

Jah-Jireh Charity Homes

Jah-Jireh Charity Homes Wigan

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

We carried out an unannounced inspection of Jah-Jireh on 03 and 05 May 2017.

A comprehensive inspection was last carried out on 01 and 02 March 2016, when we rated the service as 'requires improvement' overall and found two breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, these were in relation to following safe procedures in the recruitment of staff and assessing risk. At this inspection we found the provider was now meeting the requirements of these regulations.

Jah-Jireh provides accommodation, personal care and nursing care for up to 45 people who are baptised members of the Jehovah's Witness faith. The care home is a purpose built two storey building with bedrooms on both floors. It is situated in a residential area of Wigan close to shops and public transport links. At the time of our inspection there were 39 people living at the home.

At the time of inspection the home 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.

Each person we spoke with told us they felt safe. Relatives expressed no concerns about the safety of their family members and were positive about the level of care provided. We saw the home had appropriate safeguarding policies and procedures in place, which gave instructions on how to report any safeguarding concerns to the local authority. Staff had received training in safeguarding vulnerable adults and demonstrated a good knowledge of how to identify and report any safeguarding or whistleblowing concerns.

We found the home was clean throughout and had appropriate infection control processes in place. Hand hygiene guidance and equipment was located in all the bathrooms and daily, weekly and monthly cleaning schedules were in place which specified the different tasks that needed to be completed and the equipment needed for each task. We saw immediately after the lunch time meal, staff vacuumed the dining room carpet to ensure it was free from crumbs and food items.

Staffing levels throughout the day and night were appropriate to meet people's needs. Staff, people who used the service and relatives we spoke with confirmed this. A dependency tool was used and updated each month to ensure levels remained safe and effective. The home had considered which times of the day were the busiest and organised rotas based on this information, for example two staff were rota'd to work 8.00 - 13.00 purely to assist with bathing during morning routines.

We saw medicines were stored, handled and administered safely and effectively. Staff responsible for administering medicines were trained and had their competency assessed. Audits were completed regularly

in a range of areas including administration and recording and we saw evidence these had identified issues and lead to improvements in practice.

Staff demonstrated a sound knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which is used when someone needs to be deprived of their liberty in their best interest. We saw the service was working within the principles of the MCA, and conditions on authorisations to deprive a person of their liberty were being met. Applications had been submitted where required and systems in place ensured re-applications had been made prior to authorisations expiring.

The home was in the process of completing a training matrix after the registered manager identified this was not in place when they commenced working at the home. As this was a work in progress, we noted a number of gaps, however staff confirmed they had completed all required training sessions and we saw a plan was in place to ensure refresher session had been completed with all staff during the next two months. Staff told us received regular supervision and annual appraisals, which along with the completion of regular team meetings, ensured they were supported in their roles.

We observed meal times to be a positive experience, with people being supported to eat where they chose. Staff engaged in conversation with people, explained the choices available and provided support where needed. People we spoke with were complimentary about both the quality and choice of meals available, with individual requests being facilitated if people didn't like what was on offer.

Throughout the inspection we saw interactions between the staff people who used the service were both positive and appropriate. Staff were observed to be friendly, caring and treated people with kindness, dignity and respect. People using the service commented on everyone being like 'one big family' and feeling very 'happy' about living at the home. The registered manager told us, "We are a family, everyone here is a practising Jehovah's Witness and we all worship together." We saw throughout the inspection that people's spiritual needs and wishes were at the forefront of the service's ethos and supported accordingly.

We looked at six care files which contained detailed information about the people who used the service and how they wished to be cared for. Each file contained detailed care plans and risk assessments, which helped ensure people's needs were being met and their safety maintained. People had been involved in discussing and planning their care. Reviews were completed on a monthly basis; and whilst people told us they were involved in discussions, care files did not capture this had occurred.

