Jah-Jireh Charity Homes

Jah-Jireh Charity Homes Blackpool

Inspection report

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Ratings

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

Overall summary

This inspection took place on 17 December 2014 and was unannounced. This meant the staff and provider did not know we would be visiting. The service was last inspected in October 2013. They met the requirements of the regulations during that inspection.

Jah-Jireh is a detached building located in central Blackpool. The home is registered to accommodate up to 36 older people, people with sensory impairment or with physical disability and people living with dementia, who require assistance with personal care. Jah-Jireh cares for people who are Jehovah's Witnesses. All care staff are Jehovah's Witnesses. At the time of our visit there were 28 people who lived at the home. Accommodation was arranged around the ground and first floor. There was parking to the front of the building and a garden area to the rear. There was a passenger lift for ease of access and the home was wheelchair accessible.

Summary of findings

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was a mix of views regarding staffing levels but some acknowledgement that there were not always enough members of staff available for more dependent people. One person said, "There's always somebody if you want help." However another person stated, "We could do with more staff." We saw that there were not always enough members of staff on shift to support people. Staff were not deployed in an effective way.

At mealtimes more dependent people were not assisted with their meals as they needed. It was also evident from our observations people who had high care needs, were left sitting unattended, with little stimulation or attention for long periods of time. You can see what action we told the provider to take at the back of the full version of the report.

We looked at how medicines were prepared and administered. We saw medicines were not always given as prescribed or stored safely. Failing to give people their medicines properly places the health and welfare of people at unnecessary risk. 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 felt safe and well cared for. However this did not always reflect the practice we saw. The home was not designed or adapted to effectively support people living with dementia. We have made a recommendation about staff researching best practice in dementia care.

The right care and support was not always provided to people living with dementia. Staff had only basic awareness of dementia care. You can see what action we told the provider to take at the back of the full version of the report.

Staff did not always receive the training they needed to provide effective care to people, particularly where people were living with dementia. You can see what action we told the provider to take at the back of the full version of the report.

People told us that staff were very caring and kind. One person told us, "They've been very good, nothing is a bother." Another person said, "Absolutely wonderful, they're kind and they're always there." However this did not reflect our findings. Although staff were pleasant, they did not focus on the well-being of more dependent people or those who challenged the service. There were no management strategies in place to guide staff in supporting people with behaviour that challenged.

There were significant periods of time where people living with dementia, who were supported in an open plan lounge, were left unsupervised and unsupported. At other times although staff were present they did not interact with people living with dementia and they were left unstimulated and inactive. You can see what action we told the provider to take at the back of the full version of the report.

Although the home had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), the registered manager and management team did not have a working knowledge of them. The MCA was not implemented in any formal way in this home. You can see what action we told the provider to take at the back of the full version of the report.

Care planning was not person centred. Choices of when to receive personal care and support were limited by the staff routines. These were task centred rather than in response to people's individual needs and preferences. Social and leisure activities were limited, particularly for people living with dementia. We have made a recommendation that the service develops a person centred way of working, and provides suitable activities.

People told us that their views were sought on a regular basis. They and staff found the registered manager supportive and approachable. One person told us, "The manager is wonderful, very kind and listens to us." However we found the registered manager was not fully aware of their responsibilities as the registered person.

There were procedures in place to monitor the quality of the service. Audits were being completed by senior managers from the organisation and by the management team in the home. Yet the audit systems were not picking

Summary of findings

up the areas of concern identified during this inspection process. You can see what action we have told the provider to take at the back of the full version of the report.

Resident and relative surveys had recently highlighted some issues including around improving activities and dementia care. Action was planned but had not yet been taken when we inspected.

All the people and their relatives we spoke with confirmed that staff were kind and compassionate. It was evident that people who lived and those who worked in the home had a special bond sustained by their faith where “brothers and sisters” were recognised and valued. People were praising of the spiritual support they received from staff and the faith they shared. Communal prayers were said before meals and there were frequent bible study and worship times. This celebrated the shared spiritual beliefs of people.

People were complimentary about the meals and told us they enjoyed them. People were offered a choice of nutritious meals.

