

Jah-Jireh Charity Homes

Jah-Jireh Charity Homes Wigan

Inspection report

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Ratings

Overall rating for this service

Requires improvement



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?

Requires improvement



Overall summary

We carried out an unannounced inspection of Jah Jireh Charity Homes Wigan on 25 and 26 March 2015. We last inspected the service on 8 September 2014. At this time we found the service was not meeting standards in relation to staffing levels. At our inspection on 25 and 26 March we found the service was still not meeting requirements in relation to staffing levels.

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

Summary of findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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.

We found four breaches of the regulations in relation to staffing levels, medicines, safe premises, and monitoring the safety and quality of the service. You can see what action we told the provider to take at the back of this report.

There were not always sufficient staff on duty at Jah Jireh to meet people's needs. The service had increased staffing levels since our last visit, however agreed staffing levels were not always achieved due to shifts not being covered when staff were on annual leave or off with illness. We were told the needs of people living at the home had also increased adding extra pressure to the staff team.

The environment was not always safe for people living at Jah Jireh. The water felt very hot and temperatures were not tested to ensure people's safety before bathing them. We saw a section of missing carpet exposing a manhole with a loose fitting cover in one area of the home, which created a trip hazard.

Adaptations had not been made to make the environment dementia friendly. Doors were painted the same colour and there were no signs to indicate what rooms the doors led to. This would make it more difficult for people with dementia symptoms to retain independence or orientate in their home. We have made a recommendation in relation to dementia friendly environments.

Medicines were not always kept safely as the service had not consistently monitored the temperature of medicines kept in the fridge. We also found a loose tablet in a bathroom that was accessible to people living at Jah Jireh.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards

(DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We found the service was submitting DoLS applications to the local authority where a need was identified.

We saw people were not always given support when they requested it at meal times. We found that one person was not receiving support at meal times that was consistent with their care plan.

We were told an effective and thorough handover was always given to ensure staff were aware of current support needs. However care plans were not always up to date and consistent with the care being provided to people. This increased the risk of inconsistent or inappropriate care being given.

Staff told us they felt well supported by the managers and colleagues. We saw staff undertook training in areas including safeguarding, health and safety and MCA/DoLS. New staff worked supervised until they felt confident and were deemed competent by a supervisor. Staff also spoke positively of team meetings, which they told us were full of training and provided opportunity to feedback to the manager.

Most of the interactions we observed between staff and people living at Jah Jireh were respectful and friendly. However, staff had little time to spend with people at busy times such as mealtimes.

Whilst some people felt there were enough activities, others said there was not enough to do and some people said they would like more trips out. Staff told us there would be more trips in the summer when the weather was warmer. People's spiritual needs were well met and there were close links with the congregation as well as regular trips to the Kingdom Hall.

There was not a robust system of audit in place that would have allowed the manager to monitor the quality and safety of the service being provided. There were no care plan or medicines audits carried out by the manager, which were areas where we identified shortfalls.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Shifts were not always covered when staff were absent on annual leave or due to sickness. Staff told us this could mean they would struggle to support people to get up or go to bed at times.

A safe environment was not maintained. A bathroom light did not work and sections of carpet were missing where works were being undertaken. This presented a trip hazard where a manhole cover with a loose fitting cover was exposed. The service had difficulty controlling the hot water temperature and was not testing or recording temperatures before supporting people with bathing.

Medicines were not always stored and administered safely. The service was not taking steps to ensure medicines requiring refrigeration were kept at an appropriate temperature as the thermometer had broken. We found a tablet in one of the bathrooms, which presented a risk to other people living at Jah Jireh.

Inadequate



Is the service effective?

Some aspects of the service were not effective.

We saw eating and drinking guidelines in one person's care plan were not followed. Staff were not always responsive to people requesting help to eat and drink.

There were few adaptations to the environment that would support people living with dementia to retain independence in their home. It was difficult to identify which doors led to bedrooms, bathrooms or other areas.

Staff undertook a three month induction during which they worked supervised. We spoke with a member of staff who had recently started and they told us they felt well supported throughout their induction.

Requires improvement



Is the service caring?

Some aspects of the service were not caring.

At times we observed positive interactions between staff and people living at Jah Jireh. However, at busier times of the day staff did not always respond to people trying to get their attention and one person told us staff could be "sharp".

Staff had a positive approach to respecting people's privacy and dignity. Staff showed they understood people's routines well.