The home had a comprehensive activity schedule in place, which was heavily focussed on people's spiritual needs. Everyone we spoke with was positive about the type and frequency of activities available and felt what was offered reflected their needs and wishes.

The home had a range of systems and procedures in place to monitor the quality and effectiveness of the service. Audits were completed on a daily, weekly and monthly basis and covered a wide range of areas including medication, care files, infection control, health needs and the overall provision of care. We saw evidence of action plans being implemented to address any issues found.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe.

Staffing levels were appropriate to meet people's needs.

People we spoke with told us they felt safe living at Jah-Jireh.

Staff were trained in safeguarding procedures and knew how to report concerns.

Medicines were stored, handled and administered safely by trained staff that had their competency assessed.

Is the service effective?

Good 

The service was effective.

Staff reported sufficient and regular training was provided to enable them to carry out their roles successfully.

The dining experience was positive and we saw nutritional needs were being assessed and met with appropriate care plans in place.

All staff spoken with had knowledge of the Mental Capacity Act (MCA 2015) and Deprivation of Liberty Safeguards (DoLS) and the service was working within the principles of the MCA, effectively managing all applications.

Consideration had been taken to ensure the environment was 'dementia friendly' with a range of aids, adaptations and pictorial signage in place. Plans to develop a dedicated dementia unit within the home had been submitted to the local authority for approval.

Is the service caring?

Good 

The service was caring.

Throughout the inspection we observed positive interactions between staff and people. Staff members were polite and respectful and took their time to listen to what people had to say,

with appropriate physical contact used.

Both people living at the home and their relatives were positive about the care and support provided. People were able to make choices about their day such as when to get up and how to spend their time. Staff understood the importance of promoting people's independence.

Is the service responsive?

Good ●

The service was responsive.

Assessments of people's needs were completed and care plans provided staff with the necessary information to help them support people in a person centred way. Care plans and other records were regularly reviewed.

The home had a comprehensive activities programme in place, which met people's social and spiritual needs. Everyone we spoke with was positive about the activities and events provided.

The home had an effective complaints procedure in place, with all complaints being investigated and outcomes documented.

Is the service well-led?

Good ●

The service was well-led.

Both the people living at the home and staff working there said the home was well-led and managed and that they felt supported by management.

People told us they liked living at Jah-Jireh and would recommend the service to other people with similar needs.

Team meetings were held regularly with each designation of staff, to ensure everyone had input into the running of the home, were made aware of necessary information and could discuss their own agenda items.

Audits and monitoring tools were in place and used regularly to assess the quality of the service, with action points and completion dates generated.

Jah-Jireh Charity Homes Wigan

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.

The inspection took place on 03 and 05 May 2017 and was unannounced.

The inspection team consisted of two adult social care inspectors from the Care Quality Commission (CQC).

Before the inspection we looked at any information we held about the service. This included any notifications that had been received, any complaints, whistleblowing or safeguarding information sent to CQC and the local authority. We also spoke to the quality assurance team at Wigan Council.

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

During the inspection we spoke with five people who used the service to ascertain their views about the care and support provided. We also spoke with two relatives and nine staff members, which included the registered manager, clinical lead, senior supervisor, cook and five care assistants.

We looked around the home and viewed a variety of documentation and records. This included five staff files, six care plans, five Medication Administration Record (MAR) charts, policies and procedures and audit documentation.

Is the service safe?

Our findings

We asked people who used the service if they felt safe living at Jah-Jireh. Each person we spoke with told us they felt safe and well looked after. We asked relatives whether their loved ones received appropriate and safe care which met their needs. One said to us, "12 months ago I would have said no, but the new manager is so much better, we now feel very hopeful."

We looked at the home's safeguarding systems and procedures. The home had up to date safeguarding policies and procedures in place along with detailed reporting guidance. This ensured that anyone needing to report a safeguarding concern could do so successfully.