Staff recruitment was robust and reduced the risks of unsuitable staff working in the home.

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?

Inadequate

The service was not safe.

Although people told us they felt safe staff were not providing consistently safe and appropriate care to all people in the home.

Staffing levels were not always sufficient. Staff were not appropriately deployed to provide safe care for more dependent people. People who had high care needs, were left sitting unattended, with little stimulation or attention for long periods of time.

Medicines were not always given as prescribed or stored safely.

Is the service effective?

Inadequate

The service was not effective.

Procedures were not in place to enable staff to assess peoples' mental capacity, should there be concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk. Senior staff did not have a working knowledge of them.

People were offered a choice of nutritious meals. The people we spoke with told us they enjoyed their meals. However people who were more dependent did not have their nutritional needs effectively met.

Although providing care for people living with dementia, the home was not designed or adapted or staff trained to effectively support people.

Is the service caring?

Requires Improvement

The service was not always caring.

Although most staff attended to people's needs with compassion and calmness, we also saw one person spoken with in a brusque manner on several occasions.

People living with dementia were left in their armchairs all day, including mealtimes, except when they were taken to the toilet or for personal care. This meant unless they were able to attend the Bible meetings, they remained sitting in the same positions throughout the day.

It was evident that people who lived and those who worked in the home had a special bond sustained by their faith where most "brothers and sisters" were usually recognised and valued. People were praising of the spiritual support they received from staff and the faith they shared.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

Care was not personalised but task orientated with set times for bathing and limited social and leisure activities.

Care plans and risk assessments were completed soon after admission. However although the care plans were in place, some information around people's preferences was missing.

The home was very much part of the Jehovah's Witness community and all staff were also Jehovah's Witnesses. This supported people to practice their religious devotion and helped meet their spiritual needs.

Is the service well-led?

Inadequate

The service was not well led

The management team did not ensure that care was safe and person centred or that staff were deployed effectively. They did not have all the knowledge needed to manage the home well.

Although audits were carried out regularly, the audit systems were not highlighting the areas of concern identified during this inspection process.

Suitable arrangements were not in place to identify and analyse accidents and use the data to inform practice. This put people at risk of injuries.

Jah-Jireh Charity Homes Blackpool

Detailed findings

Background to this inspection

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

This inspection took place on 17 December 2014 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor who had experience of providing services for older people and people with dementia 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. The expert by experience for the inspection at Jah-Jireh Charity Homes Blackpool, had experience of services that supported older people and people with dementia.

Before our inspection we reviewed the information we held on the service. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who lived at the home. We also checked to see if any information concerning the care and welfare of people living at the home had been received.

We spoke to the commissioning department at the local authority and contacted Healthwatch Blackpool prior to our inspection. Healthwatch Blackpool is an independent consumer champion for health and social care. This helped us to gain a balanced overview of what people experienced whilst living at the home.

Before the inspection the registered manager completed a Provider Information Return (PIR). This 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 our inspection we spoke with a range of people about the service. They included the registered manager, members of staff on duty, twelve people who lived at the home, three relatives and health care professionals. We spent time observing the care and support being delivered throughout the communal areas of the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records of five people, the medicine records of 10 people, the previous four weeks of staff rota's, recruitment records for four staff, the training matrix for all staff, and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

People who lived at the home told us they felt safe at Jah-Jireh Charity Homes Blackpool. One person said, "Nobody can get in. There are always people around." Another person said, "We are always kept safe and looked after well here. I've never heard the carers shout."

Staff we spoke with said they would have no hesitation in reporting abuse. They were able to describe the action they would take if they became aware of abuse. They told us they would contact the registered manager or another member of the management team. They added that they would contact the local authority if a senior manager was not available.

We noted there had been three safeguarding alerts raised with the local authority in 2014. The registered manager had raised two of these alerts with the local authority. It is a requirement of the Care Quality Commission (Registration) Regulations 2009, that the provider must notify the Commission without delay of any serious injury to a service user or any abuse or allegation of abuse in relation to a service user. This is so that we can monitor services effectively and carry out our regulatory responsibilities. Our systems showed that the Commission had not been notified, by the service, about two of the three safeguarding alerts. This demonstrated that although the registered manager had the necessary knowledge and information to understand about safeguarding people, they did not always follow the correct procedure.

