

Walmley Care Home Ltd

# Marian House Nursing Home

## Inspection report

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08 November 2016

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## Ratings

Overall rating for this service

Inspected but not rated

Is the service safe?

**Inspected but not rated**

Is the service effective?

**Inspected but not rated**

# Summary of findings

## Overall summary

We carried out an unannounced comprehensive inspection of this service on 20 and 21 July 2016. Breaches of seven legal requirements were found and the service was placed into special measures. This was because people were not always supported by suitably deployed staff who had received sufficient training and guidance to care for people safely and in line with their needs, for example with safe moving and handling practices. We also found that staff did not always meet people's needs or interact with people with care or respect.

After our comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the seven breaches of regulation. We also met with the provider to discuss our concerns about the service and to hear about the improvements they planned to make.

Following this contact with the provider, we received further information of concern in relation to the safe moving and handling of people who were living at the home. We received information about two incidents that had occurred at Marian House Nursing Home showing that two people had come to harm, and that this could have potentially been avoided.

The information we received indicated that people were not always supported to move safely in line with safe moving and handling guidelines. As a result we undertook an unannounced focused inspection on 8 November 2016 to follow up on these concerns. This report only covers our findings in relation to this. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Marian House Nursing Home on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

The registered manager of the service had left in September 2016 and the provider had recruited a new manager to the post in September 2016. The new manager was in the process of applying to become 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.

Marian House Nursing Home provides accommodation for up to 42 older people who require nursing care and support with their personal care. There were 37 people using the service at the time of our inspection. During this focused visit, we looked at the risk to people living at the home who required support with moving and handling.

The manager had taken some steps to improve the quality and suitability of equipment at the home where they had identified that people were not always supported to use equipment that was safe and in a good working condition.

The manager had taken some steps to improve staff deployment and ensure that people were always

supported by the correct number of staff, although people could not be always confident that their personal needs would be met in a timely way.

The manager had begun to investigate and analyse trends of accidents and incidents that had occurred at the home to help prevent the risk of similar occurrences in future.

Staff had not always received appropriate training and guidance in relation to safe moving and handling practices, including for example, supervision and competency assessments. Some staff who had been supported to receive such guidance recently, told us that they had found this useful.

We observed that people were supported to move around the home safely and that staff practice in this area had improved. The manager had clarified the guidance available to staff about people's needs in relation to equipment use and moving and handling. Most staff we spoke with demonstrated an understanding of people's moving and handling support needs or knew where to access this guidance.

People's consent was sought and we observed that people's choices were respected by staff. Processes were not always followed to ensure that people's consent was sought in relation to the use of specific equipment to help keep them safe.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### **Is the service safe?**

People told us or indicated that they felt safe at the home.

The manager had begun to address concerns they had identified in relation to staffing and the equipment that people used, further improvements were required.

People were supported by staff who had access to guidance about their moving and handling needs.

**Inspected but not rated**

### **Is the service effective?**

People were supported to move around the home safely and in line with their needs during our visit.

Staff had not always been supported to receive training and guidance about safe moving and handling practice. This was being addressed and most staff we spoke with demonstrated an awareness of people's needs or how to access such guidance.

People's choices were respected and staff sought their consent in practice, however processes were not effective for seeking consent for people's use of specific equipment.

**Inspected but not rated**

# Marian House Nursing 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 and to look at the quality of the care people received in relation to safe moving and handling practice at the home.

We undertook a focused inspection of Marian House Nursing Home on 08 November 2016 to review whether people received safe moving and handling support. We inspected the service against two of the five key questions we ask about people's care: 'Is the service safe and effective?' This is because the registered provider was not meeting some legal requirements and we had received additional information of concern within these areas. This inspection was unannounced and was conducted by an inspector and an enforcement inspector. This inspection was conducted to assess whether improvements had been made to meet specific legal requirements, as planned and agreed to by the registered provider following our inspection on 20 and 21 July 2016.

As part of our inspection, we reviewed the information we already held about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur, including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection.

During our inspection, we spoke with one person who used the service and observed the care of other people living at the home who were not able to speak with us. We spoke with five members of staff, the new manager of the home, the registered provider and an external consultant who was supporting the registered provider to address concerns at the home and improve the quality of care people received. We also sampled nine people's care records and records maintained by the service about risk management, staff training and care planning.

Following our inspection, we spoke with a commissioner who had recently visited the home to check the

quality of care that people had received. The commissioner told us that they found that the registered provider had begun to address concerns we had raised following our inspection in July 2016. The commissioner told us that they had noted some improvements in the way staff supported people when assisting them with moving and handling.

