Joseph House (Trading) Ltd

Joseph House Nursing Home

Inspection report

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10 October 2017

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This was the provider's first inspection since being registered with the Care Quality Commission on 31 July 2017.

Joseph House Nursing Home provides accommodation and personal care for up to 20 older people and people living with dementia. This inspection was completed on 9 and 10 October 2017 and there were 19 people living at the service.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by the Care Quality Commission. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

A registered manager was in post. 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.

There was a lack of provider and managerial oversight of the service. Quality assurance checks and audits carried out by the registered provider and registered manager were not robust, as they did not identify the issues we identified during our inspection and had not identified where people were placed at risk of harm and where their health and wellbeing was compromised. The registered provider and registered manager were unable to demonstrate how they identified where improvements to the service were needed and lessons learned so as to ensure compliance with regulatory requirements and the fundamental standards.

The majority of staff were aware of their responsibilities with regard to safeguarding people from abuse and knew how to report concerns. However, robust procedures and processes that make sure people are protected had not always been considered and followed.

Suitable control measures were not put in place to mitigate risks or potential risk of harm for people using the service as steps to ensure people and others health and safety were not always considered and risk assessments had not been developed for all areas of identified risk. People were at risk of harm due to poor manual handling practices by some members of staff.

The registered provider had not ensured the service was being run in a manner that promoted a caring and respectful culture. Although some staff were attentive and caring in their interactions with people, we observed some interactions which were not respectful or caring and failed to ensure people were treated with respect and dignity.

Pre-admission assessments provided insufficient information to inform people's care plan and the risks that might be posed to people using the service, staff and others. Not all of a person's care and support needs had been identified and documented. Improvements were required to ensure that the care plans for people who could be anxious or distressed, considered the reasons for them becoming anxious and the steps staff should take to comfort and reassure them. Improvements were needed in the way the service and staff supported people to lead meaningful lives and to participate in social activities of their choice and ability, particularly for people living with dementia.

Staff newly employed at the service had not received a robust induction and where staff were assigned a mentor; the role of the mentor was not effective in monitoring staff's practice and providing sufficient guidance and support. Training and development was not sufficient in some areas to demonstrate that people's care and support needs were fully understood by staff. Staff's knowledge and understanding of the main principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was poor. Where significant decisions were needed and the rationale to evidence these were in people's 'best interests' had not been recorded.

People were supported to have enough to eat and drink. People were supported to maintain good healthcare and have access to healthcare services as and when required. Medication practices and processes were safe and ensured people received their prescribed medication.

The majority of staff knew the care needs of the people they supported and people told us that staff were kind and caring.

You can see what actions we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Robust procedures and processes that make sure people and others are protected from harm and abuse had not always been considered and followed.

Risks were not identified for all areas of risk. Risks were not suitably managed or mitigated so as to ensure people's safety and wellbeing. The latter related specifically to poor manual handling practices.

Although the deployment of staff within communal lounge areas were seen to be appropriate, people's comments about staff were variable and improvements were required to ensure people who resided in their bedroom were not forgotten and that staff had the time to spend with them.

The management of medicines were safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staffs knowledge and understanding of training provided was good or embedded in their everyday practice.

Staff had not received a robust induction and improvements were required, particularly for people who had limited or no previous experience in a care setting.

Staffs knowledge and understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards [DoLS] was variable. Improvements were required to ensure where an assessment for significant decisions was needed, these were completed and included the rationale for why these were in people's 'best interests.'

People's healthcare needs were met and people were supported to have access to a variety of healthcare professionals and services as required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always treat people with respect and dignity. Improvements were required to ensure people's privacy and confidentiality was maintained at all times.

People deemed on end of life care did not have a robust end of life care plan in place and improvements were required.

Little information available to demonstrate that people using the service are actively involved in making decisions about their care, interventions and support.

People told us that staff were kind and caring.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements were needed to ensure the pre-admission assessment process and procedure was robust.

Not all people who used the service had a care plan in place detailing their care and support needs. People's care plans were not sufficiently detailed to include all of a person's care needs and the care and support to be delivered by staff.

Not all people who used the service were engaged in meaningful activities or supported to pursue pastimes that interested them.

People could not be confident that their complaints would be taken seriously and acted upon.

Is the service well-led?

Inadequate

The service was not well-led.