Staff did not always act on issues of safety. We saw the hot tap on one washbasin in a communal toilet was very hot with only a small handwritten sign to advise of this. When checked it was uncomfortably hot. This posed a risk to anyone who was not sensitive to temperature or was living with dementia.

We also noted that there were numerous incidents relating to people who had fallen. It was noted that people had fallen in their bedrooms. They had difficulties summoning help as call bells were not available on cords. We found evidence in records of people having to shout for help or summon help from other residents when people had fallen.

We looked at care records of a small number of people who we were informed had behaviours that challenged the service. There were no assessment and risk management plans in place and no management strategies to support people. We observed staff interactions as to whether these would improve the wellbeing of one person. There was little positive interaction in place and the person was often ignored or told to 'sit down'. Staff were unaware of management strategies in managing behaviour that challenged. They were not aware of how to reduce the likelihood of behaviour that challenged or of techniques to de-escalate specific behaviours.

This was a breach of regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

We looked at how Jah-Jireh was being staffed. We did this to make sure there were enough staff on duty to support people throughout the day and night. We looked at previous staff rotas as well as observing staffing on the inspection. We asked people if there were enough staff on duty. There was a mix of views but some acknowledgement that there were not always enough staff available for more dependent people. One person said, "There's always somebody if you want help." Another person felt that there had been difficulties but added, "They've got a few more staff in and it's adequate now." We were told by another person, "Staffing is OK because I don't need looking after." However another person stated, "We could do with more staff."

When we arrived at the home on the day of inspection, we were told the registered manager was not there. The member of staff did not know who was in charge or when the registered manager was in. We asked to see the staff rota but the information was not recorded so it was not clear who had responsibility at that time for people's safety and the running of the home.

We spoke with staff members about staffing levels at the home and asked if there was enough staff on duty. One staff member told us, "Yes, got a lot better. There is an extra carer in the morning." Another member of staff told us, "At the moment we do not use any hoists, so it's okay, but at other times it can be busy and two staff can be tied up using a hoist." They said that this impacted on them and the care they provided. We spoke with the registered manager about the staffing levels. They told us they reviewed staffing levels to make sure they met people's needs and dependency levels. They felt that the staffing levels were enough to support people well.

Inadequate

Is the service safe?

We spent time in all areas of the home, including the lounge and dining areas. This helped us observe the daily routines and gain an insight into how people's care and support was managed. We saw staff members being responsive to the needs of the people they supported however this was not always consistent. Staff deployment was not effectively organised to ensure there was a staff presence as oversight of people in the lounge areas. We observed there were long periods of time when people were left unattended, with little stimulation or attention.

Some people managed their own medicines, but we were unable to speak to anyone who did so on this inspection. People who had medicines administered by the care staff all said they received it on time. However we saw that medicines were not always managed appropriately. We saw that on one occasion, one person's prescribed controlled medication had gone missing. A controlled medication is a prescription medicine that is subject to strict legal controls. Although the management team contacted CQC for advice, they had not followed the correct procedures in reporting the incident to the local authority safeguarding team and the Police.

Staff told us that they worked to The National Institute for Health and Care Excellence (NICE) guidelines for managing medicines in care homes. NICE guidelines provide recommendations for good practice on the systems and processes for managing medicines in care homes.

Staff gave one person who lived at the home covert medication. The registered manager told us they had received direction for use of covert medication from the GP surgery in the best interests of the person. However the use of covert medication requires that the person proposing to give the medication must have assessed the person's capacity in line with the requirements of the Mental Capacity Act. A best interests assessment must be undertaken and there must be written evidence of the decision making process. The home had not followed these measures.

Staff told us that there were plans to develop protocols for when necessary (PRN) medicines, but these were not yet in place. This meant that it was not clear under what circumstances people needed to take when necessary medicines. Where there was a choice of one or two tablets to be given. It was not clear how many people had been given.

