Stapely Jewish Care Home Limited

Stapely Residential and Nursing Home

Inspection report

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

Summary of findings

Overall summary

This inspection took place on the 25, 26 April 2018 and the 1 May 2018. The first day of the inspection was unannounced and the second and third days were announced.

At our last inspection on 13 and 14 February 2017 the service was rated Requires Improvement overall. We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of Regulations 12 and17. This was because the registered provider had failed to ensure a there was a robust system to monitor and assess the effectiveness and safety of the service and that people were fully protected from the risk of unsafe premises and equipment. After that inspection the provider wrote to us to say what they would do to meet it legal requirements. At this inspection we identified that improvements had not been made, regulations continued to be breached and additional breaches were identified.

We will update the section at the end of this report to reflect any enforcement action taken once it has concluded.

Stapley Residential and Nursing Home is a care home. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Stapley Residential and Nursing Home accommodates up to 97 people in two separate buildings. One building contains the nursing and resident units and one houses a unit called Fernlea. At the time of this inspection 73 people were living at the service 29 of whom were accommodated in the nursing unit and receiving nursing care.

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 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. In addition to the registered manager there were four unit managers. One was based in Fernlea unit, one on the residential unit and two in the nursing unit. Following our inspection the provider wrote to us to inform us the registered manager was no longer working for them.

There was no effective management and oversight of the service. The three separate units operated in isolation and there were no systems in place for managers and staff to work together to share good practice and learn from mistakes. Although some checks were being completed by some managers, there were no formal systems in place to assess the overall quality of the service. Therefore shortfalls on some units in relation to the completion of care records, medication administration records (MARS), staff recruitment files, staff supervision, staff appraisals, health and safety checks and the business continuity plan had not been identified. Some of these shortfalls had been brought to the attention of the registered manager by the local authority as part of a quality monitoring visit of the service in October 2017 but had not been addressed.

Recruitment practices were not safe. Appropriate identity and security checks had not always been completed before staff started work. Although some staff received regular training and supervision from their line manager others had not.

The fire authority identified serious concerns in relation to the safety of the premises in the event of a fire. Immediate action was taken to mitigate these risks and further improvements were being made, however the providers own systems had failed to identify these concerns.

Records containing people's personal information and other records relating to the on-going management of the service were not always stored securely.

People told us that they enjoyed the food that was available to them at meal times but people on the nursing unit were not always treated with dignity and respect at mealtimes. All meals were prepared and served in line with kosher requirements and specialised dietary requirements and preferences were catered for.

People's needs had been assessed before they moved into the service and people had been consulted about their preferences for how they wanted their care delivered. People's ability to consent to their care and treatment had been assessed and support had been provided to safeguard people who lacked the ability to consent. People received the support they needed with their personal and health care and received their medication as prescribed.

People felt staff knew them well and treated them with kindness. Visiting health and social care professionals felt that staff had a good understanding of people's needs and had no concerns about the care people were receiving. Staff responded quickly to people's requests for assistance and there were enough staff on duty to meet people's needs.

A wide range of activities were provided that people enjoyed. We saw people participating in Tia chi, a 'knit and natter' group, trips out into the city, poetry reading and arts and crafts. The provider had bought a piano for people to play and was also taking delivery of exercise bikes for people to use. There were plans in place for more activities to be provided for people who spent time in their rooms.

Systems were in place and followed for dealing with concerns, complaints and potential incidents of abuse. However the CQC had not always been notified of significant events as required. People and their relatives felt safe living there and were confident to raise any concerns they had.

People spoke highly of the chairman of the board of trustees who they felt was approachable. The provider had strong links with the local Jewish community and other organisations involved in people's care. Building works were underway to join the two main buildings together and provide a new kitchen and cinema.

We found six breaches of regulations. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is Inadequate and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Pre-employment identity and security checks had not always been carried out on new staff before they started work.

Risks associated with the safety of the premises and equipment were not managed well. The plans for the continuity of the service in case of emergency were not robust.

People received their medicines safely but medication records were not always fully completed.

Sufficient numbers of staff were on duty to meet people's care needs and people were protected from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not always received the training and support they needed to undertake their role and provide safe effective care.

People enjoyed the food but were not always made aware of the alternative meals on offer.

People's capacity to give consent had been assessed but records had not always been fully completed.