Although systems were in place to regularly assess and monitor the quality of the service provided, further improvements were required as they had not highlighted the areas of concern we had identified.

Quality monitoring processes were not robust and working as effectively as they should be so as to demonstrate compliance and to drive improvement.

Systems were in place to seek the views of people who used the

service and those acting on their behalf but had not yet been implemented as the service was newly registered.

Joseph House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

Following safeguarding information shared with us by the registered provider about one person's safety and another incident whereby one person's behaviours had escalated to an unacceptable level and impacted on others living at the service, potential concerns about the management of risk at the service were identified. We needed to consider the likelihood of any current risks occurring, and the impact on people using services and this prompted our inspection.

This inspection took place on 9 and 10 October 2017 and was unannounced. The inspection team consisted of one inspector on both days. On the 10 October 2017 the inspector was accompanied by an expert by experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia.

We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven people who used the service, two people's relatives, four members of staff, the service's chef, the qualified nurse and the registered manager.

We reviewed seven people's care plans and care records. We looked at the staff personnel records for four members of staff, including staff training information and supervision records. We also looked at the service's arrangements for the management of medicines, safeguarding, complaints and compliments information and quality monitoring and audit information.

Inadequate

Is the service safe?

Our findings

Following information of concern we looked into the circumstances of an incident involving a person being injured from falling from their bed. Bedrails should have been in place to reduce the risk of this occurring but were not in place. The incident could have been avoided if information recorded within the person's pre-admission assessment and care plan had been followed by staff. The Local Authority safeguarding team investigated the matter and concluded that staff had neglected to ensure the person's safety and wellbeing.

Not all risks to people's safety and wellbeing had been identified, and suitable control measures had not always been considered and put in place to mitigate the risk or potential risk of harm for people using the service. For example, our observations showed that several people throughout the service had bedrails fitted to prevent them from falling out of bed and injuring themselves. Where these were in place a risk assessment had not always been completed to determine these were suitable for the individual person so that any risks identified were balanced against the anticipated benefits.

Although staff had received manual handling training, on both days of our inspection we observed poor staff practice in relation to moving and handling on four separate occasions. For example, we observed two members of staff assisting a person to move in a way that was unsafe and put them at risk of harm. Staff transferred the person from their comfortable chair to a wheelchair in the main communal lounge [conservatory] by placing their arms under the person's armpits and assisting the person to a standing position. This practice was repeated on a further three occasions. This technique is unsafe, can hurt and cause injury because the person's armpits have too much pressure on them.

We also observed one person trying to mobilise with a walking frame that was not allocated for them and clearly not at the correct height for them. Although the person was able to mobilise with staff support, they were unable to remain in a comfortable upright position because of their height. Staff were unaware of the unsuitability of this item of equipment, the potential risks this posed to the person mobilising or how to adjust the height of the walking frame. This was brought to the registered manager's attention at the time of the inspection and immediate action was taken by them to locate the correct walking frame.

On the second day of inspection we observed a member of staff assisting one person to eat their lunchtime meal whilst remaining in bed. We observed the person lying in bed and leaning to one side. We spoke with the member of staff and enquired as to the person's wellbeing. The member of staff told us the person had been coughing and choking whilst eating their meal. We intervened and requested that the person should be re-positioned to a more upright position so as to prevent further discomfort and to reduce the risks of choking and aspiration. This was duly completed; however when we returned to the person's room 30 minutes later, although they had finished their meal the person was laid back down in bed. This was not in line with advice provided by healthcare professionals which stated the person should remain upright for at least 30 minutes after they had eaten so as to prevent the reflux of food and aspiration pneumonia.

Environmental risks for the service were viewed, for example, those relating to the service's fire

arrangements. Specific information relating to people's individual Personal Emergency Evacuation Plans (PEEP) were completed and in place. A fire risk assessment had not been completed by the registered provider and was unavailable at the time of the inspection. The registered provider's representative assured us this would be completed. We received confirmation by email on 25 October 2017 that the fire risk assessment was completed on 18 October 2017. The registered manager was unable to tell us if a 'Business Continuity and Emergency Plan' was in place. The latter is a document that ensures the service can cope with the effects of an unforeseen emergency or crisis. The registered manager confirmed that appropriate fire detection, warning systems and firefighting equipment were in place and these had been serviced. These ensured that the service was able to respond effectively to fire related emergencies that may occur at the service. However, a record had not been maintained to confirm the service's emergency lighting and fire alarms were checked at regular intervals between servicing to ensure they remained effective and fully operational. Not all staff spoken with were aware of the service's fire procedures and knew what to do in the event of an emergency. An assurance was provided by the registered manager that both issues would be addressed.

