Jeian Care Home Limited

Jeian Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 28 October 2014 and was unannounced.

Jeian Care Home is a residential care service providing accommodation and personal care support for up to 17 older people. On the day of our inspection there were 15 people living at the service.

There was a registered manager in place who is also the registered provider. 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.

People's safety was compromised in a number of areas. This included the management of people's medicines and the recording and analyses of accidents and incidents.

The provider did not operate a safe and effective recruitment system. They did not take steps to ensure that staff were honest and of good character. This had the

Summary of findings

potential to put people at risk as appropriate checks had not been carried out to ensure that staff employed had been confirmed as of good character, honest, reliable and trustworthy.

Staffing levels were insufficient at weekends to meet the needs of people who used the service. The provider did not have a system in place to ensure continuous assessment of staffing levels and make changes when people's needs changed.

Staff demonstrated they had the required knowledge to be able to safeguard people and report any safeguarding concerns to the relevant safeguarding authority.

Staff had received training in the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). However, the provider did not always follow the principles of the MCA 2005 and was not fully meeting the requirements of the Deprivation of Liberty Safeguards.

People told us their privacy and dignity was respected and made positive comments about care staff. There was insufficient planning to support people's wishes and preferences regarding how they wanted to be cared for at the end of their life. There was also insufficient planning to promote and support people's individual leisure interests and hobbies. We were therefore not assured that the planning and delivery of care supported people's individual needs.

People who used the service could not be assured that the provider properly managed and stored records in relation to their care and treatment in a secure and accessible way. A number of records with regards to complaints and the recording and analysis of accidents and incidents were not available. The provider's systems for maintaining records required were chaotic and disorganised.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. People were being put at risk because their medicines had not been managed safely.

Staff did not have the guidance they needed to safely support people who could not mobilise without staff support.

The provider did not operate a safe and effective recruitment system to ensure that the staff they employed were honest and of good character.

Is the service effective?

Requires Improvement

The service was not consistently effective.

We found the provider did not always follow the principles of the MCA 2005 and was not fully meeting the requirements of the Deprivation of Liberty Safeguards.

Staff received regular one to one supervision meetings with their manager where they could raise any issues they had and where their performance was discussed.

People enjoyed the food provided. People who needed their food and fluid monitored, staff had monitored this and recorded what they ate and drank each day.

Is the service caring?

Requires Improvement

The service was not consistently caring. People's views had not been sought with regards to their wishes and preferences for when they reach the end of their life.

Staff interacted with people with warmth and in a kind and caring manner. We saw staff respond to choices people made and explained what they were going to do prior to giving people care or support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. We found the provider did not always follow the principles of the MCA 2005 and was not meeting the requirements of the Deprivation of Liberty Safeguards.

There was a lack of assessment and planning to ensure that people's individual leisure interests and hobbies were promoted and provided for.

Is the service well-led?

Inadequate

The service was not consistently well-led. People were put at risk because systems for monitoring quality and safety were not effective.

Summary of findings

People who used the service could not be assured that the provider operated robust and effective systems to identify, assess and manage risks to people's health, welfare and safety.

The provider did not properly manage and store records in relation to their care and treatment in a secure and accessible way.

Jeian Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 28 October 2014.

The inspection team consisted of one inspector. This inspection was carried out in response to receipt of concerning information. Concerns identified related to the management of people's medicines, unsafe moving and handling of people and insufficient numbers of staff available to meet the needs of people who used the service.

We also looked at other safeguarding matters reported to the Care Quality Commission (CQC) This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. This enabled us to ensure we were addressing potential areas of concern. We also spoke with two commissioners of the service.

On the day of our visit, we spoke with three people who used the service, three relatives, one health professional visiting the service, two care staff, the cook, the manager and the deputy manager. Following our visit to the service we spoke with a further three relatives for their feedback regarding the quality and safety of the service provided.

We observed how care and support was provided to people throughout the day. Including the midday meal within the communal lounge. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at four people's care records, three staff recruitment records, staffing rotas and records related to how the service monitored staffing levels and the quality of the service.

Is the service safe?

