Birmingham Jewish Community Care

Andrew Cohen House

Inspection report

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Birmingham
West Midlands
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 7 and 8 April 2016 and was unannounced. At the time of our visit 48 people were living at the home.

There was no registered manager at the service. 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. A manager had been appointed and was managing the home, but they were in the process of becoming formally registered as the manager of the home.

Staff knew how to recognise potential signs of abuse and how to raise concerns should they need to. Risks to people had been assessed and measures had been put in place to reduce the risk to each person. Staff had received training to enable them to provide safe care to meet the needs of the people they were supporting. Staff did not have adequate support or supervision to make sure that people's needs were consistently well met or that the support people received was respectful and dignified. You can what action we told the provider to take at the back of the full version of the report.

Changes in people's needs were identified and their care packages were amended when necessary to meet these needs. The information contained in the care records was individualised and clearly identified people's needs and preferences. However staff did not consistently make sure that people's needs were well met in the way that had been agreed. Risks people might experience with their care and environment had been identified and recorded in their care plans.

We saw that medicines were managed safely. Staff had access to information about the specific support people needed with their medicines and new systems were being introduced to monitor medication administration practice.

We saw that safe recruitment and induction processes were in place to ensure there were enough suitable staff employed to support the people who used the service.

The manager was knowledgeable of, and acted in line with, the requirements of the Mental Capacity Act (2005). Staff did not always seek peoples consent before supporting them.

There was a complaints procedure in place that was known about and used by people who used the service and their relatives. Where concerns were raised we saw that the manager had acted promptly and taken action.

People had a range of activities that they could choose to engage in every day. Staff had begun to use aids and equipment designed to enrich the lives of people living with dementia. Management had plans in place

to expand on this work and offer a service that would improve the quality of people's lives. There were systems in place for monitoring the quality and safety of the service, but these were not always effective. You can what action we told the provider to take at the back of the full version of the report.

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

The service was not always safe.

Staff knew how to recognise and respond to abuse correctly.

We saw that risks were appropriately assessed and but not well managed.

Staff were recruited appropriately and there were sufficient staff on duty to care for people.

People received their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had been provided with training, but had not received support to enable them to meet people's needs.

Staff displayed variable knowledge of the people they supported.

People had been supported to eat and drink enough to maintain their health and wellbeing.

The manager understood their responsibilities in relation to the Mental Capacity Act. Staff did not always give people the opportunity to consent to their care.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw that staff did not always support people in a kind or caring way.

People did not always receive care that was dignified or respectful.

The manager and some care staff knew people well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Peoples care plans were individualised but they were not always adhered to.

People were supported to take part in a range of activities that enabled them to maintain interests and hobbies.

People were supported to express any concerns and when necessary, the provider took appropriate action.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance systems in place were not effective in identifying and managing risks to quality of the service.

Staff did not receive adequate support or guidance.

The provider had identified and was making some improvements and the manager had applied to become registered manager with CQC.

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Detailed findings

Background to this inspection

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

The inspection took place on 7 and 8 April 2016. The inspection team consisted of two 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.

We looked at the information we held about the provider and this service, such as incidents, deaths or injuries to people receiving care, including any safeguarding matters. We refer to these as notifications and the registered provider is required to notify the Care Quality Commission about these events.

We asked the local authority if they had any information to share with us about the service. The local authority was responsible for monitoring the quality and funding for some people who used the service.

We spoke with five people who used the service and seven members of staff. We spoke with the manager and the provider, and three relatives of people living in the home. We looked at the records of six people and two staff records. We also sampled records about complaints and accidents, training and supervision. We used the Short Observational Framework for Inspection (SOFI), SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Following the inspection we spoke with four health and social care professionals.

After the inspection the provider sent us further information that we had requested. The information enabled us to telephone and speak with health professionals involved in peoples' care.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe in their own home. One person said, "I am very happy living here." A relative said, "I couldn't rate the place higher, it's like a home from home, mom's safe." Staff we spoke with told us they considered the service to be safe and that they would be happy for a relative of theirs to live at the home. One member of staff said, "The clients are safe here."