Staff worked in accordance to with the Mental Capacity Act and applications for Deprivation of Liberty Safeguards (DOLS) were submitted appropriately.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Lunch on the nursing unit was not a sociable and dignified experience for people.

People's confidential information was not always stored securely.

People felt they were cared for by kind and caring staff that knew them well.

People were supported to follow their faith.

Is the service responsive?

Good

The service was responsive.

Staff responded quickly to requests for support.

There was a wide range of meaningful activities on offer that people enjoyed which were being further developed.

People knew how to raise concerns or complaints with staff and a system was in place for dealing with these.

There were arrangements in place for people's preferences on their end of life care to be met.

Is the service well-led?

Inadequate

The service was not well led.

Action had not been taken to address breaches to legal requirements and ensure people received a safe service.

The three units operated in isolation and management lacked oversight of the service as a whole.

Roles and responsibilities were not clearly defined and there were no clear systems in place for auditing the quality of the service or gaining people's views.

Stapely Residential and Nursing Home

Detailed findings

Background to this inspection

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

The inspection was carried out on 25, 26 April and 1 May 2018. One adult social care inspector an expert by experience and a specialist advisor (SPA) carried out the inspection on the first day which was unannounced. The second day and third days of the inspection were announced and were carried out by two adult social care inspectors. The expert by experience had personal experience of caring for someone who uses this type of care service. The SPA was a nurse with expertise in care services for people with mental health conditions.

Before the inspection we reviewed information available to us about this service. The registered provider had completed a Provider Information Return (PIR). The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law.

As part of our inspection we spoke with ten people who used the service, seven relatives, one visiting health care professional, four visiting social care professionals, three visiting fire safety officers, an activities co-ordinator, the registered manager, the nominated individual who is also the chairman of the board of trustees, four unit managers, the manager of the domestic staff and six support staff.

We spent time observing the day to day care and support provided to people including people's experience at lunch time and the administration of medicines in each unit. 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 looked at a range of records including medication records, care records for ten people, staff recruitment, training and supervision records. We also looked at records relating to health and safety and quality assurance.

Inadequate

Is the service safe?

Our findings

At the last inspection we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because some parts of the building were unsafe. Some fire doors did not automatically close fully and some fire doors were propped open. Therefore they would not provide the correct level of protection in the event of a fire occurring. At this inspection we found these issues had not been addressed. In addition to this on the second day of our inspection the fire authority, who were undertaking an inspection of the premises, identified serious concerns some of which required the provider to take immediate action and some of which the provider was required to complete within a specific timescale.

There was a business continuity plan in place directing staff on what to do to keep people safe in the event of an emergency however this was not robust. Key information such as plans for the safe evacuation of the premises and where people would be transferred to and how, were missing from the document.

We also identified a bed rail on one persons bed was not operating correctly and could pose a risk to the person. We raised this with the unit manager who took immediate action to rectify this. However the checks of the safety of bed rails had not identified this issue.

The above evidence is a continued breach of Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The recruitment of staff and volunteers was not safe. Appropriate identity and security checks such as the completion of Disclosure and Barring Service (DBS) checks, obtaining proof of identity and references had not always been carried out on new staff before they started work. These checks help employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable people. Some recruitment files did not contain references from the person's last employer and the references that had been obtained had not always been verified. An explanation for the gaps in the employment history of some staff was unaccounted for and the reason they had left their last employment had not always been recorded.

The above evidence is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health and safety had been assessed. Each person's care plan had a number of risk assessments completed which were specific to their needs. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. For some people this meant aspects of their care needed to be monitored. For example some people had repositioning charts and fluid intake charts in place. However these had not always been completed. The registered manager explained that staff knew people well and were aware of people's specific needs and delivering the care accordingly but were not always recording this appropriately. Therefore it was not possible for the provider to assess whether people were receiving the care they were assessed as needing.

Records relating to the management of medication had not always been fully completed. Some peoples allergies were not stated on their medication administration records (MAR) and some did not include a photograph of the person to aid their identification. The administration of topical creams had not always been recorded and there was no specific guidance in place for under what circumstances 'as required' medication should be administered to people on the nursing unit. In addition the temperatures of the fridge and medication room on the nursing unit had not always been completed. Therefor it was not possible for the provider to assess whether or not people had were always receiving their medicines as required.