The staff we spoke with confirmed they had undertaken safeguarding training, which was refreshed and displayed a good understanding of how to report concerns. One staff member told us, "Yes, I have done it a few times. I would report any concerns to the supervisor or manager." Another said, "Yes, I have done the training and refreshers. If I witnessed anything I would report this to the manager." Staff were also knowledgeable of whistleblowing and how to report concerns. One told us, "I would report to manager, if issues is to do with them go above and report or go outside of the organisation."

We looked at five staff personnel files to check if safe recruitment procedures were in place. The home used a recruitment flowchart to ensure the process was completed fully and all necessary documentation had been received. Each staff file contained; an application form, full work history, proof of identity, two references and a Disclosure and Barring Service (DBS) check. A DBS is undertaken to determine that staff are of suitable character to work with vulnerable people. Where prospective staff had not been able to supply a full work history, or other gaps were noted in the information provided, a risk assessment had been completed to mitigate any risks to people using the service.

During the inspection we completed a walk round of the building, to look at the systems in place to ensure safe infection control practices were maintained. We saw the premises were clean throughout and free from any malodours. The home was adequately maintained and we saw evidence relating to the servicing and maintenance of equipment used within the home to ensure it was safe and fit for purpose. Bathrooms and toilets had been fitted with aids and adaptations to assist people with limited mobility and liquid soap and paper towels were available, along with signage containing correct hand washing techniques. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all the cleaning products in use.

We looked at how the service managed the control of infectious diseases. Regular infection control audits had been completed which included areas such as beds and mattresses, furniture, bedrooms and the general environment and equipment. Personal protective equipment (PPE), such as gloves and aprons were available throughout the home. Weekly and daily cleaning schedules were in place and up to date and these identified the task to be carried out and the equipment needed to do so. We saw that the home had been subject to an outbreak of diarrhoea and vomiting in November 2016 and had liaised with Public Health England regarding the appropriate management of this situation.

We asked people living at the home and relatives for their views on staffing levels. One person told us, "They are very good. I used to be a carer, so have experience in this area." Another said, "Oh yes, there are plenty." A relative told us, "There seems to be enough."

Staff members were equally positive. One said, "Since the new management came in they have massively improved. Staff levels are good and all shifts covered." Another told us, "I think we are good for staff." A third stated, "Not a problem, always fully staffed."

The home completed a review of people's dependency levels each month. The number of care hours that needed to be covered was generated from this information and staffing allocated to ensure needs had been met. We noted the home consistently allocated more staff hours than needed. For example in April the number of care hours per day was 123, whereas 163 staff hours had been allocated. The manager told us the home ran with 11 staff between 8.00 and 13.00 when need was greater, eight between 13.00 and 18.00, seven between 18.00 and 22.00 and four staff overnight. Each shift contained one nurse and one supervisor as well as care staff.

We looked at how the service managed accidents and incidents. Accidents and incidents had been recorded accurately and consistently and included a detailed record of what had occurred, a summary of the incident and an action plan. We checked historical accident records and found these had been appropriately completed and included a body map identifying the area of injury (where applicable) and the action to be taken to reduce the potential for further injury in the future.

Each of the care files we looked at contained a range of risk assessments, including ones on falls, pressure sores and nutrition. Care plans had been generated for each risk area identified, which included information on how best to support people to minimise risks.

We looked at medicines management within the home. Each person had completed and signed a document to confirm whether they wanted to take full responsibility for managing their medicines, have some involvement or hand over all responsibility to the home. Where people had chosen to self-administer medicines, a risk assessment had been completed, to ensure the person could identify their medicines, knew what to take and when.

Each person had Medicine Administration Record (MAR) chart in place. This contained the person's name, date of birth, room number, allergies and any special administration requirements such as swallowing difficulties or they received medicines covertly. An up to date photograph was also present to assist staff in identifying each person and their medicines. We checked five MAR charts and saw each had been completed fully and correctly. The clinical lead had identified issues with some missing signatures on MAR charts the day prior to our inspection, which showed that auditing systems around MAR charts were robust.