We saw that the temperature of the medicines fridge was not regularly checked and recorded. This could affect any medicines stored in there. Failing to give people their medicines properly placed the health and welfare of people at unnecessary risk.

This was a breach of regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We looked at the recruitment and selection of three members of staff. People were protected from unsuitable people working in the home because safe recruitment procedures were followed. Application forms were completed and any gaps and discrepancies in employment histories had been followed up. This meant the management team knew what work the prospective member of staff had previously been doing. References had been received before staff were allowed to work in the home.

The staff files we looked at showed us that a Disclosure and Barring Service (DBS) Checks had been received before new staff were allowed to work in the home. These checks were introduced to stop people who have been barred from working with vulnerable adults being able to work in such positions.

Staff told us they were well supported and worked well as a team. There was a low turnover of staff within the home and staff were familiar with the needs of individuals. This meant staff knew some of the support needed to care for people and were able to meet some of their needs. The shared religious belief and ethos of staff and people who lived at Jah-Jireh assisted in the community feel of the home. Agency staff were not used. There were several live in staff on call to provide additional cover when needed. This meant all staff were familiar with people's needs.

There were no unpleasant odours in any areas when we inspected the home. We saw that the home had a clean and fresh smell throughout. Staff wore personal protective clothing when involved in personal care and at mealtimes, which assisted with reducing cross infection.

Inadequate

Is the service effective?

Our findings

We spoke with people about the food provided and observed the lunch and evening meals and preparation for these. People were complimentary about the meals and told us they enjoyed them. One person said, “We have two choices, the food is very good, we have some good cooks here. The choice and quality is good.” Another person told us, “There’s more than enough to eat. It’s always served at the right temperature, but if it was cold, I would ask them to re-heat it.”

The dining tables and over chair trays were set up an hour and a half before the meal was provided. This made it difficult for people living with dementia to know when the meal was due. We observed people coming to the table once the tables were set. In one case we saw one person sat with a fork and knife in their hands for a long period of time

There was a tray of tea for people on each table. However those wanting water with their meal drank out of thin, plastic, disposable cups. These were very flimsy and several people, particularly people with dementia, had difficulty with these and spilt from them.

The experience of people in the dining room was positive and people were relaxed. This was not the case in the lounge where people living with dementia were eating. Staff interactions varied. Some staff interacted and chatted with people as they carried out mealtime preparation and assisted people. Other staff had only minimal interactions and on occasions ignored people speaking with them.

For those people needing assistance with meals, staff were rushing to assist people to eat, going from one person to the next, in an undignified manner. Two staff showed impatience when people were taking a while with their lunch. A member of staff stood over a person to give them their meal, rushing them, rather than sitting with the person and supporting them through their meal.

Staff served a variety of fresh fruit for dessert. However people living with dementia were not always given a choice of fruit. Staff spoken with told us they were familiar with people’s food preferences and in relation to those unable to express a choice, their care files were consulted for preferences. We looked at the care records of two people who were unable to express a choice and noted this was not the case; there was no information of food preferences recorded.

This was a breach of regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

Communal prayers were said before the meal. This celebrated the shared spiritual beliefs of people. People were offered a choice of meals. There was a varied four week menu with a minimum of two options at each meal. The menu was completely changed twice a year. However one person told us special diets such as vegetarian were limited. They told us, “There’s a good choice. I’m a vegetarian. They cook me veg, but they don’t make anything special."

Jah-Jireh is registered with the Care Quality Commission (CQC) for supporting older people whose predominant needs are those relating to general ageing and to dementia. From discussions, most people needed some help with personal care. When we inspected they were supporting ten or more people with moderate to severe limitations as a result of dementia. However the home was not designed or adapted to effectively support people living with dementia.

The environment did not take into account the needs of people with dementia with decoration, signage and adaptations so it was difficult for people to orientate themselves around the home. There were no measures to improve well-being and independence for people with dementia, such as appropriate signage around the home, dementia friendly furnishings and fittings or contrasting coloured equipment, crockery. The doors around the home had little to distinguish one from another. We observed one person struggling to orientate themselves around the home.