The care records for one person recorded them as being MRSA positive. MRSA is a type of bacteria that causes infections in different parts of the body. We discussed this with three members of staff and found that none of the staff spoken with were aware the person was MRSA positive. Additionally, only one member of staff understood the need for stringent infection control techniques so as to protect staff and others against the risks and spread of infection.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff training information provided to us showed staff employed at the service had received up-to-date safeguarding training. However, not all staff were able to demonstrate a good understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. Where staff's knowledge was good, staff confirmed they would report any concerns to external agencies such as the Local Authority or the Care Quality Commission without hesitation.

Robust procedures and processes that make sure people are protected had not been considered and followed by the registered provider or registered manager of Joseph House Nursing Home. The registered provider and registered manager had failed to notify the Local Authority and the Care Quality Commission of a safeguarding concern. Although the member of staff was given a change of role, no evidence was available at this inspection to ensure further poor practice or abuse was not repeated and lessons learned. No management plan had been put in place to monitor the member of staff's performance so as to ensure people were protected from abuse and improper treatment. Furthermore, an internal investigation had not been conducted and minutes of a meeting held with the member of staff, the registered manager and the registered provider's representative had not been recorded and retained. This demonstrated that neither the registered provider nor registered manager fully understood their associated responsibilities in relation to preventing abuse of people using the service and to keep them safe. Following the inspection and at our request a safeguarding alert in relation to the above was forwarded to the Local Authority.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's comments about staffing levels at Joseph House Nursing Home were variable. One person told us, "I think there are enough staff." Another person told us, "Yes, I think there are enough staff." Where comments were less than favourable, one person told us, "I just sit up here. No one comes in and talks to

me, I want to die." The person became visibly distressed and we alerted the registered manager to the person's distress. Another person told us when asked if staff came in and spent time with them, "I am left on my own mostly. The staff just walk in and then out again. They [staff] have little proper time for you." Our observations on both days of inspection showed that the deployment of staff was suitable to meet people's needs and people's care and support needs were met by staff in a timely manner. However, this related to people who resided within the communal lounge areas on the ground floor and not people who remained in their bedroom throughout the day. We noted that people who remained in their bedroom were visited by staff during the day, however staff did not spend any quality time with them and all of the interactions centred on tasks.

Staff recruitment records for three members of staff appointed since 31 July 2017 showed that minor improvements were required in relation to the registered provider's recruitment practices. No recent photograph had been sought and the interview record for one employee was blank. No information was recorded as part of good practice procedures relating to the interview so as to demonstrate the outcome of the discussion and the rationale for the appointment. We discussed the latter with the registered manager and they confirmed the employee was due to commence employment at the service week commencing 9 October 2017. The application form for one employee provided no employment history. Other relevant checks had been carried out and included the attainment of written references, proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service [DBS].

Comments about the provider's medicines management arrangements from people using the service were positive, as people confirmed they received their medication as they should. Our observations showed that people received their medication in a timely manner as the medication rounds were evenly spaced out throughout the day to ensure that people did not receive their medication too close together or too late. Suitable arrangements were in place to record when medicines were received into the service, given to people and disposed of. We looked at the Medication Administration Records [MAR] for 10 out of 19 people living at the service. These were in good order, provided an account of medicines used and demonstrated that people were given their medicines as prescribed.

Requires Improvement

Is the service effective?

Our findings

The registered manager confirmed the majority of staff employed at the service had received mandatory training in line with the organisation's expectations and that the training matrix was up-to-date. However, no training information was recorded for one member of staff who had commenced employment at the beginning of October 2017 and training relating to three topics only was evident for another member of staff who had commenced employment at the end of August 2017. We discussed this with the registered manager and they confirmed that both people had completed training for all mandatory courses but were awaiting their certificates. We spoke with both members of staff and they confirmed what the registered manager had told us.

We found that one member of staff's knowledge and understanding of training provided was remarkably poor in relation to several subjects, including, safeguarding and whistleblowing, dementia awareness and how to respect and treat people with dignity. Furthermore, our observations showed that not all staff effectively applied their learning so as to demonstrate positive outcomes for people using the service. For example, as already highlighted some staff member's manual handling practices were inappropriate and unsafe.