Topical medicine charts, for creams and lotions were in place and had been completed and patch location charts had also been utilised, which indicated where medicines prescribed in a 'patch' form had been placed, the date of application and when to be removed. We saw a running tally was kept on MAR charts for all boxed medicines.

The home had when required medicines (PRN) protocols in place. These explained what the medicine was, what signs to look for that the person may require this, non-medicinal interventions to try before administering medicines, the required dose to be given and length between doses. PRN variable dose sheets were also in place, onto which nurses recorded the date, time, strength and quantity of any PRN medicines administered. This ensured 'as required' medicines were being administered safely and appropriately.

We checked the controlled drug (CD) cupboard and saw this was locked with the key stored separately. We checked the stock levels of two people's medicines in the CD cupboard and saw that these tallied with the CD register. We also noted that all entries were supported by two staff signatures as is required.

The home had detailed, up to date medicines policies in place. We saw that all the staff authorised to give medicines had completed training in this area and had their competency assessed before doing so. A sample signature sheet was also in place, to assist with identifying who had administered and signed for medication. The home completed a number of medicines audits, including an in depth 47 point monthly audit, which covered staff training and competency, MAR charts, administration practices, ordering and storage. Action points and responsibilities for completion had been generated.

Is the service effective?

Our findings

We asked people living at the home for their views on the food. One person told us, "Meals are good. We get two choices at lunch and tea-time." Another said, "Its good food and we get a choice." A third stated, "I am a bit fussy and used to eating different sorts of food than what they make here. I tell the cook if I don't like something and they will make me something different." A relative told us, "I have no concerns with the meals here, all seem very good."

During the inspection we observed a positive meal time experience within the home. Dining tables were set up prior to meals being served, with each one containing a table cloth, napkins, cup and saucer and cutlery. A menu was available and people able to make choices about what they wanted to eat. People were able to eat in a place of their choosing, such as the lounge or their room; although on the day the majority had decided to use the dining room. People who needed support with eating, received this in a dignified manner, staff sought consent before each mouthful and went at the person's own pace. In the morning we observed staff taking breakfast to people who wished to stay in their room on nicely presented trays, that helped make the food look inviting to eat. We saw that prior to entering people's bedrooms staff knocked on the door and awaited for a reply before going in.

We looked at how the home managed people's nutrition and hydration needs. Each person had a Malnutrition Universal Screening Tool (MUST) in place; this is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. We saw these had been completed and updated timely to reflect people's changing needs. We saw special diets were catered for, food allergies had been clearly documented and people had nutrition and hydration care plans in place. Information on different diet types, such as a soft diet, had been sought from the speech and language therapy team (SaLT) and this informed the kitchen staff how to prepare and serve these types of foods. Advice from SaLT had also been provided regarding the provision of thickened fluids.

We looked to see how the home managed people's pressure care. Body maps were in place to document any marks or skin breakdown and a 'skin marks and bruising tool' was utilised, which identified potential issues and causes and led to the creation of a care plan. We saw Waterlow scores were consistently monitored. When people had been identified as at risk, we saw they had the necessary equipment in place to provide a reduction in pressure on vulnerable areas such as heels and the sacrum. This ensured people's pressure care needs were being met and monitored accordingly.

We saw the service worked closely with other professionals and agencies to meet people's health needs. Involvement with these services was recorded in people's files and included general practitioners (GP), chiropodists, district nurses and speech and language therapists (SaLT).

People who lived at the home told us staff had the right knowledge and skills to provide effective care. One person said, "Yes, the staff are well trained. They are confident and competent." Another told us, "They have regular meetings and do lots of training, all know what they are doing." A relative stated, "In regards to dementia, overall I would say no, however this is changing, there has been a definite improvement since

[registered manager] took over."