Staff had only received basic dementia awareness training which did not fully meet the needs of the people living with dementia. When we discussed dementia care with staff, we could not identify any recognition that people living with dementia required specialist care. Management and staff were not equipped when we inspected to provide for the complex needs of people with dementia.

Inadequate

Is the service effective?

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivations of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

Although the home had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), the registered manager and management team did not have a working knowledge of them. Indeed although the registered manager said she had information on MCA and DoLS she could not access this information when asked. She later showed us that she had training in 2009 but no updates since. There was no evidence that members of staff had received this training.

The MCA was not implemented in any formal way in this home. There were no records of any MCA assessments or best interests' decisions having been undertaken. This meant the management team did not make appropriate arrangements where there were concerns about a person's ability to make decisions for themselves, or to support those who lacked capacity to manage risk.

The MCA provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. In situations where the act should be, and is not, implemented then people are denied rights to which they are legally entitled.

The registered manager told us there were not any residents that were subject to DoLS. A member of the management team told us, there was no need for it because "There is no one who is banging on the door to get out." This showed they had little understanding of DoLS.

During the inspection we saw evidence that one person wanted to leave the home and was not able to. The person told us, "I don't want to be here, I want to go home and they won't let me go".

The registered manager said they had been told they did not need a DoLS and had not looked into this further. We saw from the care records that although it stated on documents from a local authority that the person did not have capacity, there was no MCA assessment. Jah-Jireh records showed a reference to a DoLS being considered, because the person was not "settling", but this was not followed up in any documentation.

The management team had no knowledge of up to date case law. There were a number of people in Jah-Jireh when we inspected, where this may have been relevant because of their lack of capacity.

This was a breach of regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

We saw people's care plans usually contained clear information and guidance for staff on how best to monitor people's health. People told us staff organised for the GP to visit if they were unwell. Appropriate referrals were made where people needed GP advice and treatment.

We spoke with the staff who told us that they had frequent training. We saw records showing that staff in the organisation had access to an induction programme, and mandatory training. This included health and safety, moving and handling, food hygiene, safeguarding and for senior care staff, medication administration.

However training records were limited and only provided general information about the numbers of staff within the organisation who had received training. It did not provide information about the training individual staff had received or when this had been undertaken. This meant it was difficult for the registered manager to ensure staff had received relevant training and updated this as needed. However it was evident that recent MCA and DoLS training had not been provided and dementia training was at a basic level. This meant staff did not always have the necessary skills to carry out their roles.

This was a breach of regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We saw that staff received formal supervision. This is where individual staff and those concerned with their performance, typically line managers, discuss their performance and development and the support they need

Inadequate

Is the service effective?

in their role. It is used to assess recent performance and focus on future development, opportunities and any resources needed. Staff told us they felt well supported through these and the regular staff meeting.

We recommend that the service finds out more information, based on current best practice, in relation to the specialist needs of people living with dementia.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were very caring and kind. One person told us, "They've been very good, nothing is a bother." Another person said, "Absolutely wonderful, they're kind and they're always there."

We asked people if they liked living in the home, one person replied: "I love it; the only way you could get me out is in a box." Another person stated, "Yes, because I couldn't manage on my own." "However one person was less satisfied and said, "I don't like living here, they've all got their funny ways. For certain people it's wonderful, but I don't want to be here, it's stunted me."

We asked about privacy and security of possessions. People told us they had keys to their rooms and could use them, and access their bedrooms freely. This allowed them privacy as they wanted. If people didn't want to be disturbed they locked their door so the engaged sign was displayed. One person replied: "There's a lock on my door I know my things are safe. No-one just walks in. The communal lounges were small and comfortable and there were enough of them so that people could entertain their visitors privately if they wish.

People felt they had trusting relationships with staff and that they respected their privacy and dignity. They said they could speak to staff in confidence and this would not be discussed with anyone who should not have the information. People told us they felt the staff were kind and caring, they told us: "They're very good. They are very kind and trustworthy. I'm a bit careless with money but they will tell me if I've dropped any under the bed."

We saw that staff treated people with affection and kindness, and most attended to their needs with compassion and calmness. However staff did not always treat people as individuals. We saw most staff were task focused and were busy doing 'jobs' rather than interacting with people.