Our findings

The provider had not taken steps to check the validity of references they had received. A review of recruitment files showed us that staff had completed application forms and two references had been obtained. However, for two staff we noted that they had not provided the details of their most recent employer but had provided the details of a colleague, references had been provided, however these references were not from their previous employer but from a colleague with whom they had previously worked. The provider had not checked that these were appropriate references and accepted them as accurate. This meant that checks had not been carried out in accordance with the provider's recruitment policy.

The provider told us that they had been informed that one person had been dismissed from their previous employment. They did not however take steps to confirm with that employer the reasons for the dismissal. This had the potential to put people at risk as appropriate checks had not been carried out to ensure that staff employed had been confirmed as of good character, honest, reliable and trustworthy.

This meant that there had been a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked people if they felt safe living at the service and what safe meant to them. All of the people we spoke with told us they felt safe. Comments included, "Yes I do feel safe, the staff are always kind.", "I do not worry about being safe I am well looked after here."

People's risks had been assessed; individual risk assessments identified risks such as moving and handling, risk of developing pressure ulcers and nutritional risks. However, there were no plans in place to guide staff in the safe use of mobilising equipment for two people who could not mobilise independently without staff support to transfer and did not record how many staff were required to safely carry out these transfers. This had the potential to put people a risk from staff using unsafe moving and handling practices. The manager told us they would update this persons records immediately following our discussions with them.

At the time of inspection, which was a week day, we observed there to be enough staff on duty to meet the personal care needs of people who used the service. However, relatives of people and staff told us there was not enough staff available at the weekends. One relative told us, "There is a stark difference in the number of staff available at the weekends. Staff are more rushed and not always around when you need them. There is no manager and there does not appear to be anyone with the knowledge to answer your questions fully."

A review of staff rotas and discussions with the provider confirmed what we had been told that there was a reduction in the number of staff available at the weekends. Rotas evidenced only two care staff had been made available on each shift at the weekends for the majority of the month of October 2014. Care plans confirmed at least two people required two staff to support them with all transfers, therefore with only two staff available, staff could find it difficult to provide the care to meet people's needs. There was no cook available at the weekend's care staff cooked and served meals. Care staff also provided the laundry services as well as personal care support to people. The provider did not have systems in place to assess staffing levels and made the necessary arrangements according to people's needs.

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at information in medication administration records and care notes for five of the 15 people who lived at the service. There was a lack of photographic identification for people to assist staff with the safe administration of people's medicines. This meant that for staff administering medicines, it was not always easy to identify the person to whom they were administering medicine.

A check of stock for one person prescribed anticoagulant warfarin, a medicine used to thin the blood indicated that this person may not have received their medicine as prescribed. The number of tablets remaining did not balance with the records of receipt and administration of their medicines. This demonstrated that this person may not have received their medicines as prescribed.

There was no system in place which would enable effective monitoring of medication stocks and records of people's medicines. We were unable to account for some medicines in our audit because the amount in stock did not match the administration records. We also found numerical discrepancies. We noted that some records were unclear,

Is the service safe?

had been duplicated or deleted without explanation. There were also records that had inaccurately indicated that medicines had been administered when a check of stock evidenced that they had not been administered. The records of medicines received into the service for one person were inaccurate and in some areas duplicated and amended which caused confusion for staff.

Where people had been prescribed medicines on a 'when required' basis, for example for pain relief, or when they were prescribed in variable doses, for example 'one or two tablet, we found there was insufficient guidance for staff in care plans as to the circumstances when these medicines were to be used. Where one or two tablets for example of paracetamol had been prescribed for pain relief, there was no record of the number of tablets administered.

We observed medicines being given to people during the morning and at lunch time. Medicines were given at different times to those on the medication record form, the actual time they were given was not recorded. We discussed this with the manager and informed them that this could result in people being given medicines too close together.

These concerns around medication management show a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us and records confirmed that all staff had received training in the safeguarding of adults from abuse. Staff demonstrated a good understanding of what constituted abuse. Staff told us that if they suspected abuse they would report it to the provider. This demonstrated that staff had the required knowledge to be able to safeguard people and report any safeguarding concerns to the relevant safeguarding authority.