We asked for copies of all the health and safety checks and records confirming the routine servicing of equipment however these were disorganised therefore we could not assess whether all equipment had been serviced. For example we were shown invoices for the servicing of individual slings and hoists but there was no overall list detailing each piece of equipment and when it was serviced. The date on the invoice for the servicing of the gas was illegible and there was no evidence of whether recommendations made when the lift was serviced, had been completed. We asked the registered manager to send this information to us but it was not received. Therefore the provider had no way of assessing whether or not the equipment had been serviced as needed.

The above evidence are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored securely in line with legal requirements and were administered by staff who had completed the relevant training and whose competencies had been checked. People who were assessed as safe to do so were supported to manage their own medicines. People told us they received their medicines on time and that 'as required' medicines such as pain relieving medicines were available to them when they needed them. We observed that staff administered medicines to people individually and completed the Medication Administration Record (MAR) before administering medicines to the next person.

The registered manager told us all accidents and incidents were recorded on incident reports. They explained these were reviewed on a daily basis and when appropriate to do so were reported to the local authority for them to consider under local safeguarding protocols. The majority of accidents and incidents had been recorded on accident and incident reports had been managed safely and appropriate action taken to reduce the risk of re-occurrence. Where appropriate, any identified potential abuse had been reported to the local authority for them to consider under safeguarding protocols. Any changes to people's support plans were communicated to the staff in the relevant unit at staff handover.

People who used the service told us there were enough staff on duty to provide the support they needed. The registered manager told us extra staffing was arranged if required and that a member of the management team were always on call to provide assistance if needed. The registered manager told us staff vacancies were covered through offering staff additional hours or by using agency but that they always had permanent members of staff on duty and records confirmed this.

The service was clean and odour free and staff had access to personal protective equipment (PPE) when needed. All staff had completed training in infection control and food hygiene. The kitchens in the nursing and Fernlea units of the service had been awarded a five star food hygiene rating as part of the environmental health service rating. The provider told us a new kitchen would be provided as part of the on-going refurbishment and development of the service.

Requires Improvement

Is the service effective?

Our findings

Staff had not always completed the training and received the support they needed to undertake their role effectively. The personnel files for the staff that worked on Fernlea did not contain evidence of training completed, supervision meetings or of annual appraisals of performance. Supervision provides staff with an opportunity to meet with their manager in private to discuss their training and development needs. We saw records that showed one member of staff had failed an online moving and handling training course in July 2016. There were no records to show that this staff member had retaken and subsequently passed this course. The registered manager told us this staff member worked at night and was on duty with one other carer. Therefore the provider could not be assured that this staff member had the skills they needed to safely support anyone who required the support of two staff to move.

Feedback from staff who held a managerial position at the service was they had not received an induction into their role or received supervision or an annual appraisal of their performance from the registered manager for a long time. They also told us they did not feel always feel supported in their role and were not always clear about their roles and responsibilities.

The registered manager was unable to provide us with an overview of the training staff had completed or when staff had received supervision and an annual appraisal of their performance by their line manager. Therefore the provider had no way of assessing whether staff had the skills and competencies needed to support people effectively.

The above evidence is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff who worked in the residential and nursing units told us they had completed training the provider considered to be mandatory such as infection control, moving and handling and health and safety. We were told the training was on line but that staff also had to complete a workbook that was then sent off for marking. There were 15 workbooks in total covering a range of subjects relevant to their role. They also told us they could request specialist training such as diabetes care and received regular supervision with their line manager. The personnel files of these staff confirmed this.

The service was set up to provide accommodation for people who followed the Jewish faith and served Kosher food and followed Kosher rules for preparing and serving meals. Kitchens were located in Fernlea and in the nursing unit. Both buildings had separate milk and meat kitchens to comply with religious requirements. Kitchen staff were aware of people's specialist dietary requirements and preferences and these were catered for. One person told us "I have special food as I have an eating problem. They are very good about it; they often make a separate meal for me." The majority of people who gave us their view told us they enjoyed the food. People's comments included "The food is quite nice." "The food is good and I'm a fussy eater". "The food is better than what it was."

The menus on display in each dining area specified the lunch time meal but did not indicate whether any

alternatives were available. Staff told us if people did not want the meal, then they could choose something else. One person confirmed this and told us "Staff would find something else if I didn't like it". However other people were not aware they had a choice. One person told us "There's not really any choice, sometimes but rarely. The food is just presented." Another person commented "Not really offered any alternatives, staff just bring food in". Our observations were although some people were given a different meal, staff did not explain to people that alternatives were available and only one cold drink option was available to people on the Fernlea unit. These were areas of practice that we identified as needing improvement.