Staff did not focus on the well-being of more dependent people or those who challenged the service. There were significant periods of time where people living with dementia, who were supported in an open plan lounge, were left unsupervised and unsupported. At other times although staff were present they did not interact with people living with dementia and they were left unstimulated and inactive.

People living with dementia who were unable to move around independently, were left in their armchairs all day, including mealtimes, except when they were taken to the toilet or for personal care. One of the management team told us, "They don't not go into the dining room for meals as it is too difficult to move them all to the dining room". This meant unless they were able to attend the Bible meetings, they remained sitting in the same positions throughout the day, except for being taken to the toilet or for personal care. This was for staff convenience not for reasons of care.

We spent time observing care in all communal areas of the home. This helped us to observe the daily routines and gain an insight into how people's care and support was managed. Although the inspection found some good care we also found areas of concern. At a mealtime, one member of staff sat with a person living with dementia, who was not eating saying "Come on good girl," And "Umm it's yummy." The staff member then said to another member of staff "They are just like children. Once they get a taste they are fine". This showed the staff member did not treat the person as an adult and with the respect and dignity they deserved. We rarely saw any staff interacting with this person in a meaningful way.

One person frequently walked around the home and tried to engage people in conversation. We saw a member of the management team tell the person to go and sit down in a brusque manner on several occasions. When discussing this person it was clear that senior staff saw them as challenging and disruptive to the running of the home. We saw few people interacting with them or looking for person centred ways to meet their needs.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

We also saw some good practice. We observed a member of staff treating one person in a dignified and respectful way. The person was walking slowly with support. The member of staff was very patient and encouraging, allowing the person to move in their own time. In this way the person was encouraged to remain as independent as possible.

Requires Improvement

Is the service caring?

All the people and their relatives we spoke with confirmed that staff were kind and compassionate. It was evident that people who lived and those who worked in the home had a special bond sustained by their faith where most “brothers and sisters” were usually recognised and valued. People were praising of the spiritual support they received from staff and the faith they shared.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt they had personalised care, but then told us they didn't have a choice of when they had a bath or shower because there was a bathing rota. All bathing was carried out by a bathing team who bathed people on a rota at a set time each day. One person said, "There are only certain ones who can shower me - the bathing team." One member of staff said, "It [the system] is marvellous as nobody gets missed." They did not see that this system reduced choice for people.

The management team said that said that people had a gender choice for bathing and personal care and that was respected and recorded. They added that only one person objected to a care staff of the opposite sex carrying out personal care. One person said they had a choice of male or female carer, but other people said; "It's always a women who showers me." And "Sometimes its girls, but I've got used to it." One person told us, "Nobody asked me if I preferred a male or female carer but I would object to a man."

From this information we saw that some people were not aware that they could have a gender choice of care staff for personal care. Neither was the choice recorded in the files we looked at. We also saw in one person's file that they found it traumatic having staff attend to their personal care needs and did not like men attending to them. However on some occasions male staff had been present when staff were attending to the person's personal care. This led to a conflict situation and the individuals behaviours were seen as challenging.

A member of staff told us "Breakfast is any time after 8 a.m. The night staff get people up and start serving breakfast." Nobody we spoke with could say if they had a choice about what time they got up.

Meals were at defined times, as were drink and snack times. We asked people if the meals could be served later if requested. One person said; "They have set times, I wouldn't ask for my lunch later."

We saw some examples of personal preferences being responded to when we looked around the home, particularly where people were able to speak for themselves. We saw people had equipment to assist them to remain independent and comfortable. The management team told us that each person had a telephone so that they could stay in touch with their relatives. We saw that a skylight in one room had been blocked off because the resident did not like the light coming in. We saw people had made their bedrooms their own with personal possessions and equipment. One person told us "I am very comfortable and content. They said I would only stay here for two weeks!" Another person said, "I am very satisfied here, very happy."

We asked people about the choice of social and leisure activities. The main focus of activities was spiritual and religious in nature with prayer and bible meetings and services. We were invited in to a meeting where we were made welcome. The meetings were well received by people who lived at Jah-Jireh. They were pleased to be in a home responsive to their spiritual needs and beliefs and to be cared for by people of the same religious faith.

