Care Quality Commission

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Ismeer

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 28 and 29 October 2014. A breach of legal requirements was found. This was because recruitment procedures which were designed to keep people safe were not consistently followed. For example, some staff members had been employed without providing references from their previous employer.

After the comprehensive inspection the acting manager wrote to us to say what they would do to meet the legal requirements in relation to the breach. We undertook this focused inspection on 1 April 2015 to check they had followed their plan and to confirm they now met legal requirements.

Following the comprehensive inspection of 28 and 29 October 2014 the provider received information about concerns in relation to the service. As a result we also looked into these concerns during our focused inspection. The concerns were about how information about people's needs in relation to medicines was recorded, whether people's consent to care and treatment was sought out and recorded appropriately, particularly in respect of end of life care and whether people were supported to have sufficient amounts to eat and drink.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ismeer on our website at www.cqc.org.uk.

Ismeer is a care home for up to 27 people who require accommodation and personal care. At the time of the

Summary of findings

focused inspection there were 18 people living at Ismeer. All of the people who lived at the home were older people. The majority of people were living with dementia. Some people had physical or sensory disabilities.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had advertised the position and interviews were being organised to fill the vacancy. Ismeer was being managed by an acting manager at the time of the focused inspection.

At our focused inspection we found the acting manager had made improvements to systems in place to help ensure recruitment processes were robust and protected people from the risks associated with being cared for by unsuitable staff.

People received their medicines when they needed them. There were arrangements in place to help ensure all staff and external professionals were aware of people's needs in respect of medicines.

People and their families were supported to make decisions about their end of life care. The acting manager acted in accordance with the legislation when assessing whether people had mental capacity to make such decisions. Staff had clear guidance on action to take when people's health deteriorated.

People's dietary requirements were considered and assessed. Where necessary people's food and fluid intake was monitored. One person had been assessed as needing to have their weight monitored weekly. However records showed this was not happening. The acting manager assured us they would address this straight away.

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?

Requires Improvement

We found that action had been taken to improve the safety of the service. Recruitment procedures had been improved to minimise the risks associated with people being supported by unsuitable staff. This meant the provider was now meeting the legal requirements.

There were systems in place to help ensure care staff and other professionals were aware of people's needs in respect of medicines.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for safe at the next comprehensive inspection.

Is the service effective?

Requires Improvement

We found that action had been taken to improve the efficiency of the service following concerns raised. People's wishes regarding end of life care were sought and respected.

The acting manager displayed an understanding of the requirements of the Mental Capacity Act 2005. Plans were in place to further their knowledge and share it among the staff team.

People's dietary needs were monitored and recorded. However people's weight was not consistently monitored when they had been identified as being at risk.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for safe at the next comprehensive inspection.

Ismeer

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. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Ismeer on 1 April 2015. This inspection was completed to check that improvements to meet legal requirements after our comprehensive inspection on 28 and 29 October 2014 had been made. We were also checking to see if areas of concern which had been raised with the provider had been addressed satisfactorily. We inspected the service against two of the five questions we ask about services: is the service safe; is the service effective? This is because the previous breach and concerns raised were in relation to these two questions.

The inspection was carried out by one inspector. Before our inspection we reviewed the information we held about the home, this included the action plan which had been provided by the acting manager which set out the action they would take to meet the legal requirements. During the inspection we spoke with the acting manager, a district nurse and three people who lived at Ismeer. We observed care and support provided to people in a lounge area.

We looked at four people's care plans, food and fluid records, records pertaining to planned training sessions and three staff files.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection on 28 and 29 October 2014of Ismeer we found recruitment procedures which were designed to keep people safe were not operated effectively. For example, some staff members had been employed without providing references from their previous employer. This meant the provider had not obtained satisfactory evidence of conduct in previous employment.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection 1 April 2015 we found that the acting manager had taken action to address these shortfalls. We looked at staff files including those of two new employees. The acting manager had introduced a new system for recording the recruitment process. Files contained references from the employee's last employer as well as one other. In addition they contained copies of job applications, job offers and terms of employment. The acting manager had applied for Disclosure and Barring checks to be carried out for the new employees although these had not yet been returned. The acting manager assured us these members of staff would not be working on their own until the DBS checks had been completed.