Not all staff appeared to recognise that their practice in relation to interactions, exchanges and communication with people using the service, particularly for people living with dementia required improvement. This was because several interactions and exchanges did not always ensure that people were given sufficient time to respond to questions from staff. Staff did not always address the person who was trying to communicate and this meant in some instances that the person was ignored. Moreover, it was evident that not all staff fully understood what the person was saying to them as their first language was not English, however instead of asking the person to repeat what they were saying or to seek assistance from a colleague, the member of staff walked away.

The registered manager confirmed that all newly employed staff received a comprehensive induction. Records were available to show that newly employed staff had completed an 'in-house' orientation induction. Staff had not commenced a more robust induction such as the 'Care Certificate' or equivalent. The Care Certificate is a set of standards that social care and health workers should adhere to in their daily working life. This was a particular concern where staff had no previous experience working within a care setting and had not attained a National Vocational Qualification at Level 2 or above; or the Qualification and Credit Framework [QCF]. The latter referred to two newly employed members of staff employed since 31 July 2017.

The registered manager confirmed to us that the above was accurate. We asked both members of staff about their induction, one member of staff advised that after their 'orientation induction' they had been expected to commence working as a full member of the staff team. The other member of staff was unable to discuss anything about their induction and what this entailed. We discussed this with the registered manager and were advised that both members of staff would be commenced on the 'Care Certificate' or an equivalent in due course. Additionally, the registered manager told us the member of staff who had no

previous experience working within a care setting had been assigned two mentors. A mentor is someone allocated to provide advice and supervision to the new member of staff, to support their learning and to act as an effective role model. Our observations at this inspection showed that neither mentor was an effective role model as there were many occasions where the member of staff was left on their own without support from the mentor and their care practices were not being monitored.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager confirmed and records showed that they formally supervised the qualified nurses. Information available showed the qualified nurses had retained their registration with the Nursing and Midwifery Council [NMC] and maintained their Continuing Professional Development [CPD] so that they could continue to practise safely and effectively.

Variable comments were made by staff in relation to the support they received. Staff told us they did not always feel supported by the registered manager or the qualified nurses. The rationale provided was that the registered manager spent a lot of time in the office and the qualified nurses were busy dealing with visits by healthcare professionals, making telephone calls or undertaking the administration of medication. The registered manager confirmed that formal supervision was to be undertaken at bi-monthly intervals and records showed that the majority of staff had received one formal supervision in September 2017.

The Mental Capacity Act [MCA] 2005 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had a variable knowledge and understanding of MCA and Deprivation of Liberty Safeguards (DoLS). Information available showed that each person who used the service had had their capacity to make decisions assessed. This meant that people's ability to make some decisions, or the decisions they may need help with had been recorded. Where more significant decisions were required, and people were unable to make these decisions for them self, a 'best interest' assessment was required about the care, support and treatment to be given and why it was deemed to be in their best interests. We found that these had not been considered or completed, for example, in relation to the use of bedrails and sensor alarms to alert staff when a person gets out of bed or from their chair so as to reduce the risk of falls.

Where people were deprived of their liberty, we found that although the previous registered provider of the service and the current registered manager had made appropriate applications to the Local Authority for DoLS assessments to be considered for approval, where these had been approved and the date for authorisation expired, a new assessment had not been completed and resubmitted. In addition, where applications had been made and submitted in 2015, no information was available to show if these had been followed up with the Local Authority to confirm their status. We discussed this with the registered manager and they confirmed that they were unaware of the above but would address this in due course. Following the inspection we were advised that the registered manager had received confirmation from the Local Authority that they will be visiting the service so as to undertake DoLS assessments.

The majority of people told us they were happy with the quality of meals provided and that the food was good. One person told us, "The food is good here." Another person told us, "The food is reasonably good; I don't have any concerns about it." Although people were not encouraged or asked if they would like to sit at a dining table, the dining experience was noted to be relaxed. At lunchtime we saw that the meals were nicely presented and staff were seen to encourage people to eat independently according to their needs and abilities. Where people required assistance and support to eat and drink, in all but two instances this was provided in a sensitive and dignified manner whereby people were not rushed to eat their meal and were able to enjoy the dining experience at their own pace.