Is the service effective?

Our findings

Staff we spoke with and a review of training records showed us that staff had been trained in understanding the requirements of the Mental Capacity Act 2005 (MCA). This is an act to protect people who lack the mental capacity to make certain decisions about their everyday lives. Add in additional evidence of MCA here. Staff conversation. This showed us that staff had the required knowledge to ensure that they worked within the law and uphold people's human rights.

We looked at how the service was applying the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of adults who use the service by ensuring that if people's freedom of movement is restricted the provider considers this may be a deprivation of their liberty and takes action to ensure people's best interests are assessed by professionals who are qualified to do so. The manager told us that there were no current DoLS applications or authorisations in place and that no one living at the service was being deprived of their liberty.

The provider did not always follow the principles of the MCA 2005 and was not meeting the requirements of the DoLS. The provider told us they knew about the recent case law, which could mean people who were not previously subject to a DoLS may now be required to have an authorisation in place. People who had been had not had their mental capacity assessed to determine their capacity to make decisions about their everyday lives. For example, staff and a relative told us that one person had their medication crushed and medicines were covertly administered within food such as yoghurt. A letter from this person's GP confirmed only their authorisation for the crushing of the medication but not to covertly administer. We were therefore not assured that the provider had taken action to protect this person's human rights by ensuring a best interest's assessment had been carried out of this person's mental capacity and their ability to consent to this practice had been carried out.

During the morning we observed one member of care staff asking one person fi they wanted to go out in their wheelchair. This person insisted when asked on several occasions that t they did not want to go. However, the member of care staff persisted and the person gave in to pressure to please the member of staff. When asked on return whether or not they had enjoyed the trip the person told us, "They don't usually ask us to go out and I didn't want to go."

This meant that there had been a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they had received the training they needed to meet the needs of the people who lived at the service. The provider had recorded the training staff had attended. Training had been provided in a variety of different subjects. Staff told us how training in health and safety and care for people living with dementia supported their knowledge in meeting the safety and welfare needs of people. We spoke with one newly appointed member of staff. They told us that they had been provided with opportunities to shadow other staff for three shifts before they provided personal care support to people but had not been provided with any other training. Given that this member of staff did not have previous care experience there was a potential risk that they may not be equipped to understand and meet the needs of people who used the service.

At the time of our inspection staff told us they received regular one to one supervision meetings with their manager where they could raise any issues they had and where their performance was discussed. We also saw records of planning for annual appraisals.

We received mixed comments from relatives of people who used the service with regards to how well the service supported people to access healthcare support when needed. Four of the six relatives we spoke with told us that staff had supported their relative with access to dieticians, opticians, GP's and community nursing staff. However, two relatives expressed concern that staff had on recent occasions not responded quickly enough to ensure that their relative had access to healthcare professionals when this had been required. For example, one relative told us they had expressed concerns on two occasions regarding their relative's health and had themselves needed to intervene and arrange a GP to visit. A lack of response from the provider had the potential to put people at risk of not having their health and welfare needs met in a timely manner.

Is the service effective?

A visiting health professional told us, “I cannot fault the kindness of staff but they don’t always keep us informed. For example, letting us know when dressings need changing and when they need support to access equipment to prevent pressure sores. They do their best here and we support them as best we can but they could keep us more informed. We will be supporting them with training in diabetes care and the monitoring of glucose levels.” This demonstrated a risk that people’s health care needs may not be attended to as promptly as required.

With the exception of one person, all of the people we spoke to were positive about the food provided. Comments included, “The food is good and plenty of it.”, “It is good homely cooked food.” And “It’s not the type of food I would have been used to but what can you expect, it’s passable.”

During our observations at lunch time we saw that people were supported appropriately and provided with one to one assistance from care staff. Staff ensured that people ate and drank enough to keep them healthy. People were provided with snacks and drinks throughout the day. We spoke with the cook who told us they produced homemade dishes which included soup, baked cakes, savoury pies and puddings. They evidenced how they provided a choice of meals. The cook also evidenced their knowledge of how to provide fortified foods to people who had been assessed as nutrionally at risk of malnutrition. We saw milk shakes had been produced for one person following a dietician assessment of their needs.