## Is the service safe?

### Our findings

We conducted this inspection due to concerns that people did not always receive safe moving and handling support in line with their needs. We conducted this inspection to check whether the registered provider had made improvements in this area to help keep people safe. We found that some steps had been taken to improve people's safety at the home, for example, people's risk assessments had been updated with clearer guidance for staff, and moving and handling equipment of a more suitable quality had been sought for people living at the home. We identified that further improvement was required however, for example, to ensure that staffing levels at the home always met people's needs and that equipment assessments and other maintenance tasks were completed correctly.

One person we spoke with told us they felt safe living at the home. During our visit, we observed that people were supported to move at a pace that met their needs. Staff reassured people and talked to people about what was happening whilst supporting them to move around the home. Staff that we spoke with showed that they understood how people needed to be supported to move safely and in a way that met people's needs. On one occasion, we found that the method that one staff member used to support a person who walked independently, caused this person to rush and move at a slightly faster pace than they were able to, we raised this with the manager who told us that they would address this issue with the staff member. We found that the manager had recently completed risk assessments for people living at the home to advise staff of the support that people required with moving and handling and the correct equipment to use to support people safely. Most staff we spoke with demonstrated that they accessed and understood this information and one staff member we spoke with told us, "[The person's sling] is on the back of their bedroom door or we check the person's care plan [to check which sling is correct to use for the person]."

Most people living at the home required the use of a hoist and a sling so that they could move safely, with the support of staff. The manager was taking action to address concerns where people had not always been supported to use safe equipment that met their needs. One staff member we spoke with told us, "People's slings [to support people to use moving and handling equipment] are not in good order. People don't have their own equipment and the equipment they need." During our visit, we found that the manager was in the process of reviewing this area to ensure that people would always be supported to use equipment which was in a safe working condition and met their personal care needs. For example, the manager told us that all the slings in the home had recently been reassessed for quality and to make sure they were the appropriate sized slings that people required, as they had identified this as a concern. It was positive that the manager was taking this action, although we found that not all people's assessments for their slings had been completed correctly to ensure that people were supported to move using safe and comfortable equipment. The manager told us that they would continue to address this concern until they were assured that people had access to the correct equipment. The manager told us that they were ordering new individual slings for each person living at the home so that they could be confident that all people's slings were in a suitable condition and well fitted for people's needs.

Whilst the manager had begun to improve the quality and appropriateness of equipment for people to move safely, further improvement was required. Recent risk assessments had failed to identify that some people's

equipment for their beds, including bed rails, were unsafe and did not protect them from harm. We saw that the manager took action during our visit to address this issue to help keep these people safe. The registered provider had not established a clear process for staff to report ongoing maintenance issues at the home, including for example where two people's call bells were not working. The manager told us that people's call bells and equipment for their beds would be checked more frequently so that concerns could be promptly identified and resolved to help keep people safe.

The manager had established a more thorough method of reviewing incidents and accidents that occurred at the home, for example, looking at where and when people may have fallen and how to prevent similar occurrences in future. The manager told us that they had recently introduced a system whereby any such incidents such as falls, or changes to people's needs were identified by staff and reported in a timely way to help keep people safe and well. The manager was taking action to address a number of areas of concern at the home and was responsive to methods of driving improvement at the home.

The manager was taking steps to ensure that people were always supported by the correct number of staff to help keep them safe. The manager told us that they had become aware following previous incidents at the home that people had not always been supported with their personal care or to move around the home by the correct number of staff in line with their needs. One person had experienced a fall on two occasions where they had not been supported by the correct number of staff as outlined in the person's care plan and risk assessments. This person told us, "I used to have one staff supporting me, then I fell over... that's when two staff [started] supporting me... Staff have [since] been helpful and done what's needed." The manager told us that they had reinforced this requirement with staff during training and demonstrated that they were continuing to support staff to be effectively deployed to meet people's needs. Staff we spoke with were aware of the number of staff required to support people safely. One staff member told us, "I had heard, it is changing now, [but] in the past [staff] have been working solely on their own [when providing personal care to people]... I would personally refuse to do that." Another staff member told us, "The majority of the time, there is enough staff. We work in twos. Sometimes one of us goes [to support a person], if we can't do something [that requires two staff members], we wait for [additional staff]."

Although the manager was taking steps to improve staff deployment, feedback showed that people could not be confident that there were always enough staff to meet their needs in a timely way. We observed that there were brief occasions where staff were not present in communal areas to spend time with people and to check that people were safe and comfortable. One person we spoke with told us, "It is short staffed at the moment. We have to wait a long time [to receive personal care to meet their needs]." A staff member told us, "Sometimes we could do with more staff, it would make life easier for residents and staff. Residents wouldn't have to wait so much, we wouldn't have to ask residents to hold on for a few minutes." Most staff we spoke with told us that there were usually enough staff at the home and one staff member told us, "There are enough staff the majority of the time but staff call in sick." The manager told us that they had taken action to reduce the risk of staff absence at the home and that they intended to ensure that staff and nurses were more visible in communal areas.