People told us their healthcare needs were well managed. Relatives confirmed they were kept informed of their member of family's healthcare needs and the outcome of any healthcare appointments. Care records showed that people's healthcare needs were clearly recorded, including evidence of staff interventions and the outcomes of healthcare appointments. Each person was noted to have access to local healthcare services and healthcare professionals so as to maintain their health and wellbeing, for example, to attend hospital appointments, see a GP, District Nurse or Community Psychiatric Nurse.

Requires Improvement

Is the service caring?

Our findings

We had concerns about the way some staff treated people who lived at the service. We were not assured that all staff understood the importance of giving people choices and respecting their wishes. For example, we observed on the first day of inspection a member of staff attempting to assist one person to eat their lunchtime meal despite the person leaning forward in their chair and having their eyes shut. Despite the person repeatedly emitting the food, striking and pushing the member of staff's hands away and verbally advising the member of staff that they did not wish to eat, the member of staff continued to attempt to get the person to eat by imposing their demands on the person. This did not respect the person's right to choose not to eat; their expressed wishes at that time or treat the person with respect and dignity. In the end the qualified nurse intervened and took over from the member of staff. Once the person had woken up fully, with time and patience and the right approach, the person was noted to happily eat their lunchtime meal.

Additionally, on the first day of inspection a member of staff was observed to take away one service user's mid-morning snack without speaking to them. The person was observed to look astonished by the member of staff's actions and although they held out their hand the member of staff continued to walk away without acknowledging the person either non-verbally or verbally. At lunchtime the same member of staff was observed to assist one person to eat their dessert over a 15 to 20 minute period. The member of staff remained standing during this period and did not attempt to get a chair. The member of staff did not engage in any conversation, however there were several occasions when the person attempted to engage and verbally communicate with the member of staff. The member of staff smiled but provided no verbal response. We discussed this with the registered manager and they confirmed that English was not the member of staff's first language and that their comprehension and understanding of English as a second language was poor; however they were attending a college course to improve their language skills.

The majority of staff were able to verbally give basic examples of what dignity meant to them, for example, knocking on doors, keeping the door and curtains closed whilst delivering personal care and providing explanations to people about the care and support to be provided. However, our observations showed that staff did not always understand or consider people's right to privacy and confidentiality. For example, during the inspection a visiting healthcare professional was observed to visit the service and to openly discuss within the communal lounge area one person's medical healthcare needs with the qualified nurse. No consideration was given by the qualified nurse to seek an alternative space for the conversation to take place where they could not be overheard by others. We discussed this with the registered manager and the rationale provided was that the qualified nurse may have felt unable or overawed to suggest to the healthcare professional that the above was inappropriate.

This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this poor practice people and their relatives told us they felt staff cared for them in a kind and caring way. One person told us they were happy with the care and support provided at Joseph House Nursing Home. They told us that prior to their admission they lived on their own and had experienced periods of

extreme loneliness. Since being admitted to the service they now got to see people during the day and to talk with them. They told us, "I am much more relaxed now." Another person told us, "They [staff] do everything for me here." A third person told us, "They [staff] look after me very well. I have no complaints and they [staff] take me out for a smoke when I want one."

The majority of interactions by staff with people using the service were task and routine led. For example, the majority of interactions primarily related to tasks and routines of the day, such as, providing drinks, supporting people to eat their meals and assisting people with their personal care and comfort needs.

There was evidence to indicate that some relatives had been consulted and involved in their family member's care plans. Relatives confirmed they had seen their member of family's care plan and had provided information as part of the pre-admission assessment process. However, there was little evidence to demonstrate that people using the service had been actively involved in planning their care.

People's preferences and choices for their end of life care were not robust or as detailed as they should be. We found that the needs of one person approaching the end of their life and associated records relating to their end of life care needs contained minimal information, was generic and not person-centred. For example, the care plan provided little or no information detailing the person's pain management arrangements and the care to be provided so as to provide comfort and dignity for the person nearing the end of their life.

People were supported to maintain relationships with others. People told us their relatives and those acting on their behalf were able to visit them at any time. Relatives confirmed there were no restrictions when they visited and that they were always made to feel welcome by the staff team and could stay as long as they wanted.

Requires Improvement

Is the service responsive?