Where people needed their food and fluid monitored, staff had recorded what they ate and drank each day. We saw that two people who had been assessed as being at risk of not eating or drinking enough, staff had made the appropriate referrals and developed a care plan with guidance for staff in how to support these people. However, we saw that for one person where a dietician had advised the service to ensure regular weekly weight checks, staff had continued to weight this person monthly and not weekly as advised. This meant that risks identified had not been monitored effectively.

Is the service caring?

Our findings

People told us they were happy living in the service and that staff were kind to them. All of the people we spoke with told us that they were well treated and the staff were caring and compassionate. One person told us, "The staff are all very kind." Another said, "The staff do their best and are always kind to me." However, two relatives of people who used the service spoke of their concerns regarding one member of care staff who they described as; "rude and abrupt", "un caring" and "Should not be working in a care home." We discussed these concerns with the provider who told us they would take immediate action to investigate and respond.

Care plans used to guide staff described people in a derogatory manner. For example, one person had been described as, '[person] has a mental problem'. Staff had not been given a description of this person's diagnosed metal health condition and how this may present in terms of their behaviour and how best to support them.

People told us they had not been involved in the planning of their care, treatment and support other than choices offered with regards to daily living tasks associated with provision of personal care, food and drinks. We asked the provider how they supported people to express their views and actively involve people in making decisions about their care, treatment and support. They told us that they asked people their views when reviewing their care plans. However, we noted that care plans did not evidence people's involvement in the review of their care. Care plans did not evidence that people's views had not been sought with regards to their wishes and preferences for personalised activities and consultation with regards to any advanced directives for when they reach the end of their life. As a result of this lack of consultation there is a risk that people may not have their individual wishes and preferences fulfilled.

Staff interacted with people with warmth and in a kind and caring manner. We saw staff respond to choices people made about what food they wanted to eat and staff explained what they were going to do prior to supporting people with personal care. For example a member of staff approached one person to ask them if they would like some help with personal care. This was done in a sensitive, discreet manner which respected the person's dignity and choice.

People told us that staff protected their privacy and promoted their dignity when supporting them with personal care. One person told us, "They put me at ease when washing me. They close the door and do not make me feel uncomfortable." One relative of a person who used the service told us that their relative preferred to have a male family member support them with a bath as they preferred not to be supported by the female staff. We noted that this was not recorded within their plan of care.

During our visit we saw that when health professionals visited to change people's dressing's staff used screens to protect people's privacy and their dignity had been respected.

Is the service responsive?

Our findings

People with capacity told us that they felt able to raise any concerns they might have. Two people said they would talk things through with their relatives who would deal with any issues of concern directly with the manager. One person said, “I can approach the staff for help.” One relative we spoke with told us, “Things have improved a bit around here recently following my previous complaints to the manager. However, I am not satisfied that all my concerns have been addressed.” The concerns expressed by this relative related to the attitude and behaviour of a member of staff.

We discussed with the manager concerns raised by several people at this inspection regarding the behaviour of this one member of care staff. The manager told us they had considered previous complaints regarding the named staff member but had not taken any action as they believed this to be a cultural misunderstanding and miss-communication. However, they also told us they would take immediate action to re-investigate. We were not assured that people’s concerns and complaints had been properly investigated and resolved to their satisfaction and in a timely manner.

A notice board displayed a weekly plan of group activities such as ball games, quizzes and games such as ‘hangman’. We observed one member of staff asking each person in the lounge if they wanted to play a ball game. The majority of people declined this offer. One person told us, “We are not children, I don’t want to play ball games.” Another told us, “There isn’t much to do so we play games, it’s something to do I suppose, better than watching TV all day long.” We observed one person was asked if they wanted to go out in their wheelchair for a trip into the local town. They were reluctant at first but care staff persisted in encouraging this person until they agreed. We noted that care plans did not contain any assessments which would evidence any planning to support people with their individual leisure interests and hobbies. We were therefore not assured that the planning and delivery of care supported people’s individual assessed needs.