## Is the service effective?

### Our findings

We conducted this inspection in response to concerns we had received that people were not always supported by staff to move safely and in line with their needs. At this inspection, we found that improvements had been made to the support people received, for example, people were informed of the care they received and staff had begun to receive training in safe moving and handling practice which they had found useful. Improvements were required in this area however, for example, as staff did not always receive the training they required for their roles and correct processes had not always been followed in relation to people's consent being sought.

Following our comprehensive inspection in July 2016, the registered provider had sought the support and guidance of an external consultant to address areas of concern at the home, including staff awareness of moving and handling practices. The external consultant was present at the home during our inspection. The consultant told us that they had conducted some staff observations during which they had provided staff with feedback about appropriate moving and handling practice, and addressed any concerns with staff practice that they identified to ensure people were supported safely.

One person we spoke with told us, "Staff are good at their job, they're kind." Most staff we spoke with told us they knew where to access guidance about people's equipment and the support people required to move safely. One staff member we spoke with demonstrated their understanding of why it was important for some people to use equipment to protect people in the event of a fall. Staff we spoke with described how they supported people with correct positioning based on their needs, to help keep these people safe whilst they were in bed. During our visit, we saw that people had been supported into this position appropriately.

The registered provider had recently organised moving and handling training for staff which some staff had completed at the time of our inspection. The manager assured us that plans were in place for all staff to have received this training within the fortnight following our inspection. Most staff we spoke with, who had completed recent moving and handling training, reported that this training had been useful. One staff member told us, "I found the training very interesting and detailed... I was reminded of things and I'm [now] able to carry out those tasks as we should, the training was quite an eye opener, because you forget little details that are very important." During our inspection, we observed that people were kept informed and given choices by staff before they received support to move around the home. We saw that people were made comfortable when they sat in communal areas of the home and when they rested in their bedrooms. Most people were supported to move at a pace that suited their needs and we saw that some people had access to their own mobility aids as required to help them to move safely around the home.

Some staff had completed moving and handling competency assessments which had been arranged by the manager to ensure that staff understood how to support people safely. The manager had begun to support staff through supervision sessions and competency assessments for their ongoing learning. One staff member told us, "It's a while ago since I had that... well over twelve months or longer since I had overall supervision and moving and handling supervision." Another staff member who had started more recently told us that they had not yet had supervision or a competency assessment. One staff member told us, "I had

a competency check a few weeks ago... to monitor and check how I support people. I feel supported in my role." A nurse we spoke with told us, "We supervise staff and ensure all moving and handling is done in the correct manner... people must be handled with care." The nurse provided examples of the equipment that people used to help keep them safe and confirmed details that we had viewed in people's care plans.

The registered provider had failed to ensure that staff had always been equipped with training and guidance to help them understand how to safely support people. New staff working at the home had not been supported to complete an induction that was in line with the Care Certificate, a set of minimum care standards that new care staff must cover as part of their induction process. Staff we spoke with had not received a thorough induction at the home. One staff member told us, "[My induction] started off well but then we were short staffed on the day so... I wasn't thrown in at the deep end as such but I sort of got on with it." We asked another staff member about their induction and they told us, "I had to pick it up myself sort of, I more or less know what I was doing, I was left to my own devices." One staff member we spoke with had only received moving and handling training more recently, rather than when they had first started in their role. Our discussions with this staff member showed that they had not previously been equipped with the full knowledge and skills about how to use equipment to support people to move safely and minimise risks. However, the staff member had routinely provided this support to people during the number of months that they had worked at the home. The manager told us that they had plans to provide additional training to staff and to review their induction process. Although the level of support that staff received for their roles had improved and most staff we spoke with had benefitted from their recent moving and handling training, not all staff had received such guidance at the time of our inspection.

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. We observed that people were provided with choices throughout our visit. People's decisions were respected by staff when people were supported to move around the home. We identified that staff practice had improved in relation to how people's consent was sought by the staff supporting people with their needs.

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 authorisation 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. During our last inspection, we found that people were not always supported in line with the principles of the MCA. During this inspection, we observed that staff practice had improved in this area, for example, people were asked for their choices and consent before they were provided with support by staff. Some people living at the home required the use of restrictions such as bedrails and lap belts to help keep them safe. We found that consent had not always been sought from people, or DoLS applications made in relation to these restrictions. Where people did not have capacity to give consent, best interest decisions had not always been taken with the involvement of their relatives and others. Guidance for the use of these possibly restrictive measures was not always clear in people's care plans. The manager assured us that this would be addressed.