anything up at these meetings and I would be listened to. The manager does listen and does try to make changes". We saw that a range of systems of communication were in place within the home, for example handovers. We found these were effective at ensuring staff had the information they required to provide people with the care and support they required. Staff told us they were clear about their role and what was expected of them and that they were encouraged to express their views and make any suggestions which could improve the quality of the service. This meant that the management of the service provided staff with the support they needed. □

Staff described how they would report any concerns they had if they learnt of or witnessed bad practice. A staff member, "I would whistle blow if I went through all the channels here to resolve an issue and I felt nothing had been done I would contact CQC, the local authority or the safeguarding team". The provider had a whistle blowing policy, for staff to refer to and this detailed how staff could report any concerns.

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. The most recent survey not as yet analysed or shared had predominantly positive comments based on the ones so far received back. Where any comments were less than positive, the registered manager had contacted the person directly to alleviate and/or address their concerns. For example, some feedback received identified that although a window in a person's room was frosted, ensuring their privacy, a blind would be beneficial at this window; this was put in place.

The provider had displayed their rating at the home and on their website that was given to them by the CQC as is required by law.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>People's cultural needs were not always understood by staff or met. Assessments and reviews of peoples individual care needs lacked their involvement or that of their representative in their development.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had not fully addressed concerns identified to them as part of their effective governance and oversight of the service. The provider's quality assurance systems were not always effective in identifying and addressing issues of concern and that may affect people's safety.</p>