Following the comprehensive inspection we received information of concern in relation to the recording and management of people's medicines. During the focused inspection we looked at medicines administration records (MAR). People's medicines were given to them as prescribed and recorded appropriately. Where people refused medicines this was also recorded and action taken according to the person's care plan. For example, one person had declined their morning medicine. This had been put away in the secure medicine trolley and care staff would offer again during the morning. If the person continued to refuse it would be disposed of. Care plans documented what action staff should take in the event people refused medicine over a period of time.

Care plans contained information about what medicines people received. We had received concerning information that one person had been prescribed medicine which they should not have been taking due to their health needs. The acting manager had redesigned admission sheets and care plans and there was a space for information in relation to allergies and other relevant factors when prescribing or administrating medicines on the front page of people's care plans. This meant people were protected from the risks associated with taking medicines which were not suitable for the individual.

Requires Improvement

Is the service effective?

Our findings

Following our comprehensive inspection on 28 and 29 October 2014 we had received concerning information in relation to care staffs' understanding of the service's policy for resuscitating people in an emergency. At this focused inspection we looked at the guidance and support in place for staff in these circumstances.

There were clearly displayed procedures for staff to follow in the event of an expected or unexpected death. Staff meetings had been held to discuss what action staff needed to take in these circumstances and all staff had undertaken CPR (Cardiopulmonary resuscitation) training. First aid training was also due to be given to all staff by the end of the month.

Some people had Allow Natural Death Orders (ANDOs) in place. These had been signed by the GP and the person to indicate they agreed with the decision. Where people had been assessed as not having capacity to make the decision relatives and/or power of attorneys had been involved. The ANDOs were clearly displayed in the front of people's care documentation and accessible to staff. Newly developed pre-admission forms included a requirement to discuss with people and/or their families what their wishes were in relation to end of life care. This meant the service was able to start to identify people's wishes prior to them going to live at Ismeer.

The acting manager had discussed the implications of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS) with a best interest assessor from the local authorities DOLS team during a formal telephone conference. The MCA provides a legal framework for acting, and making decisions, on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The legislation states it should be assumed that an adult has full capacity to make a decision for themselves unless it can be shown that they have an impairment that affects their decision making. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The assessor was satisfied the acting manager had an understanding of the legislation and we saw communication to confirm this. DoLS applications had been made for eight people and urgent authorisations had been put in place while awaiting the outcome. The acting manager and a senior care worker were booked to undertake training in the MCA and DoLS. There were plans in place to then train the whole staff team.

Following our comprehensive inspection on 28 and 29 October 2014 we received concerning information in relation to how people were supported to have sufficient amounts to eat and drink. At this focused inspection we checked to see how staff could be sure people were eating a balanced diet and what action was taken if people were identified at risk from not eating well. Staff recorded what people had eaten and drank throughout the day. People told us the food was "good" and they had enough to eat. There was fresh fruit available in the lounge area and people were offered drinks regularly. One person's care plan stated; "Likes to have a couple of cups of tea during the night when they are being checked."

During a handover between the acting manager and a member of staff who had been off work for a short time we heard the acting manager update the member of staff in a number of areas regarding people's health including their diet. For example we heard them say about one person; "They are eating and drinking well. They might just need a bit of encouragement." Information was kept in the kitchen which recorded people's individual requirements, for example those people who needed a pureed diet.

Care plans contained information regarding people's preferences in respect of food and detail about the support people might need to eat and any special equipment that was required. Everyone was weighed on a monthly basis with their consent. Risk assessments were in place to identify anyone who might be at risk from poor nutrition. These took account of the amount of support people needed when eating, their general appetite and any specific dietary needs. Where people were identified as being at high risk their weight was monitored more regularly. However, one person had been identified as being at risk and therefore needed to be weighed on a weekly basis. This was not being carried out. In addition they had refused to be weighed the previous two months which meant their weight was not being monitored effectively. There was no indication that people were asked if they would agree to be weighed at different times if they refused on the first request. We discussed this with the acting manager who assured us they would address the problem straight away.