Requires improvement



Summary of findings

Staff told us people had a choice in relation to what time they went to bed or got up. Staff told us people had allocated days for baths or showers but could request an alternative day should they wish.

Is the service responsive?

Some aspects of the service were not responsive.

Care plans were person centred and comprehensive. However, two care plans we viewed did not contain all the information in relation to how the support those people required or were currently receiving.

Whilst some felt there were enough activities, others did not. A member of staff who had supported some of the activities had recently left, and people told us there had not been any recreational trips out for some time. Staff told us there would be more trips out in the summer.

Regular residents' meetings were held to gain feedback and involve people in development of the service. However, some people didn't think anything changed as a result of these meetings.

Requires improvement



Is the service well-led?

Some aspects of the service were not well led.

There was no audit of care plans or medicines carried out. Therefore the issues we identified in these areas had not been acted upon.

Staff told us they felt well supported by both the managers and other team members. Staff told us team meetings were useful and full of training.

Policies were not clear or easy to follow. Most policies we looked at had not been reviewed for several years and did not always contain information that was required. This would make it difficult for the service to act in a consistent way in line with best practice and current legislation.

Requires improvement



Jah-Jireh Charity Homes Wigan

Detailed findings

Background to this inspection

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

The inspection took place on 25 and 26 March and was unannounced. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. A third adult social care inspector who was undertaking induction training at the time of the our visit also joined the inspection team.

Before the inspection we reviewed information we held about the service. This included notifications the service is required to send us about any deaths, alleged abuse and other significant events. We contacted Wigan Healthwatch, the Wigan safeguarding and quality monitoring teams for feedback on the service. We reviewed the provider information return (PIR) sent to us by the service. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we took a tour of the building and looked at all areas including the kitchen, lounges, bathrooms and some of the bedrooms. We observed the mid-day medicines round and also observed the support people received at meal times. We spoke with nine members of staff. This included six care assistants/supervisors, the chef, the senior nurse and the senior supervisor. We also spoke with an agency nurse who covered regular shifts and was working at the time of our inspection, and another visiting healthcare professional. As the registered manager was not present at the time of our inspection, we spoke with them by telephone following the inspection.

We spoke with eight people living at Jah Jireh and two relatives who were visiting at the time of the inspection. Not all people living at Jah Jireh were able to tell us about their experience of living there. For this reason we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care and support to help us understand the experience of people who could not talk with us.

We reviewed records relating to the care people received including eight care files, eight medication administration records (MARs) and accident reports. We also looked at three staff personnel files, minutes of staff and resident meetings and other documents related to the running of a care home such as maintenance and service records and environmental risk assessments.

Is the service safe?

Our findings

At the time of our last inspection we found shifts were not always covered when staff were absent due to illness. Staffing levels at that time were not sufficient to meet the needs of people living at Jah Jireh and this was a breach of the regulations. The provider sent us an action plan to tell us what they were going to do to address this. Identified actions included allocating extra staff to the morning shift to ensure people received support in a timely manner.

We found these actions had been taken; however, shifts were still not always covered when staff were absent due to illness or annual leave. We were told there was always one nurse on shift and that these shifts would be covered by agency staff if required. However, agency staff were not used to cover carers' shifts as the ethos of the home was to provide support from people of the same faith.

On our arrival we were told there had been one agency nurse and two carers providing support on the night shift (10pm to 8am) to the 41 people living at Jah Jireh. We were told there should have been three carers, however one of the carers had been absent due to illness and this shift had not been covered. When we reviewed the rotas and shift cover books we saw there had been eight instances in the previous six weeks when the night shift had been short by one member of care staff. In this same period records indicated there were nine occasions on day shifts where agreed staffing levels had not been reached.

During breakfast we saw the room was left unsupervised for short periods and at other times was frequently left supervised by one nurse who was also conducting the medicines round. At one point the nurse had to quickly lock the medicines trolley to provide support to someone with a hot drink. Had the nurse been in the process of administering medicines at this time there would have been a risk one of the people would not have received the support they required as it would not have been possible to support both individuals at the same time. Although staff were present in the adjoining kitchen, no other staff members responded to assist the nurse.