We looked at the homes staff training documentation. The manager was in the process of finalising a handwritten training matrix, as we were told the previous manager had not had one in place. We noted a number of gaps on the training matrix, which meant it was not possible to confirm staff had all completed necessary training modules. The registered manager told us previously certificates had been kept to evidence completion, however any that had expired had been destroyed, which they admitted was a mistake. They confirmed all staff had completed mandatory training sessions; however some refresher sessions were required. We saw a plan was in place to ensure staff were up to date with all training needs by the end of June 2017.

Upon commencing employment each staff member completed an induction programme, before they could work with people living at the home. One staff member told us, "I did things like moving and handling and dementia, induction taught me enough to start doing the job." Another member of staff told us, "As well as training, I also shadowed an experienced staff member; they provided any additional information I needed." We asked staff for their overall opinions on training provided by the home. One stated, "Management do a good job in this area, make sure we do training and all complete NVQ's." Another told us, "Training is good, we are doing a lot of stuff online, and do practical sessions in the home. We also have regular meetings to cover different areas."

We saw evidence that the Care Certificate was in place at the home. The Care Certificate was officially launched in March 2015 and employers are expected to implement the Care Certificate for all applicable new starters from April 2015. The registered manager told us supervisors and new staff had commenced the certificate initially, once complete, the supervisors would support all other staff to complete the process.

When looking at the homes files, we noted the manager had received feedback from a health and social care assessor which stated, "I just wanted to let you know that all your staff are working well towards the NVQ programme. You have some excellent staff with lovely values that I am sure are an asset to you and the residents they support."

There was a staff supervision schedule in place, which identified meetings during the year and was in accordance with the organisations supervision policy. Annual appraisals had taken place. The supervision schedule identified the name of the supervisor and supervisee. We verified this by looking at the notes of staff supervision meetings. We saw that recent discussions included the staff rota, any concerns or worries the staff member had, personal development, time-keeping, standards of working and working with colleagues. Staff confirmed meetings were completed regularly. One said, "I had my last one a couple of months ago. We can discuss all sorts of things including anything we want to do." Another told us, "We try and do five over the course of the year as well as an annual appraisal." A third stated, "Supervisions are done regularly, they are definitely useful."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The 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. We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff confirmed they had received training in these areas and had an understanding of both. One staff member told us, "DoLS is deprivation of liberty safeguards. The MCA states you have the right to make your own decisions if you have capacity, even if this isn't a wise one." A second said, "I have done training in these, we need to request a DoLS assessment when a person is being restricted."

The home had a DoLS tracker in place, which included the person's name, date application was submitted, who it was sent to, date it was chased up, date authorisation received, when authorisation expired and any conditions stipulated. We saw that applications had been submitted for any person lacking capacity who was deemed to be deprived of their liberty and re-applications had been submitted in a timely manner prior to DoLS in place expiring.

We looked at how the home sought consent from people. Each care plan contained consent forms, which had been signed by either the person themselves or their representative. During the course of the inspection we observed staff knocking on people's doors and waiting for a response before entering, staff asked people if they wished to take their medication and would they like to participate in the activities on offer. One person told us, "The staff are very good at doing this." Another said, "The staff always ask me, they are very polite."

Observations during inspection showed that some consideration had been given to ensuring the environment was dementia friendly. We saw there were some adaptations to the environment, which included pictorial signs on some doors and various areas of the building had been painted in a themed colour, which would assist some people living with a dementia.

At the time of the inspection the service had submitted plans to the local authority for the further development of a dedicated dementia unit on the first floor of the building. People who used the service and their relatives had been consulted about this and their feedback had been taken into account. Plans comprised of creating a more 'dementia friendly' environment including areas where people could walk around and also access the large and secure garden areas. The design of this new unit had been done in partnership with architects who were familiar with designing dementia friendly environments and the service had also consulted the latest research materials for this area of service provision.

Is the service caring?