There were two religious meetings in the home each week. Also there was a direct link from the Kingdom Hall to the home. This allowed people to follow the services on the televisions in the home, so that those services can be relayed to them even if they were not able to attend in person. The management team also assisted people who wished to attend the local Kingdom Hall to the service. People from the congregation frequently visited so people continued to be part of the 'community'. This focus enabled people to practice their religious devotion and helped meet their spiritual needs.

There was a limited programme of in house social and leisure activities in place with few activities aimed at people living with dementia. The registered manager told us that volunteers assist with activities in the home. We asked people how they spent their day, one person said, "Reading, they give you religious meetings, "I listen to TV and I get monthly study discs from Brother XXXX". Another person told us, "I can't do very much, I go to a talk. Sometimes they do exercises." Other people told us they talk, read or are able to go for a short walk. People told us they try to help others. One person told us, "I put paper napkins on the tables and help others if they need it."

The registered manager told us a volunteer visited the home twice weekly to facilitate activities for those with dementia. Another member of staff said that they, "Throw a ball around for exercise". However we did not see any social or leisure taking place in the lounge where people living with dementia sat. People seemed to spend the day just sitting\sleeping in chairs, sitting in a semi-circle. There

Requires Improvement

Is the service responsive?

seemed to be few social organised activities available, particularly for people living with dementia. Where people were unable to occupy themselves unsupported, this made for a long and unstimulating day. The lack of meaningful social contact and companionship also increased social isolation and loneliness.

The registered manager told us social and leisure activities in the local community could be made available to people. However these were charged for separately. The registered manager said that they were unable to release staff for day trips so they had to pay the cost of an escort as well as the costs for the leisure activity and for taxis. One person told us, "I would like to go out but I've never been asked if I want to go out." Another person said, "I couldn't go far without support."

We spoke with the registered manager about how they developed care plans when people were admitted to the home. Senior staff told us care plans and risk assessments were completed soon after admission. However risk assessments were not always dated or signed. We saw on the care records we looked at that these were completed and assisted staff with information so they could provide the right care and support for people. People told us that they were given the opportunity to discuss their care but this was not recorded on their care records,

We looked at five peoples care records and other associated documentation. We saw evidence that people who lived at the home, and/or their family members had been involved with providing this information. The care records were laid out in such a way that it was easy to locate information. However although the care plans were in place, some information around people's preferences was missing. Three of the files did not have information completed on the person's likes and dislikes; and two had no life history completed. There were no management strategies in place to guide staff in supporting people with behaviour that challenged. The daily records were not informative and mostly consisted of a one line entry. This meant staff did not have the knowledge they needed to provide person centred care for people.

Person centred care aims to see the person as an individual. Instead of treating the person as a collection of illnesses and behaviours, person-centred care considers the whole person, taking into account each individual's unique qualities, abilities, interests, preferences and needs. Person-centred care also means treating residents with dignity and respect. It makes the rules and procedures fit the individual rather than the individual fitting the rules and procedures.

We asked people if any complaints were dealt with quickly and appropriately. People told us they had no complaints about the home and were happy there. They told us they were aware of how to make a complaint and knew these would be listened to and acted upon. The home had a complaints procedure which was made available to people they supported and their relatives.

Concerns and complaints were taken seriously, explored thoroughly and responded to in good time. We saw there hadn't been any recent complaints. The registered manager told us the staff team spoke regularly with people and their relatives. She said any ideas, or minor issues were dealt with before they became a concern or complaint.

We recommend that the service develops a person centred, flexible way of working, and provides suitable person-centred activities within the service or in the community.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider. The registered manager had been in place for several years and people who lived in the home and staff said they found her supportive and approachable. One person told us, "I haven't thought about it, but if I had problems, I would go to the manager or staff." Another person said, "The manager is wonderful, very kind and listens to us." Staff felt the registered manager was very supportive and kind. However we did not find the home well led.