We spoke with staff about their understanding of protecting people from abuse. They told us they had undertaken safeguarding training. They understood what to do if they witnessed bad practice or other incidents that they felt should be reported to external agencies. Staff were aware of the whistle blowing policy and knew where they could find the phone number to call. Records confirmed staff had received training in this subject. We found that the manager responded to all safeguarding concerns appropriately. This made sure that people were protected from bullying and abuse.

Risk assessments were available but not always followed by staff. The manager had made sure that people had up to date risk assessments that were specific to them. Records we sampled told staff how to support people while keeping them safe from avoidable harm. We saw that all risk assessments were individualised. We found that one person had very clear instructions in their risk assessment as to the type and timing of their specific medication. We looked at the persons care records and spoke with their relative and found that these instructions were not being followed by staff. We found other examples of staff not following the instructions as specified on the care records. One staff member spoke with us about the need to support a person to move who spent long periods of time in bed, they said, "We are meant to move her, but she doesn't keep still anyway." When we spoke with staff they were not clear about how each person's support needed to be given to keep them safe. We found that risks were identified and recorded well, but were not consistently managed in a way that kept people safe.

Accidents and incidents were recorded well by the manager. We saw that incidents were discussed with the staff team in the daily meetings and looked at by the manager on a monthly basis to check for any patterns or trends. We saw that actions had been taken to reduce the likelihood of these being repeated in the future.

We spoke with the staff who maintained the building and any equipment used by people. We found that they had robust processes in place to make sure the building and equipment such as hoist, wheelchairs and baths were kept safe for people to use. There was also a clear fire procedure that staff knew about and had been practiced by the staff team to keep people safe in the event of an emergency.

There were enough staff to support people safely. Throughout the inspection we saw staff were with people at all times. Some people however were made to wait. On some occasions staff did not respond to people quickly. We saw one person wait for over half an hour to be assisted to the bathroom, and other people requested drinks and snacks which they did not get in a timely manner. Staff were available to respond to people but did not do so. Staff told us they felt there were enough staff employed to meet the needs of the people living at the home. The manager told us and we saw that extra staff had been appointed since our last inspection. We found the new staff had been in post for a very short time and were available to support

people as well as the established care staff.

A satisfactory recruitment and selection process was in place. The manager told us that staff were not allowed to commence employment until a Disclosure and Barring Service (DBS) check had been received. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Staff we spoke with confirmed that they were not allowed to work alone with people until this check was completed. Staff files sampled showed that application forms had been fully completed and appropriate references obtained.

Medicines were given in a safe way. Care records contained information about the support each person needed with medication administration. We saw that people required varying levels of support from prompting to take medicines through to administering medicines to the person. Staff had received medication training and staff confirmed that only those who had received training were able to support people with their medicines. We saw that medicines were stored in a safe place and in the correct manner.

We spoke with staff who told us about the procedures for managing people's medicines safely, including recording medicines that had been taken or refused. We saw records that confirmed that people had been given their medicines correctly and what happened if there was an error.

People sometimes were prescribed medicines for occasional use 'as required'. We saw that the system for monitoring when people had these types of medicines was not robust and that the manager could not be sure why the medication had been given on any particular occasion. We saw that new systems to audit medication had recently been introduced. These audits had not yet proved to be effective. The manager was aware of this concern and had plans to rectify it.

Requires Improvement

Is the service effective?

Our findings

The home cared for a number of people who were living with dementia and we saw that the home had commissioned a report about becoming more dementia friendly. A positive impact was being felt by people as initial recommendations had been implemented. These changes included removing a loudspeaker system, developing more individualised care approaches and using therapeutic empathy dolls. We saw people enjoying these. There was a sensory garden room being constructed and changes had been made to the environment to support people's orientation around the building. We found that the manager had a vision for the home that was in line with best practice when supporting people living with dementia .

Staff we spoke with said they had a good induction when they began work at the home, and that they received regular training. Staff comments included: "I've done my training," and, "The training is good." We saw that the home had an effective way of recording the training that staff had completed, and that all staff had received core training in areas such as safeguarding, dementia care and manual handling. The manager told us that the home had started using the Care Certificate. The Care Certificate is a nationally recognised induction programme for new staff. We found that staff had been given training and learning opportunities that supported them to do their job well.