Our findings

The people we spoke with told us they liked the staff and found them to be caring. One person told us, "The staff are so kind; I don't know how they do it." A second said, "Whenever they see you they always greet you and say things like good morning, how are you, would you like anything. They are all lovely"

People told us they were treated with dignity, respect and were given privacy at the times they needed it. One person said, "They always knock on the door before coming in to my room." Another said, "I feel treated with dignity, when I have visitors, they respect our privacy and leave us alone."

We asked staff members how they ensured people they supported were treated with dignity and respect. One told us, "Make sure anything that needs discussing is done in private, when providing personal care, cover people up with towels or a blanket." Another said, "Use people's names, refer to them using their preferred name, be discreet at all times and cover up when providing personal care."

We asked staff how well they knew the people they cared for and how they knew what they wanted. One told us, "We have regular resident meetings, things are raised here, plus we ask people what they want." A second said, "By communicating with people, involving them. I think it's important to cultivate friendships and relationships with people." A third stated, "Spend time with them, ask questions." People using the service confirmed staff discussed what was important to them. One said to us, "The staff come and chat with me, ask me what I want and like. We are like a big happy family here."

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights through good person-centred care planning. People's spiritual needs were of paramount importance to the service as well as to the people who used it, and we saw this was very much part of the daily routine within the home with regular family worship was available for all people and their relatives.

Over the course of the inspection we spent time observing the care provided in all areas of the home. Interactions between people who used the service and staff members were very warm and friendly. Staff attitude to people was polite and respectful, always referring to them by their name or chosen designation, which people responded positively to. It was clear staff had a good understanding of the individual people they supported. For example, during breakfast we saw a staff member gently assisting one person, encouraging their involvement whilst maximising the person's independence and recognising what they could do for themselves. We saw staff showed patience and encouragement when supporting people and also observed many occasions where staff spoke privately on a one-to-one basis with people.

We looked to see how staff promoted people's independence and offered them choices. A person told us, "Yes, they definitely do this. I get myself up, washed and dressed. They only help when I ask for it." Another said, "They let me do what I can and only help with what I can't." A third stated, "When I first came here I was encouraged to do as much for myself as I could. The girls encourage me and if I can't manage somebody will help me. Everything is always done with a nice smile and generous attitude." A staff member told us, "We

make sure we offer people choices and let them do what they can for themselves. If people can't answer verbally, we look for non-verbal cues to determine what they want."

At the time of the inspection no person using the service was in receipt of end of life care, however most of the staff members we spoke with told us they had all received training in this area. One said to us, "Yes, I have done an online course and day training at an external provider." Another said, "Yes I have, we also discussed this in one of my recent supervisions." However one staff stated, "I don't think I have."

We saw the home had put its name down with the local authority for training courses and pilot schemes in end of life care. The registered manager told us that key staff had completed training in this area and once additional training had been sourced this would be provided to all staff. Within the care files we looked at, we saw advanced care planning had been completed with people who had consented to do so.

Is the service responsive?

Our findings

People we spoke with told us they had been involved in making decisions about their care. One said, "Yes, I have. They talk to me about this." Another told us, "I discuss my care and what I want. I am involved in any changes that are made." A third stated, "They come to talk about this now and again and I look at the care plan. I am really happy with things."

We saw that people received care that was personalised and responsive to their individual needs and preferences. Prior to any new admission a pre-assessment was carried out with the person and/or their relative(s). People's support needs were carefully described within their care plans so staff knew exactly what tasks to undertake and how best to support each person. An admission checklist was in place, which included a range of questions relating to the process to ensure this had been completed correctly and all necessary documentation had been completed. People's care files evidenced individuals and their relatives had been involved in care planning and personal preferences had been discussed.

