Jeian Care Home Limited

Jeian Care Home

Inspection report

322 Colchester Road
Ipswich
Suffolk
IP4 4QN

Tel: 01473274593

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Jeian Care Home is a residential care home providing accommodation, personal care, and support to 12 adults some of whom may have dementia, at the time of the inspection. The service is one adapted building over two floors accessed by stairs or a lift. The service can accommodate up to 17 people.

People's experience of using this service and what we found
The registered manager and staff lacked an understanding of what constituted a safeguarding incident and how to deal with it and report it appropriately. A staff member told us they would be reluctant to whistle-blow incidents of poor care or harm. They explained that they would not wish to report on their colleagues. This demonstrated to us a lack of openness and transparency.

Due to a lack of staff training on positive behavioural support, people's increased anxiety behaviours were dismissed by the registered manager and staff as just, 'known behaviours'. Staff did not record incidents in enough detail and there was a lack of actions documented. The registered manager did not analyse incident records to look for patterns or trends to help reduce the risk of recurrence of these events.

The registered manager had not made sure appropriate organisations such as the Care Quality Commission (CQC), were informed when incidents happened, and things went wrong. Staff when spoken with had a lack of understanding of what constituted learning from an incident and were reluctant to share examples.

The registered manager had not notified the CQC of incidents they were required to. Relatives told us that although communication was good, when an incident happened such as the outbreak of COVID-19 or an accident at the service, the registered manager and staff did not inform them in a timely manner or in a transparent way.

There had been some improvements made since the last CQC infection control and prevention inspection. However, the registered manager and staff did not always follow up-to-date national guidance on COVID-19 infection control and prevention. We have signposted the provider to resources to develop their approach.

There were missing risk assessments about people's known risks, including a fire safety risk. Where people had risk assessments and care plans in place, some of these records lacked information to guide staff fully.

There were not enough staff to meet people's care and support needs. Staff worked hard but had become task orientated. Staff had little or no time to engage people with conversation and or activities. This did not promote people's well-being. People waited too long for personal care support. A staff member when spoken to about people waiting for support demonstrated a lack of empathy to the situation. This was due to the lack of staff, making staff task orientated rather than supportive.

Recruitment procedures were in place to check whether a proposed new staff member was suitable to work

at the service.

There was a lack of organisational oversight at the service. The service had a history of not sustaining improvements made. The registered manager could not evidence they were carrying out audits to monitor the service provided and drive improvement. Several documents such as, audits and corresponding action plans were requested by us as part of this inspection, but they failed to supply us with these. Relatives told us they were not given opportunities to feedback and make suggestions on the running of the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was good (published 26 January 2018). Since the last rated inspection an infection prevention and control non-rated inspection was carried out on 17 December 2020. The service was found to be in breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvement had been made around infection prevention and control, but not enough improvement had been made in safe care and treatment and the provider was still in breach of regulations.

At the last inspection the CQC took urgent action to restrict new people being admitted into the service.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. The inspection was also prompted in part due to concerns received from the local authority about staffing levels, poor governance systems, poor staff morale and lack of organisational oversight. A decision was made for us to inspect and examine those risks. This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Jeian Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the safe care and treatment, staffing, good governance and notification of other incidents at this inspection. This puts people at an increased risk of harm.

Following the inspection, and the identified breaches, we had serious concerns about the quality monitoring systems of this service and so we took enforcement action. The provider is now required to send us a report each month to tell us the actions they are taking to monitor the service and make the necessary improvements.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will also meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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 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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Jeian Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by one inspector.

Service and service type
Jeian Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had two managers registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. One manager had resigned and deregistered with the Care Quality Commission during the inspection.