Staff supervision was not always consistent at the home. Some of the staff we spoke with said they had not received supervision for some time, and did not feel supported in their work. One staff member said, "If we do something wrong we have supervision, but we don't have supervision regularly." Another member of staff said, "We don't have supervisions really and I'm not sure about spot checks." The manager told us that new senior care staff had recently been appointed, whose role would be to undertake supervisions in the future. We looked at supervision records and found they indicated that supervision and appraisals had not taken place regularly. This meant that there were missed opportunities for staff to discuss their work, concerns or any training and development requirements they had, in a confidential setting.

Information about people's needs had not always been communicated fully or in a timely manner. During our inspection we saw many examples of poor communication. Relatives said, "There's a problem with them not sharing information about [the persons] needs." and "The care plans are detailed but no one looks at them." Another relative said, "The written word isn't always what happens in practice." Staff told us, "The communication could be better, especially about the residents. Sometimes we don't know what's going on." Another staff member said, "Documentation and communication is poor." We looked in detail at the care one person was receiving. We saw that the recent care records which instructed staff about what sort of food the person should eat due to their underlying health concerns. The manager confirmed those instructions were correct. At lunch time we saw the person eating food that was not in line with the stated diet, and could have had a detrimental effect on the person's health. We were informed about a situation when another person who had sustained a serious injury was not taken to hospital for over six hours due to failures in timely communication. We found that there were many processes in place to enable good communication but they were not consistently effective.

The service did not always enable people to give or withhold their consent. The staff we spoke with were

aware that they needed to ask people for their consent at all times. However we saw a very varied approach from staff. On some occasions peoples consent was not sought. One example we saw was a member of staff wiping a person's mouth after dinner from behind them without engaging with them. There were also several examples of people being moved in their wheelchairs without staff speaking with them first. We saw other people being moved but no explanation was given as to where they were going or why. Managers were aware of this concern and told us of their plans to address it.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application process for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked to see if the service was working within the principles of the MCA. The service had made DoLS applications as required. We saw from the records that the service was compliant with the law and that the senior staff had a good understanding of protecting people's rights and choices if they lacked capacity.

We spoke with staff and management about their understanding of restraint when supporting people with their personal care. Staff were clear about what constituted restraint and spoke of only using distraction techniques and returning to a person if they declined care.

We observed that people enjoyed a pleasant lunch time meal experience within the home. People had access to drinks throughout the day. We found that people had a nutritious diet and they were supported to eat and drink. Staff told us people were given a choice of meals earlier in the day. At lunchtime we saw meals just being placed in front of people, without them having the opportunity to change their minds from the choice they had made in the morning. One person said, "We get what we're given." Food was well presented and hot. The main lounge also had a 'hydration station' where people could help themselves to a cool drink. We spoke with kitchen staff who had a clear system for making sure that people received the correct diet depending upon their health needs. Their instructions were received from care staff and clearly recorded. We saw that menus were varied and took account of the specific cultural needs of people who lived at the home. Kitchen staff were very aware of peoples nutritional needs and actively promoted different types and presentations of food to encourage people to eat well. After our inspection health professionals told us that the home was good at following their recommendations.

We saw that people had access to relevant health professionals, and any involvement around this was recorded in their care plans . This included regular and routine appointments such as opticians and dentist appointments. However, one healthcare professional we spoke with told us that they were often called to see people in an uncoordinated way. For example they went to the home to support one person and then were asked to see a second person on an ad hoc basis. They had then judged that the second person had far greater need of their medical support at that time. The second person had needed the medical support for some hours, but this had not been prioritised by the home. A social care professional told us that, "The home needed to liaise more closely with healthcare professionals."

Requires Improvement

Is the service caring?

Our findings

Although we received a number of positives comments we saw many short interactions between staff and people that were not kind or respectful. These were usually around tasks that were being 'done to' a person. Examples of this included: people being given tea or food without being spoken to, people being wheeled about the home with no interaction from staff, and staff talking about people as if they were not present. A relative told us, "I heard two carers talking to each other over [the person] when they were helping him with his care." We found that there were many examples of staff interactions that were not conducted respectfully.