During the inspection, other than during mealtimes, we saw that people were supported promptly when they required assistance. One person told us staff responded quickly when they needed help. However, three people we spoke with living at the home told us the service was short

staffed and they thought more staff were needed. One person told us; "If people need to go to the toilet and have a pad changed, they [the staff] can be in a flat spin". Whilst staff told us staffing levels had improved, two staff felt that the needs of people living at Jah Jireh had increased and that this placed extra pressures on staff. We compared staffing levels to those at our last inspection and saw there were additional staff on the set rota in the mornings, but not afternoons or nights.

Two staff members said they would like to be able to spend more time working one to one with people. One member of staff told us "People are generally well looked after, but perhaps don't have the quality of care due to pressures". Another staff member said they wished they were able to spend more one to one time with people and also stated "no, there are never enough staff". Staff also indicated they could be rushed due to staffing levels and that this could impact on people they were providing care and support to. One member of staff said they could struggle when there were only two carers on the night shift as had been the case the night prior to the inspection. They also told us "We struggle on the 6pm-10pm to put people to bed". One person we spoke with said they would sometimes have to wait to receive support at night when the staff were "running behind". Another member of staff told us they could be rushed trying to get people up in the morning. On the morning of the first day of the inspection a member of staff was overheard saying that one resident was still in bed as there had only been two members of staff on the night before. The provider had failed to ensure there were sufficient numbers of staff deployed. This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Four of the five people living at Jah Jireh who we asked if they felt safe told us they did. One person however told us they did not feel safe and raised a number of concerns. We referred this person's concerns to the local authority to investigate. Staff were able to describe how they would recognise potential abuse, such as looking for any bruising or a change in behaviour. Staff were aware of the procedure for reporting any concerns and all staff said they would be confident action would be taken by the registered manager or supervisors. Staff told us the phone numbers for the local safeguarding team were kept by the phone in one of the offices and that they could call if they had any

Is the service safe?

concerns. We saw that safeguarding had been covered in a recent team meeting and the registered manager had highlighted parts of the local authority policy to discuss with staff. This would ensure staff were aware of their responsibilities in relation to safeguarding.

We looked at whether medicines were stored safely, including medicines kept in the fridge. We found the fridge thermometer was broken and that temperatures had not been recorded for around five months. This meant the service was not able to ensure that medicines were being kept at a safe temperature to ensure their effectiveness. We raised this with the nurse who told us a replacement thermometer had been ordered. They followed this up during the inspection and a replacement was provided on the second day of our visit.

We found there were no 'when required' (PRN) protocols in place. When required protocols provide information on the reason a medicine should be given as well as details such as dose, when to give the medicine and what it is expected to do. We reviewed the homes medicines policy and found it contained no reference to a process in relation to 'when required' medicines. The provider told us information on details of when to give 'when required' medicines could be found in notes in service user files. However, these notes were not present in the medicines file for staff to refer to at the time of administration. The absence of PRN protocols is contrary to good practice guidance from the National Institute for Health and Care Excellence (NICE). We saw that one person was prescribed a variable dose of paracetamol but there was no indication on the MAR sheet or in the medicines file to indicate what dose should be given. We asked the nurse administering medicines who said they knew this person was usually given a particular dose. However, if other staff such as agency staff had been administering medicines this information would not have been clear. We also saw that the actual dose administered was not indicated on the MAR sheet. This meant there was a risk this person would not receive their medicine in line with their care needs. We saw the administration of a medicine for one person had not been signed for from five days prior to the inspection. We raised this with the nurse who later confirmed the medicine had been given as directed.

When carrying out an initial tour of the building we found a tablet in one of the downstairs toilets. This presented a risk to other people living at Jah Jireh who might have taken

the tablet. We alerted the nurse to this who told us they were unable to identify where it had come from, but said they would brief staff to monitor people when giving medicines. We later observed a person who had been administered medication and was having difficulty swallowing it. They told the staff member administering the medicine they could not swallow the tablet to which the staff member asked if they would prefer the liquid form of the medicine. They left the person with the tablet on their tongue. This person attempted to gain the attention of carers but was not seen or heard to do this. They then removed the tablet from their mouth and placed the tablet down the side of the chair. We told the nurse who found the tablet and ensured this person had received the medicine they required. They told us they believed the person had swallowed the tablet. The provider had failed to ensure the proper and safe management of medicines, which was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the tour of the building we noticed some areas where maintenance or repair was required. A light in a downstairs toilet did not work resulting in this area being dimly lit. The provider sent us evidence that this had been noted as requiring repair 11 days prior to our inspection visit. We also saw two sections of carpet were missing in a downstairs corridor. One section at the far end of the corridor had a manhole cover exposed. This was loose fitting and moved when walking on it. Whilst people living at Jah Jireh would be unlikely to access this area, there was nothing to prevent people accessing this area should they choose to do so. This would present a trip hazard to anyone accessing this area. A staff member told us the carpet had been removed a few months ago and confirmed there had been no incidents reported as a result of the works.