People were encouraged to keep in touch with people who were important to them. One person told us, “I have my mobile phone and staff help me to charge the battery so I can speak to my family.” One relative told us, “I can turn up whatever time of day I choose, there are no restrictions.”

Is the service well-led?

Our findings

The provider did not have a robust, organised and easily accessible system in place to regularly identify, assess and manage risks to people who used the service and others. Prior to our inspection we received information of concern from commissioners of the service in relation to a person recently admitted to hospital from the service with a grade four pressure sore. We discussed this with the provider who confirmed that they had not sent a statutory notification of this incident to the Care Quality Commission (CQC) as is required by the law. They also told us that they had not carried out any formal investigation into this incident. People who used the service could not be assured that the provider took steps to report important events that affect their health, welfare and safety so that, where needed, investigations could take place and action taken.

This meant that there had been a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The provider told us that they had a system of monthly quality and safety audits to identify and address medication errors. The last completed audit was in August 2014. We noted that the provider's audits were brief in detail and did not identify the omissions, errors and shortfalls we identified during this inspection. We were therefore not assured that the provider's audits were effective and robust in identifying and responding to medication errors promptly.

The provider told us they carried out satisfaction surveys on an annual basis. We reviewed copies of responses from these surveys and noted that the last survey was carried out over two years ago. All of the nine out of 17 responses received from people who used the service were positive with no concerns recorded. However there was no up to date feedback from people using the service or their relatives about the quality of care provided

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

We asked to view the provider's complaints records. They told us again that they were unable to find their complaints file despite attempts to locate them within their disorganised office. We therefore could not be assured that the provider had an effective system in place for identifying, receiving, handling and responding to people's complaints and concerns.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider did not ensure that people were protected against the risks of unsafe and inappropriate care and treatment arising from a lack of proper information about them. We asked the provider what system they had in place for the recording of accidents and incidents and how they would analyse these. They told us they were unable to find their accident reporting records despite attempts to locate these records among piles of files on their desk and chairs and in a filing cabinet. They also told us they were unable to access records on their computer as this was in need of repair. They did however; provide a note book where they had recorded two recent incidents in relation to one person going missing from the service and another person sustaining a skin tear. We noted that these records did not contain any evidence of any actions taken by the provider in response to these incidents. People who used the service could not be assured that the provider properly managed and stored records in relation to their care and treatment in a secure and accessible way.

This meant that there had been a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service was led by the provider who was hands on and available in the service during the week. We found the service to be disorganised in regards to paperwork and recording of accidents and incidents. The provider has not accepted the support of health and social care professionals to support the service to improve and was not involved in provider support organisations. There was no indication that the systems in place would support improvement where needed. However, One person told us, "The manager is very nice and helpful." But, a relative told us, "The manager is always approachable but can be defensive when we need to point out things that are not right but otherwise we like him." Staff told us they worked as part of a friendly team. They also told us they felt supported by the manager and that they were confident that any issues they raise would be dealt with Another

Is the service well-led?

relative said, “The manager is always here in the week but things are not so good at the weekend when there are not enough staff around and communication is not always good.”

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: The registered person did not protect people against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the recording, handling, using safe keeping and safe administration of medicines. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider did not identify, assess and manage risks relating to the management of people's medicines. Regulation 10 (1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person did not notify CQC without delay of incidents of Grade 3 and above pressure ulcers. The registered person did not follow the principles of the MCA 2005 and was not fully meeting the requirements of the Deprivation of Liberty Safeguards. Regulation 18 (1) (2) (a) (b)(ii) (c)(d)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records. People who use services were not protected against the risks arising from a lack of proper information about them. Records were not kept securely and could not be located promptly when needed. Regulation 20 (1) (a) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not take proper steps to ensure that at all times, there are sufficient staff numbers of suitably qualified, skilled and experienced persons are employed and available to meet the needs of people. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The Registered person failed to operate effective recruitment procedures They did not take steps to ensure that they checked on the validity of references received and ensure these were from the most recent employer in order to ensure that no person is employed unless they are verified as of good character, honest, reliable and had the qualifications, skills and experience necessary. Regulation 21 (a)(i)(ii) (b) Schedule 3