The registered manager did not show all the necessary skills and knowledge to manage effectively. They were not fully aware of their responsibilities as the registered person. They did not ensure that care was safe, that staff were deployed effectively or that care was person centred. They did not have appropriate knowledge in relation to the law on Mental Capacity Act and DoLS. Although the registered manager had notified CQC of some issues that affected the running of the service as they were required to do, they had not notified CQC of others. These included serious injuries, pressure sores and DoLS. This meant the information we received was inconsistent and did not provide us with a full picture of events in the home.

The registered manager had not responded in a safe and effective way to when managing medicines issues or improve practice where care was poor. There were several breaches of regulations.

The registered manager told us they had completed dementia mapping observations in the past but "…not this year." Even though the registered manager had knowledge of dementia care and dementia mapping, they were not following current good practice for people living with dementia and did not have information from organisations that could provide guidance in these areas.

The registered manager had information on staff training but this related to percentages of staff who had received training rather than training individual staff had received. This meant that the manager could not easily access which staff had and hadn't received particular training.

The management team had not developed the staff team to make sure they displayed the right values and behaviours towards people. Although most staff displayed caring and appropriate behaviours, we saw some staff, even one of the management team, referring to and acting towards some people in a way which didn't respect people's dignity.

There were some systems in place to assist the management team and staff to learn from events such as complaints, concerns, whistleblowing and investigations and there were some audits carried out. These included monitoring the homes environment, care plan records, financial records, medication procedures and maintenance of the building. Senior managers audited the home at least monthly and followed up on any issues found in order to improve the service. The home also had some systems in place. Yet the audit systems were not picking up the areas of concern identified during this inspection process.

Accidents and critical incident reports had not been audited to highlight the number of falls people had had. This meant suitable arrangements were not in place to identify and analyse accidents and use the data to inform practice. For example the number of falls people had in their bedrooms. This left people at risk of injury.

These were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

The registered manager told us the views of people who lived at the home were sought by a variety of methods. This was confirmed by talking with staff, relatives and people who lived at the home. There was a range of ways for people to feed back their experience of the care they received. This included surveys about the person's experience of living in the home and residents meetings. Comments from the surveys included, "I am very happy with Jah-Jireh, home sweet home. and "I am grateful to be in the home and cared for. I thank the staff." People told us that these occurred 'quite often'. These gave people the opportunity to voice their opinions. We saw the improvement plan for 2015 which said it would be concentrating on issues raised by people who lived in the home. These included developing activities, improving dementia care and laundry but did not give detail of how this would be carried out.

Inadequate

Is the service well-led?

The registered manager said senior managers analysed any suggestions or negative comments and acted upon them. Staff meetings were also held to involve and consult staff. Staff told us they had meetings every six to eight weeks and they were able to give their opinions on any issues.

We had responses from external agencies including the social services contracts and commissioning team about the home. The contracts team told us they had no current concerns about the home. Other professionals told us that they found the registered manager and staff team very approachable and keen to make relevant changes. However professionals also told us about one incident where the home had been late asking for guidance and involving them in the care. This information in addition to discussions in the home helped us to gain a balanced overview of what people experienced living at Jah-Jireh.

We also contacted Healthwatch Blackpool. We were told that they had been refused entry to the home. Healthwatch have the statutory power to enter and view health and social care services. The registered manager said they did not know who Healthwatch were so cancelled a visit. However they did not check with Healthwatch what their role was or seek information about them.

There were procedures in place to monitor the quality of the service. Regular audits were being completed by the registered manager and by senior managers from the organisation. They had recently highlighted some issues including around improving activities and dementia care. However no action had been taken when we inspected.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person had not taken proper steps to ensure that each person was protected against the risks of receiving unsafe or inappropriate care as they had not taken action to ensure the welfare and safety of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person had not taken proper steps to effectively assess and monitor the quality of the services provided.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected against the risks associated with medicines because the registered person did not have appropriate arrangements in place to manage medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person had not taken proper steps to ensure that each person received appropriate support to eat and drink sufficient amounts of food for their needs.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users, particularly in relation to the Mental Capacity Act 2005 and particularly deprivation of liberty safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Staff were not provided with appropriate training to assist them to support people effectively.