We also saw that areas at the bottom of stairwells accessible to people living at Jah Jireh were being used to store items including items that presented a potential hazard such as spray adhesive and opened cans of paint. Action was taken to remove these items as soon as this was raised with the provider. The provider had told us in the provider information return (PIR) that the hot water in the home ran off the heating system and that this had been altered to adapt to changing weather conditions. We found the water in the downstairs washbasins felt uncomfortably

Is the service safe?

hot. Staff told us there had been recent problems with the water temperature and weren't sure how to control it. We found the service was not testing water temperatures, including when people were supported to bathe or have showers. This meant there was a risk people could be harmed by water that was excessively hot. The provider had failed to provide care in a safe way by mitigating risks to people's health and safety and ensuring the premises were safe. This was a breach of regulation 9 of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed staff records and saw robust procedures were in place to ensure only suitable and appropriately qualified staff had been recruited. We saw staff were interviewed, references obtained and a Disclosure and Barring Service check carried out. This would highlight any previous convictions, or if the applicant was barred from working with vulnerable adults or children

Is the service effective?

Our findings

We asked five people what they thought about the food on offer. Three people told us they liked the food served, however, one person told us they did not like the food and another person said “The food is a bit boring sometimes. There is a four week rota.” The 2014 survey results we viewed showed that around 65% of the sixteen people surveyed were happy with the food. We saw there were comments that people had requested increased variety of the food offered.

We observed the mid-day meal and saw people were offered a choice of main meal and drink. One person told us that in the past they had requested, and been given an alternative. On two occasions people were not always given time to complete their first course before being given a second course. This meant the meal time was not relaxed and people might have felt rushed. People who required assistance to eat were supported in one lounge by between one to three staff members. These people were seated in lounge chairs and there was little space in the room to allow staff to assist people. We saw assistance being given by staff standing in front of people or sitting on foot stools nearby. This made it difficult for the staff to support people comfortably or effectively. There were not always enough staff present to provide people with the support they required. We observed one person trying to get the attention of staff to receive help with their meal which was unnoticed by the staff present.

We observed the support given to one person that we had seen had a nutritional risk assessment in place that indicated a high level of risk. There were some limited guidelines in an eating and drinking care plan around the support this person required with eating and drinking although there was no nutritional care plan. The guidelines stated this person needed “help” and stated this person should sit in a quiet area whilst eating and drinking. We saw this person was supported in the lounge, which was not quiet, and was given intermittent support. Staff also seemed uncertain about the appropriate diet this person required. We saw this person was given thick brown buttered bread that was left with them. When another member of staff came into the room they commented this person had struggled to eat bread in the morning and said to ask the person what they wanted to eat. We did not

observe any staff member ask this person what they wanted. The nurse told us this person was not on a soft diet, but could sometimes struggle with certain foods. These details were not recorded in the care file.

We found there were people living at Jah Jireh who were living with dementia. We saw staff responded and supported people with dementia care needs appropriately. However, there were few adaptations to the environment to make it dementia friendly or that would support these people to retain independence within their home. We saw a small number of people’s room doors had their photo on it, however the majority did not. There were no adaptations such as contrasting handrails, directional signage or themed areas that would have assisted people to mobilise round the building or understand where they were if assisted by staff. We found that nearly all doors, including those leading to bathrooms, bedrooms and storage areas were painted the same colour, with nothing visual to identify where that door led. This would make it hard for some people living with dementia to find the bathrooms or their bedrooms.

We recommend that the service reviews current best practice guidance on developing dementia friendly environments.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Staff were seen to ask people for consent before providing care, and they were able to explain to us how they supported people to make decisions, such as providing a visual choice of clothes they could wear.

We found the registered manager had submitted DoLS applications to the local authority where it had been identified that people lacked capacity and restrictive practice was required to provide them with the care and support they required.