Notice of inspection
This inspection was unannounced. Inspection activity started on 20 May 2021 where we carried out the site visit and ended on 11 June 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and three relatives about their experience of the care provided. We spoke with four members of staff including one of the registered managers. We reviewed a range of records. This included selected plans and risk assessments from five people's care records and records about people's medication. We looked at a variety of records relating to the management of the service, including incident forms, and policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements had been made around infection prevention and control. Not enough improvement had been made around safe care and treatment at this inspection and the provider was still in breach of regulation 12.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- There was a lack of understanding from the majority of staff spoken with including the registered manager as to what constituted a safeguarding event. This meant people were put at increased risk of avoidable harm and abuse. A person with increased anxiety and behaviours that presented as verbal aggression was considered to display known behaviour, rather than a reportable safeguarding incident. This demonstrated to us that the registered manager and staff did not know how to respond appropriately. A staff member said, "[Named person] is verbally abusive to staff and service users. [They] have told me to [expletive] off. I am surprised how [named person] speaks to people. It seems like that is what [they] do but I am surprised."
- Staff told us they had been trained in safeguarding people from harm. However, records showed eight out of 11 staff listed did not have safeguarding training dates documented. Two staff struggled when asked to describe the different types of harm. When asked if they would report concerns as per their duty of care, a staff member told us they would not report about a colleague.
- Staff had not been supported with up to date training on positive behaviour support. This would assist staff understand up to date ways of supporting people with increased anxieties. This demonstrated a lack of understanding of how to improve the safety of the service provided and how this behaviour could affect other people's wellbeing.
- A person had been smoking within the service which was not allowed as it is an increased fire risk. The CQC inspector raised this serious concern to the registered manager and a staff member. The staff member confirmed, "I saw [person] light up." This fire risk had not been reported by staff to the registered manager. This demonstrated poor staff practice that, placed themselves and other people at risk of harm. When asked, the registered manager confirmed that there was no individual risk assessment around the significant increased fire risk of this person smoking in their room. The inspector had to ask the registered manager to complete this.
- A person's care call bell to summon staff was not long enough for them to reach when sat in their chair. The call bell lead also trailed across the floor. The registered manager confirmed they knew the lead was not long enough for the person to use and was a trip hazard, however had taken no action to rectify this.

● Records that documented people's incidents of increased anxiety and behaviours that can challenge had not always been completed by staff or were poorly written. There was also a lack of actions recorded to help guide staff to reduce the risk of recurrence.

Using medicines safely

● One person was receiving their medication covertly. A letter from the person's GP said the decision was made but not discussed with family as this person had no immediate family. However, on asking for a list of relatives to contact as part of this inspection a relative was named. This meant there was an increased risk that correct procedures were not followed when people lacked capacity to make decisions about their medicines.

We found no evidence that people had been harmed however, the increased risk of harm due to systems not being robust enough, and or followed by staff to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed that staff explained to people and sought their permission before administering people's medicines. A person told us, "They have never forgotten to give me my tablets or have run out."

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were somewhat assured that the provider was meeting shielding and social distancing rules. The registered manager had no plans to zone areas of the service or cohort staff should a second COVID-19 outbreak occur. This is not in line with current guidance. During the first outbreak of COVID-19 at the service no additional staff worked on shift to support people who had tested positive for COVID-19 to remain in their rooms. One person failed to understand the importance of staying in their room and was walking out and about in the service increasing the risk of cross contamination.
● We were somewhat assured that the provider was admitting people safely to the service. The registered manager told us that staff on shift and people living at the service did not have their temperature checked at least once a day. This is not in line with current guidance.
● We were somewhat assured that the provider was accessing testing for people using the service and staff. The registered manager told us they did not always complete their rapid COVID-19 tests just before they started their shift but tested themselves the night before. This is not in line with current guidance.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning records to demonstrate daily cleaning of communal bathrooms to promote good infection control practice were not always completed in full. For the month of May 2021, we found two occasions of where there were four days gaps in the recording.
● We were somewhat assured that the provider's infection prevention and control policy was up to date. The registered manager told us that best interest decisions for people unable to consent to COVID-19 restrictions, testing and vaccinations had been discussed but not recorded. As part of this inspection we asked to see the most up to date infection control audit and action plan and this was not submitted.

We have also signposted the provider to resources to develop their approach.