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 be as least restrictive as possible.

People can only be deprived of their liberty to 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 or authorisations to deprive a person of their liberty were being met.

People had been assessed to establish whether they would benefit from the protection of a DoLS and where appropriate applications had been submitted to the relevant authority. However these had not always been kept under review and renewed when needed. The authorisation for one person's DoLS, which was valid for one year, contained a condition stating a new application should be submitted before the DoLS expired but there was no record that this had happened. In addition to this, although staff worked in line with the MCA, they had not received any formal training on MCA or DOLS. We also saw some MCA assessments and associated records had not been fully and accurately completed. Although we did not assess any harm had occurred as a result of these shortfalls they were areas of practice we identified that needs improving.

Some care plans contained detailed information about the decisions and choices people had made. For example one plan stated that the person liked their privacy and all staff should obtain permission before entering the person's room.

Initial pre-admission documents had been completed for each person which set out their individual physical and mental health issues and looked at them holistically. This information had then been used as a base on which to compile a care plan. Most care plans indicated the person's involvement, their choices, likes, dislikes and where appropriate the involvement of their relatives. Information also included guidance for staff as to people's mental health conditions and the specific support they required to help manage them.

People told us and records confirmed they were supported to access health care services in relation to their physical health needs. These included appointments with dentists, opticians, podiatrists, Speech and Language Therapists (SALT) and GPs. We met with health and social care professionals who visited the premises on a regular basis and they confirmed they had no concerns in relation to the care people received. Information about the support people required with their health was recorded in their care plans and visiting health and social care professionals confirmed these were followed.

Since the last inspection a substantial amount of refurbishment of the service had taken place. Issues relating to the heating and damp in the residential unit had been resolved and the unit had been redecorated. Building work to connect the residential and nursing unit to Fernlea had commenced and the

provider informed us that this new part of the building would include a cinema and new kitchens.

Aids and adaptations were in place to support people with their mobility and personal care needs. These included specialist beds, passenger lifts and hoists. Adapted bath and shower rooms were also available. Corridors were wide enough to enable people who used mobility equipment to move around easily and were uncluttered. People benefited from the use of a library and had access to the onsite café.

Requires Improvement

Is the service caring?

Our findings

Staff knew people well and we observed some warm interactions for example we saw staff offering reassurance to people when they were anxious and laughing and joking with others. However at lunch time on the nursing unit staff practices did not always treat people with dignity and respect or promote a social and pleasant experience.

On each day of our inspection on the nursing unit we observed staff appeared rushed and focussed on tasks rather than the quality of the experience for people. We saw one staff member move a person in their chair without speaking to them. We also saw another staff member put a bowl of pudding down in front of a person whilst they were still eating their main course then walk off without acknowledging them. Throughout the meal we observed staff talking to one another over the heads people they were supporting and not engaging with people or encourage them to eat. In addition to this staff were wearing disposable gloves whilst supporting people to eat which is not necessary or dignified.

We saw that each element of the meals for people who required a soft textured diet had been prepared and presented separately which meant they retained the colour and flavour of the ingredients from which they were made. This is good practice as it not only makes the meal more visually appealing but enables people to taste the individual foods. However on the nursing unit we saw staff mixed all the separate components of these meals together. This meant all the flavours were combined and the food became brown which did not look appetising. A relative also told us they had seen staff mixing food together in this way. They expressed the view that staff needed training in dignity and said that when they had observed staff supporting a person with their meal, "It was very rushed. Not a dignified way of giving someone their meal. They need training and an oversight on dignity. It has an institutional feel."

The above evidence demonstrates a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's confidential information was not always stored securely. Throughout the service we saw records containing people's private and personal information left out on shelves and stored in unlocked cupboards in unlocked offices.

The above evidence is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the shortfalls we identified most people did feel they were treated with dignity, respect and kindness by staff. When asked if staff treated people with respect people's comments included "Oh yes; I wouldn't be here if they didn't." "They all listen to what you say." "We respect each other's privacy." People confirmed that staff knocked on the door before entering and kept the doors closed while supporting them with personal care.