We were told staff supervisors and nurses completed five supervisions per year as well as an annual appraisal. The supervision records we looked at showed a variety of topics were covered in supervision including any areas where the staff member needed additional support, and specific areas the registered manager had identified such as the

Is the service effective?

business plan, the emergency plan, person centred care and safeguarding. Staff told us they also provided an opportunity to discuss any concerns. Whilst most staff members had received supervision as frequently as agreed, one staff member's records we reviewed showed they had one supervision just under three months prior to our visit, but had not had supervision prior to this since 2013. The staff member confirmed they had not received regular supervision.

We looked at records of training and saw training had been carried out in areas including safeguarding, MCA/DoLS, dementia, moving and handling and health and safety. There were some gaps in the training records where staff training had lapsed and needed to be refreshed, or where new starters had not yet completed training. However, staff told us team meetings were also used to keep them up to date in areas such as safeguarding and MCA/DoLS. We

confirmed this from the staff meeting minutes we looked at. One member of staff said they had completed an exercise running through support scenarios in relation to dementia care and had found this particularly useful.

We were told new staff went through a three month induction during which they undertook training and worked supervised. We spoke with a new member of staff who told us they felt well supported during the induction period and confirmed they had undertaken induction training and that they worked supervised until they were signed off as competent by their supervisor. The training supervisor we spoke with told us they would soon be introducing the new care certificate for induction training.

We saw healthcare professionals frequently visited the home, and a record of visits was kept in individual's care files. Staff told us any changes in people's care would be communicated during handover. The agency nurse we spoke with told us handover was taken very seriously and was an effective way of communicating information.

Is the service caring?

Our findings

Most of the people and visitors we spoke with told us they had developed good relationships with the staff and that staff were kind and caring. Comments included; "They are all nice"; "We have a bit of fun with them" and "You are treated well, it's like being at home." However, one person told us "“They [the staff] can be very sharp sometimes; I think it is because they are busy”".

Our observations of staff interactions with people living at Jah Jireh also showed the staff approach to be variable. At times we saw positive interactions, where staff were patient, respectful, kind and friendly. We observed staff demonstrate good practice when using the hoist by explaining what they were doing to the person, encouraging their participation and assisting them in a calm and reassuring manner. At other times when staff were busier, such as around meal times, the care and support we observed became much more task focussed.

During the mid-day meal there were occasions when people repeatedly tried to engage with staff and were ignored. At one point during the meal one person was heard to repeatedly say; "I want to go to bed now". The staff present did not acknowledge this person or offer other support or reassurance. Another member of staff then entered the room and replied; "I've not started yet my dear. Bed, you want to go to bed?" When speaking with one member of staff they used language that lacked respect and suggested the absence of a person centred approach to supporting people. They used the term "feeders" to talk about people requiring support to eat and talked about the lounge "where we normally keep the dementia residents".

We asked staff how they provided person centred care to people. Staff talked about reading people's care plans, learning about their life histories and understanding their likes and dislikes. One member of staff said "Person centred care starts as soon as the resident moves in. We work round their preferences and choices." Staff demonstrated they knew the people they supported well and were able to tell us about different individual's preferred routines and other preferences. For example, one staff member said "after tea X likes to move to their

bedroom and sit in their comfy chair". We observed another member of staff offering someone a drink, they said "Would you like your coffee black like usual, or would you like it with milk?"

We asked staff and people living at Jah Jireh what choices they could make about their care. Staff talked about people having allocated days for baths, and having to get people to bed by the end of a 6pm to 10pm shift. When we queried this with staff they told us if people said they wanted a bath on a different day, or wanted to go to bed later than 10pm this would be fine. However, it was not clear that choice was actively promoted in these areas. One person we spoke with said "We get our day for baths. I don't know if we can ask for a different day, but that is fine". We asked another person if they got to choose when they went to bed. They said "Oh yes, it's not restricted". One member of staff said "If people want to stay up past ten they can do, we wouldn't force anyone, but some residential with dementia wouldn't ask". We saw that people's preferences in relation to bed-times had been recorded in their care plans. This would help staff support people who were unable to communicate their preferences act in accordance with their wishes.

People told us staff respected their privacy and dignity. One person said "You can ask for help if you want it and if you don't they will leave you alone". We observed staff knocking on people's doors and waiting before entering. One staff member who supervised other staff told us they encouraged other staff to put themselves in the position of the person they were supporting and to "treat them how you would want to be treated". However, one relative we spoke with told us they didn't think their family member's privacy was respected as much as it could be as they were in a shared room. The family member said they had requested a private room several times but had not got one even though there were currently single rooms available. Staff told us there was a waiting list for rooms and that the business manager would decide if it was possible for someone to move to a single room. After the inspection, the provider told us that private rooms were not currently available due to planned works being carried out in the home that would mean other people would have to move into these rooms on a temporary basis.