Our findings

Arrangements were in place to assess the needs of people prior to admission. The purpose of this was to ensure that the service was able to meet the person's needs. Although these arrangements were in place, improvements were required to ensure that a proper robust assessment was completed prior to admission, to identify the prospective person's care and support needs and assess the risks that might be posed to people living at the service, staff and others. Where people were readmitted to the service following a hospital admission, the registered manager and qualified nurse confirmed that the person was not reassessed to ensure that the service were still able to meet the person's care and support needs.

Although some people's care plans provided sufficient detail to give staff the information they needed to provide personalised care and support that was consistent and responsive to their individual needs, others were not as fully reflective or accurate. This meant there was a risk that relevant information was not captured for use by other care staff and professionals or provided sufficient evidence to show that appropriate care was being provided and delivered. For example, no care plan had been completed for one person following their admission to the service. Additionally, although another person had a care plan in place following their admission to the service, not all of the person's care and support needs were recorded and there was a lack of clear guidance and key information for staff to enable them to support people with their specific care needs and health conditions.

Staff told us there were some people who could become anxious or distressed. Improvements were required to ensure that the care plans for these people consistently considered the reasons for them becoming anxious and the steps staff should take to reassure them. Guidance and directions on the best ways to support the person required reviewing so that staff had all of the information required to support the person appropriately and to reduce their anxiety. For example, guidance for staff in relation to one person referred to staff providing 'divisional therapies'. No information was recorded and staff were unable to state what these were. Another person's care plan referred to them living with a mental health condition. No care plan had been completed to explain the care and support provided and multidisciplinary team involvement.

People's comments about social activities at the service were variable, with some people stating they were happy to not participate and preferred their own company and others stating there was little to do and at times they were bored. One person told us, "They [people using the service] need more activities, they do get bored. I do colouring and can listen to music on my mobile, but what's the point for them. All they do is get out of bed and sit in a chair all day. There needs to be more things to do." Another person told us, "Activities, there is nothing to do, no one spends time with you."

Our observations demonstrated that people who spent their time in their bedroom had little or no stimulation, only that from staff performing a care task. There was an expectation that care staff would engage in activities with people as the member of staff employed specifically for this role worked part-time and more often than not was requested by the qualified nurse or other staff members to help with care tasks. However, staff did not have the time to promote people's wellbeing and meet their social needs. Staff spoken with confirmed this as accurate and told us they did not always have the time to spend with people,

particularly those people who remained in their bedroom throughout the day.

During the two day inspection three people were observed to have a manicure, four people completed some colouring and a bowling game was undertaken with two people who showed very little interest. Another person was observed to read a newspaper in the mornings. Apart from these activities there was an over reliance on music or the television. Following the inspection we were advised that people using the service were able to participate in a range of activities and these included seated exercises, religious observance, aromatherapy, baking and external entertainers.

We were made aware during the inspection that one person no longer liked to watch the television, partly because they no longer understood what was being said and because it was often too loud for them. On both days of the inspection the person was placed to the side of the television with their back to it. The person's relative told us, "I have sometimes come in to find them with their hands over their ears. I do tell them [staff] but nothing happens." None of the care records looked at contained a care plan that adequately demonstrated how staff responded to individuals differing needs in terms of their interests, hobbies and social activities.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaint records showed there had been two complaints since the service was newly registered with the Care Quality Commission on 31 July 2017. The specific nature of the complaint was recorded including the original complaint letter. However, details of the investigation and any action taken had not been completed. Although a meeting had been held with the complainant, information to evidence the latter had not been maintained. This did not provide an assurance that complaints would be listened to, taken seriously and acted upon.

A record of compliments was maintained to evidence the service's achievements.

Inadequate

Is the service well-led?

Our findings

The service was newly registered with the Care Quality Commission on 31 July 2017. In line with the Care Quality Commission's schedule of inspection for newly registered services, the first comprehensive inspection is normally scheduled between 6-12 months after it has been registered. However, following concerns about one person's safety and another incident whereby one person's anxiety and distress had escalated to an unacceptable level and impacted on others living at the service, potential concerns about the management of risk at the service were identified. We needed to consider the likelihood of any current risks occurring, and the impact on people using services and this prompted our inspection.

Although there were a large number of audits and checks in place which were completed at regular intervals to inform the registered manager's monthly report, these checks had failed to identify and address the concerns found as part of this inspection. This was because there were inadequate arrangements in place to effectively monitor the quality of the service and ensure that the service was operating safely. Systems in place to help identify risks to people using the service, staff and others were not robust or proactive. The registered provider's arrangements concerning pre-admission assessments and procedures and care planning arrangements did not ensure all of a person's care and support needs were recorded or met. Ineffective arrangements were in place to safeguard people from abuse and to ensure lessons are learned when things go wrong.