Although some people did not recall being asked about their preferences or being involved in planning their

care it was clear from the documentation seen that they and or their representatives had been consulted. For example records relating to one person contained information about a discussion staff had with the person offering them a different bedroom. Another person's records detailed the night clothes they liked to wear, that they liked their bedroom door shut and the side light left on.

The registered manager explained that staff were allocated to work with specific individuals each shift and where ever possible people's preferences to be supported by a male or female carer were accommodated. People living on the nursing unit also had a named key worker who co-ordinated certain aspects of their care and was a point of contact for the person and their family members.

Feedback from visiting health and social care professionals was that staff knew people well. When asked if they knew the staff they confirmed they did and their comments included "Yes I know all the staff." "Most of them (staff) know me". "Oh yes and I like them". "Yes I know them but some better than others."

Stapely Residential and Nursing Home was originally provided specifically for people of the Jewish community and has a synagogue which holds regular services which people are welcome to attend. We observed that when no services were taking place this was open for people living there to visit or sit in. The service has close ties with the local Jewish community who provide volunteers who help with the reception desk and supporting people with activities.

One unit manager explained that people of any and all faiths were welcomed into the service and people can hold religious services or receive communion in their rooms. This was confirmed by one person who told us that they were supported to retain and practice their religious beliefs.

Good

Is the service responsive?

Our findings

People spent their time as they wished. Staff told us when social events were held at the service they encouraged and supported people to attend.

At the last inspection of the service we found that activities did take place, however people told us they would like to see these increased. This particularly applied to the people living in the Fernlea unit. At this inspection we found the range of activities on offer that people enjoyed had increased. Activities were mainly provided by external organisations one of which had been contracted by the provider to co-ordinate the provision of activities across the whole service. The provision of activities was also supported by staff and volunteers to the service including children from a local school. Activities on offer over the period of the inspection included socialising in the on-site café, attending a poetry group, Tia chi, a knit and natter group, hand massages, a reading group, trips out to the community in one of the services two mini buses and art and craft.

The residential unit contained a library that people could use and we saw the service had just taken delivery of a piano which the provider told us would be made available for people and their visitors to play. They were also about to take delivery of some exercise bikes for people to use. The registered manager explained the exercise bikes had a screen which could display a number of routes that people could 'cycle' along. They told us they had consulted with people about this and in response to people's feedback had arranged for routes in and around Liverpool to be installed so that people could 'cycle' around areas that were familiar to them. Other improvements planned were the provision of a cinema in the extension that was being built and a restaurant on the Fernlea unit.

Despite the increase in activities some people and their relatives felt more could be done to keep people occupied and stimulated. Most of this feedback was in relation to the nursing unit where people spent more time in bed and therefore did not have the same opportunity to participate in group activities as others. The provider explained to us that plans were in place for more activities to be provided. A representative of the company that co-ordinated the provision of activities confirmed this. They told us they took a person centred approach and were working with individuals on a one to one basis to establish the type of activities they wanted and enjoyed. They explained they had already extended the poetry readings to include reading to people in their rooms and were providing hand massages.

Staff maintained regular contact with health professionals who were responsible for reviewing people's care arrangements. This helped to ensure any changes in people's health could be closely monitored and action taken where necessary. Feedback from visiting professionals who provided support to people at the service was that they had no concerns in relation to the care people received. Most care plans contained clear information on how to meet the person's clinical and personal care needs and staff had detailed knowledge of individuals and how to provide them with person centred care.

We checked whether the provider was following the Accessible information Standard (AIS). The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must

make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. The registered manager told us people's communication needs were always considered as part of the assessment and care planning process and records confirmed this. For example we saw that it had been identified that one person would need an interpreter to attend meetings to aid their understanding and this had been provided. This person also had a picture book which they used to aid their communication with staff. The care plan for another person who was living with dementia emphasised the importance of making eye contact and stated staff should approach the person in a calm manner, 'speaking slowly and calmly'. We saw that signage around the service was illustrated with symbols to aid people's understanding.

People told us that staff responded to their calls for assistance and were usually on hand to help when needed. People assessed as able to use them had access to a call bell in their room which they could use to alert staff if they needed help. Some people who were at risk of falls and did not have the capacity to use a call bell, had sensors fixed to their beds or sensor mats next to their bed. This was so that it would alert staff if they tried to get out of bed or walk without assistance.