Is the service responsive?

Our findings

We saw pre-admission assessments that included details of medicines, food preferences, social history and support needs had been completed for all residents. These had involved the person and where appropriate, family members. Staff told us full care plans would be completed within three to four days of admission and that staff would be given the opportunity to read them before providing support to someone. However, one person we spoke with told us “If staff are new I have to tell them about my needs but they respect what I say. I wish staff could be better briefed before they help me and maybe more detail is needed in the care plan.” Care plans were person centred, easy to follow and comprehensive. They covered areas including activities enjoyed, expressing sexuality, environment, sleeping and activities. Care plans were completed and reviewed by one of four supervisors for people supported in residential care, and by one of the nurses for people receiving nursing care. The nurse told us they were struggling to review all the care plans as they were currently missing two members of permanent nursing staff. The care plans we looked at had been reviewed regularly and recently. The personal profile pages had not been completed in two people’s care plans we looked at. The provider told us some people had picture boards containing this information in their rooms and that other people chose not to complete this information.

We found care plans did not always accurately reflect all details of the care and support people required and were receiving. We were told by a staff member that one person should be supported by two staff whenever possible. These details and other guidance relating to how to support this person effectively were not detailed in the care plan. This meant there was a risk this person would not always receive the support they required in a consistent manner and presented a potential risk to them and the staff providing support. Staff told us another person who was known to remove their hearing aids and we were told these had been lost on several occasions. There was no reference to this person using hearing aids or how to support this person if they removed them in the care plan. On the day of our visit we saw a letter writing activity taking place that involved a small number of people and people having their nails painted. However, the majority of people were sat in the lounges unengaged in activity. We saw an activity time-table, which included both recreational activities such

as card making, crafts and assisted shopping as well as spiritual activities including bible reading and letter writing. Many of these activities were supported by volunteers from the local congregation. A staff member told us a member of staff who helped out with activities had left recently and had not yet been replaced. We viewed minutes of a residents meeting, which stated that activities may take a period of time to be regularly supervised due to this staff member having left, but that the materials used for the activities could be made available to people.

We received a mixed response when asking people if they had enough to do. Some people felt there were enough activities, however others said there was little to do. Comments included; “Yes, there’s plenty to do such as writing and studies”; and “there’s not much to do. I spend time in my room on the computer”. We asked staff how they engaged people in activity and occupation who were not able to take part in the activities on offer. We were told music would be put on for people or that staff would spend time with people and “talk about spiritual things”. Staff told us they had little time to spend with people individually, but one member of staff said they would do this once their shift finished. Three people told us they would like to go out on trips more often and said there had not been any recreational trips for some time. Two people felt this was due to current staffing levels. We saw the provider had conducted a survey of people living at Jah Jireh. This showed around half of the 16 people who responded were not happy with the current activity programme. The survey analysis stated that comments were made that some would like more outdoor activities. The nurse told us more trips out were planned in the summer when the weather was warmer.

People’s spiritual needs were well met through a range of spiritual activities and close links with the congregation who regularly visited the home. Regular trips to the local place of worship, the Kingdom Hall were provided. For those people that were unable to attend the Kingdom Hall, a phone link up was provided so people could listen to the services should they choose to do so.

People told us they knew how to make a complaint and said they would be confident in raising any concerns. We saw a simple complaints policy was displayed on the back of people’s doors. We were told residents’ meetings were held every eight weeks. We viewed the minutes of the meetings including the last meeting held the week before

Is the service responsive?

our visit. Nine people and a family member had attended. We saw items discussed included activities and food preferences. The minutes stated it had been explained that it was “an impossible task to please 44 different people all with different likes and dislikes and that the menu cannot be altered to accommodate the preferences of one or two” in relation to the food provided. Although people could request alternative meals, this showed the provider was not actively considering how it could work in person centred ways. People we spoke with told us they could attend resident meetings if they wished. One person said “We have a residents’ meeting once a month, where we can talk about things”. However two people felt action was not always taken based on feedback given by people living at Jah Jireh at meetings. One person said “I have given up on the residents’ meetings as you get no information about them, there is no agenda, and nothing happens” The second person told us the meetings “only help to a degree”.

We saw an annual survey was carried out with staff, people living at Jah Jireh and their family members. Survey responses were analysed by the head office and written feedback was provided to staff at the home. One relative

we spoke with said their family member had received a survey, but said they didn’t receive any feedback. The provider told us they did not provide individual feedback to relatives but did display feedback from the surveys within the home. We saw the findings had fed into the annual business and improvement plans. Of the sixteen responses to the survey received from people living at Jah Jireh, 35% indicated they were not satisfied with the food provided and half were not happy with the activity program. We saw these were identified as areas for improvement. These areas had also been highlighted as areas requiring improvement the previous year.

We were told some people had moved long distances to live at Jah Jireh due to there only being a limited number of Jehovah’s Witness homes in the country. One person told us they were not able to visit their family as they lived several hours away and they had been told they would require a nurse to support them. However, we saw relatives visiting without restriction during our visit and were told those that lived further away were encouraged to visit and were offered use of a guest suite in return for a voluntary charitable donation.

Is the service well-led?

Our findings

At the time of our visit 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. The registered manager was not present on the day of our inspection; however we spoke to them by phone the following week.

We saw various systems were in place to monitor the quality of service provision such as daily checklists for staff and cleaning checklists. We saw accidents and falls were logged in a way that would allow any emerging patterns to be monitored and action taken. We were also told the provider carried out an audit every three months and feedback was given to staff. Although a copy of this could not be located at the time of our visit, the provider sent us a copy of the audit following the inspection.

Although there was no combined overview of supervisions undertaken, the provider told us the registered manager would review individual supervisors' records of supervisions undertaken to ensure staff were receiving the support they required. However, this had not been sufficient to pick up the lack of supervision provided to the member of staff as discussed in the effective section of this report. The registered manager told us the staff responsible for completing care plans monitored that they were up to date. However, there was no system in place to allow the overall standard or completion of care plans to be monitored by the registered manager. As such, the problems we found with care plans had not been noticed or acted upon. We also found there was no regular audit of medicines, although we were told the pharmacy carried out a quarterly audit. This had also resulted in failure to act promptly in relation to the issues we found regarding medicines. The provider had failed to put in place systems to adequately assess and monitor the quality and safety of services provided. This was a breach of regulation 10 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there were several files containing policies for the home and it was not always clear which was the current version. Most of the policies we viewed including Safeguarding, Medicines, Recruitment and MCA/DoLS had a review date of 2012 on them. The policies we saw were primarily made up of text copied directly from CQC's 'Essential Standards of Quality and Safety' and other guidance. Policies were very lengthy and many had pages of the same text repeated. This would mean the policies would be difficult for staff to understand and follow and also meant they may not be effective as they did not always detail processes and procedures specific to that home. We looked at the medication policy, which had sections of duplicated text and some pages in the policy were dated April 2003. There was no reference to the mental capacity act or administration of 'when required' (PRN) medicines in the medicines policy we were given.

All the staff we spoke with told us they thought the service was well led. Staff said the managers were approachable and they believed ideas and concerns they raised would be listened to. One member of staff said "If you have got an issue you can go and speak to management about it." Staff said team meetings were held every two to three months and we viewed minutes that confirmed this. Three staff spoke positively about the team meetings. They told us the meetings were very useful, "full of training" and that there was time at the end of meetings for people to raise any comments or issues.

Staff told us they felt the staff team worked well together and were supportive of one another. One staff member said "The culture is very good as we have the same faith. It's really nice". Another staff member said "I feel at home here, it's as if I'm taking care of my relatives." An agency nurse who had worked at the home regularly confirmed the staff team worked well together and told us "I've worked in a variety of places and this is by far the best".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity

Regulation

Accommodation for persons who require nursing or personal care

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

Treatment of disease, disorder or injury

Medicines were not managed safely. Regulation 13

Regulated activity

Regulation

Accommodation for persons who require nursing or personal care

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

Treatment of disease, disorder or injury

People were not protected against the risks of unsafe care as the welfare and safety of service users was not ensured.

Regulated activity

Regulation

Accommodation for persons who require nursing or personal care

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

Treatment of disease, disorder or injury

There were not adequate systems in place to protect service users from the risks of unsafe care or to monitor the quality of the service.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing
Treatment of disease, disorder or injury	Sufficient numbers of suitably qualified and competent persons were not deployed. Regulation 22.

The enforcement action we took:

We issued a warning notice. The provider is required to comply with the warning notice by 06 July 2015.