We asked staff how they knew what was important to people. One told us, "They tell you when you talk to them. I like to chat with people as much as I can." A second said, "Ask them. This information is also in the care plan, their wishes are also included in there"

Each care plan we looked at contained a personal history section which included information about the person's childhood, work history, family and spiritual life. These had been completed by the person themselves or a family member. Files also contained a detailed activity of daily living section, which covered 17 areas including personal care needs, social history and activity preferences, how the person expressed their sexuality and support needed at night. A care plan had been produced for each of the 17 areas, which included what the aims were, based on the person's wishes along with instructions for staff on how to support the person to achieve these aims.

We saw other evidence of person centred planning within the personal care needs section of the care file. This included information on people's communication skills and any issues they may have, which ensured staff knew the best way to communicate with each person. This section also provided guidance on people's needs and wishes relating to pressure care, pain management, memory and cognition.

We asked staff how they ensured care provided was person centred. One told us, "By chatting with them and finding out what they want." A second said, "We talk to people and every month we review their care plan and make any changes required to reflect a change in needs." A third stated, "This is about what they need, each resident personally. Support them with what they want to do, what they want to wear. It's about treating each person individually and meeting their individual needs."

We saw evidence of a personalised approach in how the home supported couple's living there to maintain a relationship. Care plans had been put in place around ensuring privacy was provided and time alone promoted and supported.

We looked at activity provision within the home. We saw people had a choice of activities to stimulate them. There was a notice board that advertised the spiritual and recreational activities on offer which included the library, reminiscence sessions, aromatherapy, arts and crafts, hairdresser, manicure, assisted shopping and outings. On the day of the inspection we saw that several people were writing letters to Russia, which was part of a world wide effort in response to recent political decisions made regarding the Jehovah Witness faith in that country.

We also observed people watching faith-related television programmes, people engaged in reading, whilst others took part in a painting and drawing activity. During the inspection a visiting activity worker, who worked for a non-profit making charity visited the home to provide a 'multi-sensory' activity which included light and sound stimulation. We spoke with this worker who told us that they had initially been requested to provide support to one person who was in need of more stimulation. They told us the initial period of three months planned support had been extended for another three months and as a result of this, the person receiving support had been able to more positively engage with people and in the activity itself.

The home had an activities co-ordinator who worked 17 hours per week, an additional four hours was provided by one of the care staff. People and staff both spoke positively about what was on offer. One person said, "We do bible reading, letter writing, attend the meeting on Tuesday's, all of the things I want to do, there is definitely enough going on." Another told us, "We are well looked after spiritually, more than enough going on."

Residents and relatives meetings were held regularly and information from these meetings was used to inform the delivery of the service. We looked at records from recent meetings and saw that discussions included prayer, the management structure, changes to the upstairs area of the home, food and house-keeping, staffing levels, trips out and laundry arrangements. People we spoke with confirmed meetings took place, one told us, "We have regular meetings, resident meetings I think they are called. We talk about all sorts of things."

We looked at how the service managed complaints and saw a complaints register was kept and the home had policies and procedures in place to enable them to receive and respond to complaints appropriately. We reviewed the complaints file and saw issues had been responded to in a timely manner. Each record identified the detail of the complaint, the reference number, name of the investigating manager, date letter of response was sent to the complainant, the investigation report date and the outcome. People told us they would speak to a member of staff or the registered manager if they had any complaints and would feel comfortable doing so.

We noted the service had received a high number of compliments. We looked at recent records and comments received included, 'A huge thank you to you and the team for all you do, not just for [my relative] but also for the elderly Witnesses you care for; even though [my relative's] dementia is worsening we have full confidence in Jah-Jireh and what it stands for; we view you all as our family, our brothers sisters and friends,' and 'I will always be grateful for the love and care you gave to [my relative] in the five years she lived at Jah-Jireh; you always made me welcome when I visited.'

Is the service well-led?

Our findings

At the time of inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, they are Registered Persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home had a clear management structure in place, with the registered manager being supported by a care manager and a business manager. A clinical lead was also in place, who oversaw the clinical aspects of the service and line managed nursing staff. The home had recently introduced the position of senior supervisor, whose role involved working alongside the registered manager, learning their role, to enable them to provide cover for any absences.