There was a complaints procedure available to people. The registered manager and provider monitored any complaints, compliments or concerns on a daily basis and used the information to understand how they could improve or where they were doing well. People told us they would feel comfortable complaining to the management if they were unhappy.

Nobody living at the service was receiving end of life care. The registered manager told us they would make referrals for support to be provided by the relevant health care professionals if someone reached the end of their life and wished to be cared for at the service. Some people's care plans detailed their preferences for end of life care and the registered manager explained that some people had not wanted to discuss this but that they would ask people for their preferences when they were ready to do so.

Inadequate

Is the service well-led?

Our findings

At the last inspection we identified a number of shortfalls in relation to the governance of service. This was because systems and processes did not operate effectively to monitor and improve the quality and safety of the service. Following that inspection the registered manager wrote to us with an action plan describing the action they would take to ensure they were meeting the requirements of the law. At this inspection we found that they had not followed their plan; the breach of regulation had continued and further shortfalls in relation to the governance of the service and the systems in place for monitoring the safety and quality of the service were identified.

At the last inspection a number of audits to check various aspects of the service had not been completed since September 2016. At that time the registered manager told us that this was due to lack of time. At this inspection we found audits were still not taking place. Therefore shortfalls in relation to the monitoring of people's care records, medication administration records (MARS), staff recruitment files, staff supervision, staff appraisals, health and safety checks and the business continuity plan had not been identified and the provider had missed the opportunity to take corrective action. In addition to this action had not been taken to address shortfalls identified by the local authority as part of a quality monitoring visit of the service in October 2107.

The registered manager told us their title had changed from 'manager' to 'matron' but they were not able to tell us what the specific roles and responsibilities of the 'matron' were. They told us each unit now had a manager who they thought were responsible for auditing the records of the people who lived on that unit and the staff who worked there. Some unit managers were doing some checks but no one in the organisation had overall oversight of all the records or of what checks needed to be completed when or by whom. In addition to this each unit worked in isolation with no meetings at which staff and managers could get together, learn from mistakes and share good practice.

At the last inspection we found some areas of the home were unsafe. At this inspection we found although immediate action was taken to address safety issues brought to the providers attention as part of this inspection and by the fire authority, the providers own safety checks and quality assurance systems had failed to identify these issues. Therefore risks to people's safety had remained unchecked and been allowed to continue.

At the last inspection there was no clear consistent method of communicating with people or gaining their views. At this inspection we found no action had been taken to address this issue. Residents meetings did not take place and there were no other systems in place to gain people's views or the service or for information to be communicated with people.

The above evidence demonstrates continued breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was aware of their responsibilities to keep the CQC informed of significant events at

the service by way of submitting statutory notifications. Although these had been submitted as required most of the time, on other occasions they had not. For example there had been incidents of potential abuse that had been reported to the local authority that the CQC had not been informed of. The registered manager had also failed to notify the CQC when applications for DoLS had been authorised.

The above evidence demonstrates a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager showed us a monthly questionnaire they completed for the NHS clinical quality monitoring department and this covered a number of areas including the number of falls that had occurred and the number of people who had developed pressure areas. They also told us that people's care plans were reviewed on a monthly basis to ensure they remained up to date and accurate. We saw most of the care plans we saw contained up to date and relevant information however there were no records to show they had been checked or audited for accuracy and completeness by management.

Most people knew who the registered manager was and everyone knew the nominated individual. The nominated individual was also chairman of the board of trustees and was at the service most days. Two people told us the chairman of the board of trustees did "Come around and shake hands" and "Comes around nearly every day." A relative commented that the chairman of the board of trustees was "Always around" "very nice and caring; goes around to all the people and very approachable".

When asked about the atmosphere of the service one person told us "I like it; don't know of one person who doesn't like it". Another person said they felt the atmosphere "Is very good". When asked if they felt the service was well managed, one person told us "I would say so yes." Another person told us "Seems ok, seems to be enough doing the work".

The provider had good links with the local Jewish community, community groups and schools. They also worked well with other organisations such as the local authority and healthcare professionals.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured that statutory notifications of incidents were always submitted as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people were always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the premises was always safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staff always received the training and support they needed to undertake their role effectively.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensures they had systems in place for the effective monitoring of the service or that action was taken to address shortfalls identified by commissioners and regulatory bodies.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	The provider had not ensured safe recruitment practices were always followed.

The enforcement action we took:

We issued a warning notice.