We noted that the checks on the quality of the service were largely based on auditing the records and paperwork in place. The quality assurance arrangements had failed to effectively measure the experience of the people being supported and cared for at Joseph House Nursing Home. This meant there was a lack of oversight based on observations of actual care being provided by staff and being experienced by people living at the service. The registered provider's quality assurance arrangements had failed to recognise and address staffs' practice and competencies, for example, in relation to poor manual handling practices, poor care practices resulting in people not always being treated with the utmost respect and dignity and ensuring care provided was 'person-led' rather than 'service-led.' Significant improvements were required to ensure key members of staff were an effective role model and mentor and induction procedures for newly appointed members of staff were robust.

The culture of the service was not always positive. Although staff told us they liked the registered manager and the qualified nurses, staff did not always feel listened to, valued or supported. Our observations demonstrated the qualified nurses were not as an effective role model as they should be as many of our observations as highlighted within the main text of this report had not been picked up. The qualified nurse's main role and responsibilities related to the management of medication and liaising with healthcare professionals. Additionally, the registered manager was not based within the main hub of the care home but in an adjacent building, therefore they were distant from what was happening within the service throughout the day unless it was brought to their attention or they happened to walk through. The registered manager lacked support and guidance from the registered provider's representative. The registered manager confirmed they had not received formal supervision since the service was registered on 31 July 2017.

We looked at the Statement of Purpose for Joseph House Nursing Home which was submitted to the Care Quality Commission in March 2017 as part of their registration application. This document described what people living there could expect as part of the service they receive. The document also contained information relating to the registered provider's aims and objectives for the service. For example, the document stated that the registered person was committed to providing high quality care, particularly for people living with dementia. It also told us that the registered provider was committed to employing competent, well trained staff. The aims and objectives did not concur with our findings from this inspection and demonstrated their overall failure to effectively assess and monitor the quality of the service provided at Joseph House Nursing Home. Additionally, the document made reference to previous guidance for registered providers on meeting compliance, namely the 'Essential Standards of Quality and Safety' and the 'National Minimum Standards' and also referred to the service as a domiciliary care agency. The Statement of Purpose required reviewing to reflect regulations applied from 1 April 2015 and the correct regulated activity.

The above demonstrated the arrangements in place to continually assess the quality and safety of the service to drive improvement or identify where non-compliance with regulatory requirements and the fundamental standards had occurred were not effective. This had led to a lack of effective oversight and governance at both service and provider level. Had a more robust system been in place it would have enabled the registered provider and management team to address the shortfalls identified sooner, to reflect on practices within the service and to enhance service improvement.

A staff meeting had been held at the end of September 2017 so as to give staff the opportunity to express their views and opinions on the day-to-day running and quality of the service and minutes of the meeting confirmed this. However, where actions were recorded, evidence of the action taken was not always recorded to show these had been dealt with and addressed.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

The registered manager confirmed that the views of people who used the service, those acting on their behalf and professionals would be sought between October 2017 and December 2017 and a report of the findings compiled. Additionally, the registered manager confirmed that a 'Dignity in Care Home Survey' was to be commenced in December 2017.

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 9 HSCA RA Regulations 2014 Person-centred care Pre-admission assessments should be detailed enough to provide sufficient information to inform the person's care plan and the risks that might be posed to people using the service, staff and others. Assessments of people's care and support needs should be robust and include all of their needs and guidance on how these are to be delivered and met by staff.

The enforcement action we took:

Notice of Decision was served

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

The enforcement action we took:

Notice of Decision was served

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not all care and treatment was provided in a safe way for people using the service. Risks were not always mitigated to ensure people's safety.

The enforcement action we took:

Notice of Decision was served

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and

	improper treatment Not all people using the service had been protected from abuse and improper treatment.

The enforcement action we took:

Notice of Decision was served

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services were not supported by the providers systems and processes to assess and monitor the quality of service provided. The arrangements in place were not effective in identifying where quality or safety were compromised.

The enforcement action we took:

Notice of Decision was served

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Not all staff had received a robust induction and improvements were required to ensure effective systems were in place for staff to receive training.

The enforcement action we took:

Notice of Decision was served