The staff we spoke with felt that the home was well-led and managed and they felt supported. One told us, "I like working here. Since the new management have been in place, it's much more enjoyable and I've noticed improvements in a number of areas. They take a personal interest in people which is appreciated." Another said, "I do feel supported. I had doubts about progressing but been very supportive, maintained good dialogue and the door is always open if I need to talk." Whilst a third stated, "I don't need to work, I do it because I love it. The management here are very good." During the inspection we spoke to an agency worker who stated, "From day one I felt thoroughly welcomed and have been made to feel part of the team; I always feel like I am heard when asked my opinion on nursing practice or possible improvements. I have worked in various homes and I feel that the honesty, kindness and team spirit are exceptional here and I thoroughly enjoy coming to work here."

We asked people living at the home if they would recommend the home to other people requiring the level of care provided. One said to use, "I have no problem with being here at all, I would definitely recommend it." A second stated, "They are very good and I am very happy living here. They make people feel very comfortable. I would recommend it to anyone."

We found the registered manager was very approachable and engaging and facilitated our requests throughout the inspection, as did the rest of the staff and management team. Staff told us the registered manager and other members of the management team were a visible presence within the home and happy to help with the provision of care. One said, "They put themselves about and are very supportive, little ways like helping out on the floor to give people a break." Another told us, "They are always out and about talking to us and the residents."

We saw that team meetings were held on a bi-monthly basis, with minutes recorded and kept on file for reference. The home held specific meetings with each designation of staff such as supervisors, nurses and care staff. As well as being used to discuss practice and the provision of care, staff could also raise and discuss their own agenda items. Staff also commented on the open door policy within the home and being able to discuss any issues in between scheduled meeting times. One told us, "I have been into the office once or twice to discuss various things. You can talk about anything, they are very approachable."

The home's policy and procedures had been purchased from an external company, Quality Compliance Systems (QPS), and included key policies on medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. Policies were updated by QPS and forwarded to the home, to ensure they stayed up to date with changes to legislation. We saw a number of the standardised policies had been amended and personalised by the home to ensure they reflected the working practices and type of care provided.

We saw a range of systems in place to monitor the quality and effectiveness of the service. End of shift checklists were completed to ensure all daily documentation and monitoring charts had been filled in fully and correctly and that cover had been arranged for any staff absence on the following shift.

Every two months surveys were carried out with people using the service. We saw people had been asked questions based on CQC's Key Lines of Enquiry (KLOE's), with each KLOE being covered separately. For example the January/February survey had looked at how 'safe' the home and care provided was. People had been asked 32 questions which included views on staffing levels, support provided and the skills and aptitude of the staff. An action plan had been drawn up to address any issues identified.

The registered manager told us upon commencing work at the home, they had identified some gaps in data protection practices. As a result a 'Caldecott' plan had been implemented to ensure information governance was improved and practices adhered to. The home now had a Caldecott champion in place.

Every three months a comprehensive internal audit was carried out by the provider. This included interviews of people and staff to gain their views and opinions, an inspection of the premises, inspection of medicines management, review of care provided; looking at consent, safe care and treatment, safeguarding practices, nutrition and hydration, activities and spirituality. The audit also focussed on CQC's fundamental standards relating to care, person centred practice, dignity and respect. Following the audit an action plan, who was responsible and timescales for completion was generated.

Internally the management team also carried out a further 18 audits which covered a variety of areas including provision of care, housekeeping and cleanliness, catering and quality assurance. For each one completed, an action plan had been generated to ensure continual improvement was maintained.

In order to maximise efficiency and ensure all necessary tasks had been completed, the provider had devised a yearly planner. This detailed when meetings were to be held, which audits needed to be done and when, which area the bi-monthly surveys would focus on, along with sections for recording information to evidence checks and monitoring had been completed. The management team told us this was a really useful tool, which ensured the service was being run and managed effectively.