Staffing and recruitment

● There were not enough staff on duty to meet people's care and support needs in a timely manner. A person asked for 18 minutes to be supported to the toilet by staff. When a staff member was spoken with about this wait, they were dismissive in their response. They stated the person asks for this type of support, "10 times an hour."

● There was a lack of staff available to promote people's well-being with activities. The site visit part of the inspection was nearly five hours long and for people in the communal lounge they had sat in their chairs for this length of time. There were no activities laid on to help engage and entertain them. People who were sat in the lounge also used their side tables to eat their meals rather than eat at the dining table. This was a missed opportunity to promote people's well-being by eating at a dining table and enjoying social interactions.

● Staff were seen to be working hard but had become task orientated. This meant there was little or no time to interact with the people they supported. A person asked for a dessert during lunch. A staff member bought it to them, they did not stop to greet the person or stop to speak to them.

● Staff told us, "Two staff is not enough. Three would be better, they have recruited a new member of staff, so you hope." And, "There are not enough staff here at the minute but the [owner] has said yesterday he is going to put on more staff [weekend mornings only]." A relative confirmed, "The number of staff can be an issue," and gave an example. A person said, "Sometimes if someone is in the toilet you have to wait."

We found no evidence that people had been harmed however, there was an increased risk of people not having their well-being promoted and supported through a lack of staff on shift. This placed people at risk of harm and poor well-being. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Potential new staff to the service had a series of checks completed on them to try to ensure they were of good character. A staff member said, "I had a DBS (criminal records) check, two references, one from my last employer...I could not start until my references and DBS had been checked." They went onto confirm they also had to prove their identity and provide evidence.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager and staff did not always ensure that people's care and support needs reflected current evidence-based guidance. Staff had a lack of understanding and training on how to deal with increased anxieties with positive behaviour support and empathy. A relative said, "They have some difficult residents who are sometimes aggressive as they have dementia."
- A staff meeting minute recorded, "[Named staff member] is not happy with staff talking out of turn to other professional bodies and that [staff] should firstly think how they worded things as I could give the wrong message." This demonstrated a culture within the home that did not promote openness and transparency.
- Relatives gave examples of when they felt the registered manager and staff were not being open and transparent with them. One relative described staff as being, "Evasive", when there was a COVID-19 outbreak at the service. Another relative told us, "When the outbreak happened, I was only communicated to when I went up there as I used to do window visits. They [staff] didn't tell me by phone. I saw a COVID-19 positive sign on my [family members] door." Relatives felt this time delay and lack of important information about their family members well-being was not acceptable. A relative confirmed, "We are not always informed quickly."
- Accidents and incident records were poorly completed, lacked information including actions to guide staff to help reduce the risk of recurrence. These records were not analysed as part of the governance system to look for patterns of trends to aid staffs learning.
- The registered manager was unable to evidence audits undertaken to monitor the quality of the service being provided. An audit seen did not record when actions were to be completed by and by whom. Several documents were requested as part of this inspection but were not evidenced. This demonstrated to us that there was little, or no monitoring of the service being provided to identify and drive forward any improvements needed.
- Staffing levels meant that people's care and support needs were not always met in a timely manner. There was a lack of organisational oversight to recognise that staff, although working hard, had become task orientated when assisting people.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● During this inspection we became aware of two incidents that the registered manager was required to notify the CQC about, which they had failed to do. Both of these incidents were of a safeguarding nature.

This was a breach of Regulation 18: (Notification of other incidents) Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Relatives told us, and people spoken with had mixed opinions about communication with the registered manager. They said in general it was good. However, when events happened, they also said they were not communicated to quickly enough.

● Relatives spoken with said they had not been asked to complete a formal survey or questionnaire to give feedback about the service.

Working in partnership with others

● During the outbreak of COVID-19 at the service the local authority team supported the registered manager and staff at the service by helping on site during the registered managers absence.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager did not notify the CQC of incidents they were required to.

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 The increased risk of harm due to systems not being robust enough, and or followed by staff to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was an increased risk of people not having their well-being promoted and supported through a lack of staff on shift. This placed people at risk of harm and poor well-being. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration.