

Botany House Limited

# Jalna Residential Care Home


## 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?

Good 

Is the service responsive?

Requires improvement 

Is the service well-led?

Requires improvement 

### Overall summary

This inspection took place on 21, 22 and 23 April 2015 and was an unannounced inspection which meant the provider and staff did not know we were coming.

The home is registered to provide care for up to 22 people. At the time of our visit there were 17 people living in the home. The home was providing personal care for older people including people living with dementia.

The registration requirements for the provider stated the home should have a registered manager in place. There was no registered manager in post on the day of our inspection. The Care Quality Commission has however

received an application from the home manager to register. 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.

# Summary of findings

We last inspected Jalna on the 23 September 2014 to check whether requirements relating to dealing with complaints had been met. We found action had been taken.

We asked people who used the service if they felt safe in the home and if they had any cause to be concerned about how they were treated. People told us they felt safe. They said, "There is no bullying and the staff are kind and respectful." However one person said, "I get shouted at, that's the normal thing." One relative told us, "The staff are excellent here. They are very professional in all they do. I visit regularly and I have never seen anything that would give me cause for concern."

We were concerned over the risk of bedroom locks being used when staff were not issued with master keys. This meant staff could not enter people's bedrooms easily in an emergency situation. People were not given information that explained the safety characteristics of the type of lock in use, and were actively discouraged to hold a key. You can see what action we told the provider to take at the back of the full version of the report

We found individual risks had been identified and recorded in people's care plans. However the level of risk was based on an overall calculation and review of risk was not always completed. Two incidents recorded regarding behaviour that challenged were not identified as a risk or referred as a safeguard issue. This placed people at increased risk of not receiving the right care and support. You can see what action we told the provider to take at the back of the full version of the report.

People we spoke with told us they had their medicine when they needed it. We found medicines were managed well and appropriate arrangements were in place in relation to the safe storage, receipt, administration and disposal of medicines.

We found the premises to be clean and hygienic. We observed staff wore protective clothing such as gloves and aprons. Soap and sanitizer dispensers to minimise cross infection were installed throughout the home.

We found individual risks had been identified and recorded in people's care plans. However we found records used to support staff to monitor risks such as nutrition were not being completed properly. This placed

people at increased risk of not receiving the right care and support. You can see what action we told the provider to take at the back of the full version of the report.

People were cared for by staff that had been recruited safely and were both trained and receiving training to support them in their duties. We heard some positive comments about the staff and we observed staff were respectful to people and treated them with kindness in their day to day care. We also heard two comments that gave us some concern regarding how staff spoke to people. You can see what action we told the provider to take at the back of the full version of the report.

Each person had an individual care plan. Staff discussed people's needs on a daily basis and people were given additional support when they required this. Referrals had been made to the relevant health professionals for advice and support when people's needs had changed.

People we spoke with had mixed views about the staffing levels and availability of staff. We found care staff covered catering duties which meant the number of staff available to attend to personal care needs was reduced during this time. We have recommended this be reviewed.

There were informal and formal systems to assess and monitor the quality of the service which would help identify any improvements needed and provide an opportunity for people to express their views. However these were not entirely effective in raising standards as people had identified areas in need of improvement such as temperature of the home and food.

We also found that monitoring the quality of service delivery such as auditing care plans, risk assessments, and the environment was not completed. Systems to assess, monitor and manage risk relating to the health, safety and welfare of people were not effective. You can see what action we told the provider to take at the back of the full version of the report.

We saw that records relating to people's care were available in the upstairs office which was frequently unmanned and the filing cabinet was left open. We have made a recommendation to ensure confidentiality of information is maintained at all times.

Staff told us they were confident to take action if they witnessed or suspected any abusive or neglectful practice

# Summary of findings

and had received training about the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). The MCA 2005 and DoLS provide legal safeguards for people who may be unable to make decisions about their care. We noted an appropriate DoLS application had been made to ensure people were safe and their best interests were considered. Staff were aware of people's ability to make decisions for themselves and knew the principles of having best interest decisions made to support and protect people.

Staff were made aware of people's dietary preferences and of any risks associated with their nutritional needs. We saw appropriate professional advice and support had been sought when needed. People's weight was generally checked at regular intervals and people were given one to one support when this was required. However we have made a recommendation about meeting nutritional needs and monitoring people's weight.

People's bedrooms had been nicely decorated and had evidence of personal items and mementoes in them. We found bedrooms and some areas in the home were cold and people using the service had been given blankets to use when sat in their chairs. We have made a recommendation regarding maintaining a comfortable temperature in the home.

End of life wishes was not always documented to give people the opportunity to discuss and document their wishes regarding end of life care. The manager assured us this was being dealt with.

Activities provided were good and included entertainers visiting the home and the usual festive and birthday celebrations. Visiting arrangements were good and visitors told us they were made to feel welcome.

There was a complaints procedure. This was displayed for all to see together with other useful information such as how to contact the advocacy service. People were encouraged to discuss any concerns during meetings, during day to day discussions with staff and management and also as part of the annual survey to give feedback on the service provided.

People told us the management of the service was good. The manager was relatively new and had applied to be registered as a registered manager with CQC. Staff commented, "The manager is lovely. We can always talk to her. She is very approachable." Staff told us the providers were very good with supporting them and were always in the home. Some accountability for staff performance was evident with spot checks by the manager. However formal supervision was seen to be a reactive response when concerns had been raised about staff conduct and failure to deliver acceptable standards of care.

Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

# 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 consistently safe.

Locks on bedroom doors were not safe because staff did not have master keys to override the locks in an emergency.

Risk assessments did not fully address identified risk, placing people at risk of not receiving the right care and support. Concerns' regarding people's treatment was not always acted upon.

Safe recruitment practices were followed and contractual arrangements and policies and procedures for people's protection were in place.

Medicines were managed safely.

Inadequate



### Is the service effective?

The service was not consistently effective.

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Appropriate action was taken to make sure people's rights were protected. Decisions made took into account people's views and values. People had access to healthcare services and received healthcare support.

Staff were supervised on a daily basis. All staff received a range of appropriate training to give them skills and knowledge to help them look after people.

People told us they enjoyed their meals.

The home was not maintained to a comfortable temperature in some areas of the home.

Requires improvement



### Is the service caring?

The service was caring.

We found staff were patient, friendly and supportive when they were helping people. Staff were instructed to treat people with kindness, respect and dignity.

Staff had a good understanding of people's personal values and needs and their caring skills was being monitored. Training was provided to support them develop further skills.

Good



### Is the service responsive?

The service was not consistently responsive.

Requires improvement



# Summary of findings

Each person had a care plan that was personal to them which included information about the care and support they needed. However people's mental health needs had not been assessed as routine and this placed people at risk of not having these needs met.

Risk assessments were not always written or not being completed properly to make sure people's changing needs were being addressed.

People were supported to take part in a wide range of group activities and visiting arrangements were good.

## **Is the service well-led?**

The service was not consistently well led.

There were systems in place to seek people's views and opinions about the running of the home but we did not see any action plan to follow up on issues people had raised.

There were systems in place to assess and monitor the quality of the service. However some of these were either not being used or effective in recognising and identifying areas in need of improvement.

The manager worked only two days in the home which meant there was no consistent leadership.

**Requires improvement**



# Jalna Residential Care Home

## Detailed findings

### Background to this inspection

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

The unannounced inspection of Jalna Residential Home took place on 20, 21 & 22 April 2015. The inspection was carried out by 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.

Before the inspection we reviewed the information we held about the service such as notifications, complaints and safeguarding information. We looked at information that

had been sent to us from four 'share your experience' forms. We also contacted the local authority contract monitoring team for updates on their investigations into complaints received about the service.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with 16 people living in the home in groups and on a one to one basis, six visitors and a visiting health professional. We also spoke with four care staff, a cook, the manager and two senior representatives of the company.

We observed care and support being delivered by staff. We looked at a sample of records including six people's care plans and other associated documentation, two staff recruitment records, training and on the spot supervision records, minutes from meetings, complaints and compliments records, medication records, policies and procedures and audits. We also looked at the results from a recent survey that had been completed by people living in the home.

# Is the service safe?

## Our findings

We looked at the arrangements in place to support people to live in a safe environment. We checked people's bedrooms. We found people had been supplied with a lockable piece of furniture and bedroom doors had safety locks on. These were the type that allowed people to lock their room for privacy, open the door without a key and allow staff to gain access in an emergency by overriding the lock with the matching door key. We were concerned there was no provision of master keys for staff to gain access into people's rooms. This placed people at risk in an emergency situation.

All bedroom keys were kept in a key safe in the office. We asked a staff member to open the key safe. This was done after several attempts to identify the key. We discussed this with the senior company representative and the manager. The company representative told us they did not actively encourage people to lock their rooms and no person held a bedroom door key. They said they found people were reluctant to have a key to their door. We confirmed there was no information provided to people that explained the safety characteristics of the type of lock in use, and no risk assessment completed to determine people's ability to operate the locks. We saw in care notes that one person had gone into another person's room in the night unsettling them. This meant people were not fully protected in the event of an emergency and they could not be confident of the security of their bedroom.

The provider had not assessed the risks relating to the application of bedroom door locks. This was a breach of Regulation 12(1)(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed safeguarding vulnerable adults procedures with six members of staff and with the manager. All staff spoken with told us they had received appropriate safeguarding vulnerable adults training and had an understanding of abuse. They confidently told us what action they would take if they witnessed or suspected any abusive or neglectful practice. There were policies and procedures in place for their reference including whistleblowing. Whistleblowing is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest'. We had been

made aware of some safeguarding concerns prior to our inspection that had been referred to the Lancashire County Council's safeguarding adult's team that were under investigation

We had received some concerning information prior to this inspection. We were told, "staff pull residents about and shout". We asked people how staff treated them. Everyone we spoke with said they felt safe. One person said, "There is no bullying and the staff are kind and respectful." Another person said, "If I was worried I would tell the manager, she is very, very good and helpful." One person however told us, "I get shouted at, that's the normal thing." Another person told us of a similar incident they had reported to the senior representative of the company and it wasn't taken seriously and they had no confidence to report anything untoward. By failing to act and investigate concerns raised by people using the service, people cannot be confident the right action would be taken to protect them or they would receive the support they need when they raise issues of concern.

The service provider had failed to act when allegations of abuse had been brought to the Company's attention. This was a breach of Regulation 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives we spoke with told us they had never witnessed any bullying or abuse from any of the staff. One relative commented, "The staff are excellent here. They are very professional in all they do. I visit regularly and I have never seen anything that would give me cause for concern." We looked at training records and saw that staff had updated training in moving and handling within the past six months. Staff were observed to move people and transfer people from wheelchair to chair in a safe way.

We found individual risks had been identified and recorded in people's care plans. We saw a wide range of risk assessments in use in care documents including Waterlow (pressure ulcer risk assessment/prevention policy tool), MUST (Malnutrition Universal Screening Tool), falls, moving and handling, use of aids and personal safety. These risk assessment scores were then aggregated and in calculating risk an average was made. This meant the level of risk identified was not accurate and people were at risk of receiving unsafe or inappropriate care. Identified risks were not consistently reviewed.

## Is the service safe?

Although we saw evidence of changes in people's needs, for example one person had lost weight and staff had recorded 'been poorly', no risk assessment had been completed to manage this. We also noted two incidents were recorded of people being 'slapped' and 'smacked' by another person living in the home. Staff had no written guidance in managing this behaviour and there was no evidence this had been dealt with using the safeguarding reporting procedures. We discussed this with the manager and senior representative of the service. This was explained to us as 'a characteristic' of the person rather than an assault; although this was not referred to in the persons care plan or assessment. We saw that incident reports were completed for example, when someone fell. These were more of a statement from staff and whilst useful, did not address the cause or any action that was necessary to improve the safety of people using the service. The risks of people suffering preventable harm were not entirely reduced because action to reduce the likelihood of similar incidents occurring in the future was not taken by review of people's risk assessments or support plans.

The registered person had failed to make sure records were complete, accurate and updated. This was a breach of regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received concerning information prior to this inspection there was insufficient staff employed to meet people's needs. During the inspection we observed how well staff were available to attend to people's needs. We found calls for assistance were answered promptly and there was a staff presence in the lounge at all times. We looked at rotas over a four week period and found all planned shifts were covered. We asked the manager about the current staffing arrangements. We were told the numbers of staff on duty were linked to people's needs. The manager told us any shortfalls due to sickness or leave were covered by existing staff.

Most of the staff had worked in the home for a number of years and therefore people were looked after by staff who knew them. We noted care staff cooked and served the evening meal that had been prepared by the cook who finished work at 1pm. This meant the number of staff attending to people's personal care needs was reduced during this time. We did not see an assessment tool used to calculate staffing levels. We asked people living in the home of their views as to the staffing levels. Most people

said staff were very good and available when needed. However, one person told us of an occurrence when staff did not come when they had shouted. This had resulted in their dignity being compromised.

We looked at three staff recruitment files. We found completed application forms, references received and evidence the Disclosure and Barring Service (DBS) checks were completed for applicants prior to them working. The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This check helps employers make safer recruitment decisions. Staff were also required to inform the provider immediately of any convictions or charges including traffic offences whilst in their employ. There was a policy of non-acceptance of gifts staff were obliged to follow. This meant people could be confident they had some protection against financial abuse and this was closely monitored.

People we spoke with told us they had their medication when they needed it. Care records showed people had been asked how they wanted their medication managed and this was kept under review. The manager told us all staff designated to administer medication were qualified and had completed training. Staff confirmed this. We observed staff stayed with people while they took their medicines.

We looked at how medicines were managed and found appropriate arrangements were in place in relation to the safe storage, receipt, administration and disposal of medicines. We saw people's medicines were checked with their GP on admission to the home. The home used a monitored dosage system of medication. This is a storage device designed to simplify the administration of medication by placing the medication in separate compartments according to the time of day. Medication was delivered pre packed from the community pharmacist with corresponding Medication Administration Records (MAR) sheets for staff to use.

We looked at all the MAR sheets and noted safe procedures were followed where hand written records of medication were used. We found that where new medicines were prescribed, these were promptly started and that sufficient stocks were maintained to allow continuity of treatment. We found there were satisfactory arrangements in place with the supplying pharmacy to make sure people requiring urgent medication such as antibiotics received

## Is the service safe?

them promptly. We noticed however, there had been a time delay of four days for one person who needed antibiotics. The reason recorded for the delay was this had been an error by the GP; however this had not been picked up by the service straight away. We checked other records in relation to urgent medication requirements and found these had been received immediately. Medicines no longer required were disposed of appropriately. All records seen were well maintained, complete and up to date and we saw evidence to demonstrate the medication systems were checked and audited on a regular basis. We saw evidence the registered provider took immediate action when any shortfall in best practice was identified.

Appropriate arrangements were in place for the management of controlled drugs. These are medicines which may be at risk of misuse and require extra monitoring. Controlled drugs were stored appropriately and recorded in a separate register. We checked one persons controlled drug and found this corresponded accurately with the register and was being managed properly. We found the premises to be clean and hygienic. We observed staff wore protective clothing such as gloves

and aprons and soap and sanitiser dispensers, to minimise cross infection, were installed throughout the home. Bathrooms and toilets were clean. There were infection control policies and procedures in place for staff reference. The manager showed us a comprehensive infection control audit she had started to complete. The service held a maximum five star rating for food hygiene from Environmental Health; however staff were observed walking through the kitchen to exit the building during their breaks. We raised this concern with the senior representative of the company who told us this practice was not allowed and would address the issue immediately.

Staff training records showed staff had received training to deal with emergencies such as fire evacuation and first aid. Security to the premises was good and visitors were required to sign in and out.

**We recommend that the service seek advice and guidance from a reputable source about assessing overall care needs in order to determine appropriate staffing levels at the home.**

# Is the service effective?

## Our findings

The people using the service we spoke with thought the staff were trained well and knew what they were doing. They made positive comments about the staff who cared for them such as, “I can talk to the staff, they listen and understand”, “nice”, and “they are good.” “We have a choice in what we eat and what we wear, they (staff) are very helpful.” We asked visiting relatives to comment on the qualities of staff. One relative said, “The staff have worked so hard for her. At first she was in bed all day and did not want to get up, but slowly the staff got her up in the wheelchair then she progressed to a walker and now she can walk on her own. Her appetite has improved as well, she is eating a lot more now.” Another relative told us, The staff are lovely and will always take time to explain things to me. I didn’t read her care plan even though they offered because I trust them completely.”

We looked at how people were supported with their health. We had received concerning information before we visited the service regarding a failure to recognise and respond to a medical condition. We found people’s healthcare needs were considered during the initial care planning process and as part of ongoing reviews. We noted staff were instructed to be ‘aware of signs and symptoms’ of medical conditions documented in people’s notes. However there was no information provided for staff to support them in understanding signs and symptoms of various illnesses. Without the relevant knowledge staff might not necessarily be aware of any deterioration of people’s health and take preventative action at the right time to keep people in good or the best of health. We asked the manager how staff would know if people’s health was deteriorating and we were told staff worked here a long time and knew the people living in the home very well. They worked well with district nurses who visited the home.

Records showed routine health screening was planned for and records were completed following healthcare visits such as chiropody. A person using the service and visiting relatives considered health care was managed well. We spoke with a visiting district nurse who told us, “The home faxes a request for someone to be seen and the referral is noted in the communication book there. They

communicate well with us. The owner is quite involved.” They also told us, “The staff are very good. They seem to know every person and their needs, and will approach me if they are concerned over people’s health.”

We discussed continence management with the senior member of the organisation and the manager as one person told us they needed support with a continence product and this had not been supplied. We were told that referrals were made to continence advisors where necessary. The service did not routinely supply continence products for people using the service.

We looked at how people were protected from poor nutrition and supported with eating and drinking. Everyone we spoke with told us the food was good. One person using the service said, “I don’t like eggs and cheese so the chef gives me other things.” Another person told us, “The home accommodates me. I like Italian coffee and they get it in for me.” People told us they were offered drinks throughout the day.

A record was kept of the meals served. People told us there were usually choices offered at each meal. We looked at the menus. Breakfast consisted of toast, cereal and porridge. One person had told us, “I would love a cooked breakfast from time to time but I am never asked.” We asked the cook if people could choose a cooked breakfast as the menu showed people had porridge or cereal and toast. They told us breakfast was served from 7.30am onwards. People could have what they wanted and one person in particular enjoyed a bacon sandwich some mornings.

The cook told us they told us they worked to a four week menu and changed menus to suit people’s preferences. All meals and confection were homemade and there was some flexibility within the menu. Fresh produce was used and there was always sufficient supplies ordered. We were told they could order what they needed and what people wanted and the provider arranged for the delivery. They prepared a choice of hot and cold food for tea that staff on duty cooked and served. We were told fresh fruit was ordered and offered to people usually in afternoons when afternoon tea was served. We did not see fresh fruit offered on the menu or a record of this on the daily food charts.

Care records included information about people’s dietary preferences and of any risks associated with their nutritional needs. People’s weight was being monitored

## Is the service effective?

however the documentation in use to monitor this was difficult to follow. There was no individual record maintained for people's weight and we saw an example where weight loss was not immediately identified.

Where risk of poor nutrition was identified, staff completed food and fluid intake charts. These should help staff to be alerted when people experienced difficulties. However we saw an observation record for one person that showed no supper had been eaten for ten days and no food intake for two days. The senior representative of the company told us staff had not completed the record. There was no action plan to deal with this. Records showed appropriate professional advice and support from the dietician had been sought for some people.

We observed lunchtime. Dining room seating arrangements were limited and we noted most people ate their meals from over leg tables whilst seated in an armchair. We saw some people were being given the support and encouragement they needed to eat their meal. Portions served were generous and one person when given a meal, told the carer there was too much and was given a smaller portion. People requiring staff assistance were given one to one attention. We observed two people with swallowing difficulties and at risk of choking being helped to eat their meal by staff. One member of staff told a person she was putting an apron on but did not tell the person what the meal was. She used a large metal spoon and did not stimulate swallowing. This meant the person was at risk of choking. The person's care plan had been reviewed following the SALT team visit and informed staff 'to assist with feeding' with no further details of what that would involve. The other member of staff chatted pleasantly during the meal explaining what the food was and used a long plastic spoon suited to the task. We discussed this with the senior management representative of the company who told us they would look at this issue more closely as staff knew the correct procedure in supporting people with swallowing difficulties to eat.

The provider has not ensured staff assisting people to eat with swallowing difficulties were competent to do so safely that meant people were at risk of choking. This was a breach of regulation 12(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook a tour of the building. People with difficulty using the stairs could access the upper floor via a stair lift. We looked in people's bedrooms and saw some had been

nice decorated and had evidence of personal items and mementoes in them. There were three bathrooms with aids and adaptations to support people with their bathing requirements. We found some areas in the home were cold and people using the service had been given blankets to use when sat in their chairs in the lounge. We had also received a concern prior to this inspection informing us people's bedrooms were cold and we noted in a returned survey from a relative this had been raised as an issue. The senior representative of the company told us staff turn radiators off when people leave their room in the morning and these are turned back on later in the day. They said people never went to their rooms and if they did then they only had to ask and staff would make sure it was warm.

We looked at how the service trained and supported their staff. From our discussions with staff and from looking at records, we found staff received a range of appropriate training to give them skills and knowledge to help them look after people. The manager told us all essential training was renewed and the provider was extremely supportive with staff regarding their training. One staff member said, "I've done a National Vocational Qualification (NVQ) in care level 2 and 3 the organisation paid for. They have a good attitude to training."

Records we looked at showed there was an induction and training programme for new staff which would help make sure they were confident, safe and competent. This included a review of policies and procedures, initial training to support them with their role and shadowing experienced staff to allow them to develop their skills.

Staff told us they considered they were adequately supervised on a day to day basis. One member of staff said, "We are like family here. There is a good team and a good team spirit all the time." Another staff member told us, "The manager does spot checks from time to time. I haven't had a formal one to one for a long time but this new manager has got it organised. Our training is kept up to date and she is really supportive."

Staff we spoke with had a good understanding of their role and of standards expected from the manager and registered provider. They said they had handover meetings at the start of their shift and were kept up to date about people's changing needs and support they needed.

We looked at pre admission assessments for three people recently admitted. We found information recorded

## Is the service effective?

supported a judgement as to whether the service could effectively meet people's needs. Furthermore people had received a contract outlining the terms and conditions of residence that explained their legal rights.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). The MCA 2005 and DoLS provide legal safeguards for people who may be unable to make decisions about their care. It sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected and ensures the least restrictive option is taken. The Care Quality Commission (CQC) is required by law to monitor the operation of DoLS. Staff we spoke with showed an awareness of the need to support people to make safe decisions and choices for themselves. They had an understanding of the principles of these safeguards and

had received training on the topic. We were given examples of the use of this such as for delivering personal care. At the time of the inspection one person using the service had been referred for a DoLS.

Care records showed people's capacity to make decisions for themselves had been assessed on admission and useful information about their preferences and choices was recorded. This provided staff with some knowledge to support people as they needed and wished. Staff spoken with had a good understanding of people's needs, interests and preferences. Staff were also aware of people's ability to make safe decisions and choices about their lives.

The registered manager told us three people had 'Do Not Attempt Resuscitation' (DNAR) consent forms in place. We looked at these and we discussed the protocol that had been followed. The decisions had been made by a medical professional and indicated this had been discussed with relatives.

# Is the service caring?

## Our findings

From our observations over the three days we were at the home, we found staff were respectful and treated people with kindness in their day to day care. One person told us, "I like living here it is very homely and the staff are very nice." Another person told us, "I have a bit of banter with the girls; I like living here." One relative said, "The staff are lovely and will always take time to explain things. She (family member) can't communicate her wishes so I'm always watching. She is always clean and tidy and I definitely wouldn't want to move her. The staff are brilliant. They always greet you with a smile." Another relative told us, "When my mother in law came in here she was in a very bad state, the staff go above and beyond to help her."

We looked in people's care records. We found evidence staff were instructed to treat people with kindness, respect and dignity. Staff were also instructed to support people maintain their independence. To make sure staff observed these values, spot checks on staff were carried out by the manager. We saw evidence the manager challenged staff behaviour and when practices did not meet with the organisations expectations. This meant people using the service should have confidence as the caring skills of staff were being monitored and training was provided to support them develop further skills.

Staff we spoke with had a good understanding of people's personal values and needs. They knew what was important to people and what they should be mindful of when providing their care and support. One staff member said, "I look at people and think, they have lives and a past. I feel privileged we have been asked to care for them and I'm honoured. It's more than just coming to work. We are a good team that shows compassion and understanding of people's needs." Another staff member said, "It makes our job rewarding when you see people smile and the good feedback we get from people's relatives."

We observed that staff were patient, friendly and supportive when they were helping people. There was a lot of good interaction between staff and people using the service and staff communicated well with them. One person was getting upset as we were chatting. He said he did not like being away from his wife when he was in hospital and one of the carers saw this and came over to give him a hug which he appreciated. Most of the people we spoke to said the staff treated them with dignity and respect. We observed staff discreetly supporting people to use the toilet in a manner that helped them maintain their dignity and privacy.

There was a range of information displayed at the service. For example information about health services, social care and information about advocacy services. People had a guide to Jalna residential Home which included useful information about the services and facilities available to them during their stay.

Before this inspection we had received concerning information from a relative who had not been happy with how end of life wishes had been handled. We looked at care plans. These showed people had not discussed and document their wishes regarding end of life care. The senior representative of the company and the manager told us they cared for people who were at the end of their life and liaised closely with family members. They had many acknowledgements from relatives thanking them for the level of care they had provided during this time. We discussed the importance of making sure people and those who matter to them contribute to their plan of care so that staff know their wishes and make sure they have dignity, comfort and respect at the end of their life. This would support people and those who matter to them to have peace of mind knowing their wishes were made known to everyone. The manager and senior representative of the company told us this was being addressed.

# Is the service responsive?

## Our findings

We looked at assessment records for six people. We noted the assessment covered physical health, personal care, mobility, nutrition, mental health and daily routines and communication. People's mental health needs had not been further assessed as routine. We saw for example one person was under the care of the Older Persons Mental Health Team for anxiety. The care plan contained no instructions about how to manage this. Another person had a note in her medical history that they had experienced Schizophrenia. There was no mention of this in their care plan which stated 'No mental health issues'. By failing to address mental health issues this placed people at risk of not having these needs met and staff would not necessarily know if there was any deterioration in people's condition. We saw difficulties people with mental health problems experienced such as 'delusional at night' and 'muddles words and gets frustrated' recorded in daily notes. We discussed this with the senior representative of the company who told us they had removed mental health from the assessment. They said they did not think they were qualified to assess this, but agreed the level and type of assessment was not to form a diagnosis of mental health, but to deal with issues such as anxiety that impact on quality of life experience for people.

The provider failed to make sure assessments took into account of mental health issues that can result in poor outcomes for people if not addressed. This is a breach of regulation 12(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care plan included a one page profile which meant, information provided about people's needs was easily understood by staff. Where people needed support in making decisions, family wishes were considered and emergency contact details for next of kin or representative were recorded in care records as routine.

People were able to visit the home and meet with staff and other people who used the service before making any decision to move in. This allowed people to experience life in the home and consider if the services and facilities on offer met with their needs and expectations.

We looked at six care plans and also looked at continuing assessments of five other people living in the home. These placed people at the centre of their care and included basic

descriptions of the support required to meet people's individual needs. They were in part specific in instruction for staff to make them personal for individuals. The manager told us she was currently writing new care plans to make them personalised for people. The home had systems in place to ensure they could respond to people's changing needs. For example, staff told us there was a handover at the start and end of each shift. They discussed how people were and any concerns they had. Care plans and risk assessments we saw instructed staff to report any changes in people's needs although supporting information on health needs was not recorded. We asked relatives visiting if they were consulted about care plans. One relative told us, "Yes, they always talk to me about her care. I liaise with the rest of the family about her needs. They (staff) tell me how she has been and I'm always asked what I think."

We saw that risk assessments were being completed. These were not being maintained adequately to make sure people's changing needs were being addressed. For example we saw charts which recorded nutritional intake and fluids taken, dietary needs and preferences and weights. We noted on two files we looked at staff were unable to weigh people because they were in wheelchairs. There was no indication of any alternative method being used to monitor people's weight. This placed people at risk of not having any nutritional concerns highlighted promptly.

People had been registered with a local GP and routine healthcare appointments were recorded. Records showed staff supported people to attend healthcare appointments and they liaised with other health and social care professionals such as district nurse, dietician, and other health and social care professionals involved in people's care. This helped to make sure people received coordinated care based on specialist advice and that they had the support of staff to help them maintain their continuing health care. We saw that referrals had been made to the relevant health professionals for advice and support when people's needs had changed. A relative we spoke with told us, "The staff tell me when my mother in law has to go to the hospital and I take her". We observed staff members responded to people's and family questions in a friendly and well-mannered way.

People had completed an assessment indicating their preferences for activities. We saw that group activities

## Is the service responsive?

regularly took place such as bingo, cards, sing along and dance, manicure, massage, art and crafts, cookery lessons, walks in the garden and board games. During this inspection we saw two students currently on placement in the home giving people hand massages and a visiting entertainer provided music for sing along and dancing that people enjoyed. One person we spoke with told us, "I like doing activities but I like knitting and I am quite happy to knit all day." The senior representative of the company told us religious services was held in the home by a visiting clergy. They conducted their own services from time to time.

We looked at how staff supported people to maintain relationships with their friends and families. Visiting was

open and relatives we spoke with told us they were made to feel welcome. One relative told us, "I come often and I'm always greeted with a smile. They make me feel welcome and I always get offered a drink."

The service had a complaints procedure which was made available to people they supported and their family members. There were 4 complaints recorded between September 2014 and April 2015. All had been investigated and the outcomes recorded. People we spoke with told us they would either tell their family or speak to the manager. People who used the service and their relatives had opportunity to discuss their concerns during meetings, during day to day discussions with staff and management and also as part of the service satisfaction survey.

# Is the service well-led?

## Our findings

The manager had not been in post very long. We spoke with her on the day of our inspection and was told us they had submitted an application to register as registered manager for the home with the Care Quality Commission. Following our inspection we confirmed an application to register as manager was made on the 9 March 2015, this was. The senior manager representative of the company told us they were working closely with the manager to support her in her role. We noted the manager application was for manager of both Jalna residential care home and another home in the group, Danesmoor.

We asked the manager what arrangements were in place to cover days she was based in the other service. We were told a senior carer took responsibility for the management duties. We looked at the rota and found there was no senior delegated to take this responsibility and there was usually more than one senior on duty during the day. This meant that there was no consistent leadership within the home. On the second day of our visit a senior representative of the company had placed an asterisk against senior staff to show they were delegated to take leadership responsibility in the absence of the manager.

Relatives visiting told us they were very happy with the service. Comments included, "The home has a lovely homely atmosphere and I would recommend this home to anyone. The thing that stands out for me is the care quality." And, "The essentials are all there." "I think the home is outstanding."

People living in the home and their relatives were asked to complete customer satisfaction surveys to enable the home to monitor people's satisfaction with the service provided. We looked at nine completed customer satisfaction questionnaires dated March/April 2015. These had the person's name on the top and were completed by the staff in discussion with people. We also saw eight verbal interviews done in April 2015 between the owner and people using the service. These mentioned concerns about the temperature of the food and the temperature of the home but we did not see any action plan to follow up on this feedback. We saw four newcomer family questionnaires which had been done by relatives. They

were very positive, but one comment seen was, "Staff are very busy which can lead to delays in attention to residents requests." There was no indication to demonstrate how this had been addressed.

There were systems in place to regularly assess and monitor the quality of the service. However some of these there were not effective in recognising and identifying areas in need of improvement. These included for example failing to audit care plans and associated documentation. Checks and audits were being carried out on medication and the environment. A new assessment tool was being introduced to oversee infection control. Guidance was also available and displayed such as health and safety in the work place and fire regulations. All accidents and incidents were recorded but we did not see an analysis of these to identify any underlying problem or action required to minimise a recurrence. The systems in place to seek people's views and opinions about the running of the home were not entirely effective in raising standards people had identified as areas in need of improvement.

The service provider had failed to have in place systems to assess monitor and mitigate risks relating to the health, safety and welfare of people. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff indicated they were happy with the management arrangements. They told us, "We all work very well together. We know what we need to do when we start work. The senior delegates bathing and other duties like that." And, "The manager is lovely. We can always talk to her. She is very approachable." Staff told us the providers were very good with supporting them and were always in the home.

We looked at minutes of staff meetings. These were held every three months and were helpful to who. However there was no attendance list and no action plan included to view. Staff told us they could speak out at their meetings and they were confident their views were taken into account and the providers and manager listened to them.

Staff were aware of their roles and responsibilities in the home. For example senior staff administered medication and they delegated duties to care staff such as bathing people. We found there were processes in place to support the manager to account for actions, behaviours and the performance of staff. Some accountability for staff performance was evident with spot checks by the manager.

## Is the service well-led?

However formal supervision was seen to be a reactive response and was undertaken when concerns had been raised about staff conduct and failure to deliver acceptable standards of care.

We saw that records relating to people's care were available in the upstairs office. This led to problems of confidentiality as this office was frequently unmanned and the filing cabinet was left open. This practice did not support the confidentiality of people using the service.

**We recommend the service seek advice and guidance from a reputable source in maintaining records data in a confidential manner.**

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

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

People who use services were not protected against the risks associated with bedroom locks as master keys for staff had not been supplied.

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

People who use services were not protected against the risks associated with abuse because the service failed to act on and support people raise concerns.

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider has failed to make sure records used were complete, accurate and updated to minimise the likelihood that risks will occur and to minimise the impact of risks on people using the service.

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

People who use services, and others, were not protected against the risks associated with ineffective processes to assess, monitor and improve the service.

This section is primarily information for the provider

## Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider failed to make sure the risks to the health and safety of service users of receiving the care or treatment was assessed or planned for to lessen the impact of such risks that can result in poor outcomes for people if not addressed.

#### **The enforcement action we took:**

We sent the provider a warning notice and have asked them to achieve compliance by 27 July 2015