People were not treated with adequate dignity. Throughout the inspection there were many instances of staff calling publically to one another that a certain person had been 'done.' By this they meant that the person had been supported to go to the toilet or had received their meal or a drink. Staff often took a task orientated approach to supporting people, where people were not always at the centre of the care they received. Staff were not able to give us examples of where they had promoted a person's independence. We found that staff had a limited understanding of how to promote a person's dignity and give them appropriate respect.
Support and communication between staff and people who lived at the home were not always respectful. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home did not actively support people to express their views about their care and support. In day to day matters staff told us that they listened to the wishes and choices of the person if they expressed them. The home did not use communication aids such as pictures to assist people to make their wishes known. We did not see examples of how information was given to people in a way that they could readily understand. We found that families were very involved in peoples care, but in such circumstances the person was not adequately supported or enabled to have their own views taken into account. We asked a person about how they found living at the home, they told us that they did not feel they really had a choice of living there or what they did. People were not appropriately supported to be actively involved in decisions about their care or their home.

People who lived at the home and their family members said the staff were kind and provided them with support and were caring. People said, "The staff are very kind to me." and "Everybody looks after me." Relatives told us, "The care now is amazing, [my relative] doesn't want for anything." and "A carer went to the hospital with [my relative], they were very kind." We saw many examples of kind and considerate interactions between staff and people and it was evident that some staff knew people and their preferences well, and that people were comfortable being supported by staff. Staff told us, "Some carers really go the extra mile." We saw that once a staff member took time to sit and engage with a person they performed that role very well. During the inspection we received many positive comments from people who lived at the home and their relatives about the care they received.

Requires Improvement

Is the service responsive?

Our findings

We spoke with the manager about how they involved people living in the home in the reviews of their care. The manager told us that many of the people did not have capacity to make decisions, or the ability to express their views. They told us that people were not involved in review process and so their relatives input was sought. This meant that the manager had not taken the appropriate steps to ensure that people had been supported to be involved in their care by alternative methods.

Relatives told us they felt staff knew their relative's needs well. One relative told us, "What fantastic staff they have here, it's like a home from home." Staff we spoke with were knowledgeable about people's preferences but only had a partial understanding of people's life histories. Care records we looked at were detailed, but did not include a person's life history. The manager told us this was a task that staff had only recently begun to do with people. Not having knowledge of people's life history could impact negatively on how well each person is cared for and if known would have enabled staff to enhance the support provided to each person.

We saw that all care staff had a daily handover sheet that listed peoples support needs. The list was of a medical and practical nature and did not include preferences, wishes or any details about other aspects of the well-being of each person. When asked to tell us about a person they supported at the home, staff were not always able to tell us in detail what their needs were or why they were supported in a certain way. Some staff told us that they often did not read the care plans for people. We found that care records were individualised but that care was not being delivered in accordance with them, which meant that people did not always receive individualised care.

We saw that there was a full range of activities for people to enjoy. One person told us there was too much to do in the home sometimes. The home employed activity co-ordinators who organised different events and supported volunteers within the home. These included film nights, tea dances, celebrating people's birthdays and music and movement. We also saw that some people were engaged in one to one activities at a pace and in a manner that was suitable for them. During our inspection a theatre event took place which people enjoyed. This happened in a room that on other days was jointly used by people from the community. Relatives came into the home during our inspection and they all said that they felt welcomed and comfortable when they visited. This helped people to take part in social activities, stay part of the local community and maintain their relationships with loved ones.

Staff and relatives told us that the home welcomed people from different faiths and cultures, one relative said, "They get the parish priest in here whenever he's wanted." We saw that some people had notices on their doors that told staff what they for wanted, for example 'No visitors thank you' and 'No male members of staff to enter'. We saw that people were given the care and support they required in terms of their personal preferences, culture and faith.

People and visitors were encouraged to comment about the experiences of the service. The home had three clearly labelled locked boxes in public areas that anyone could leave comments in. There was also a complaints leaflet available in the home and the manager told us that the boxes were well used. People and

relatives told us that they could complain and were aware of the process. We saw that complaints and concerns were responded to in a timely manner. One relative told us, "I've complained and get lots of sympathy but nothing happens." We found the service had not always use the complaints process as an opportunity to improve outcomes for people.

Requires Improvement

Is the service well-led?

Our findings

Audits and quality assurance processes were in place, but did not always work. We saw a comprehensive auditing and review schedule that was completed every month. The information was shared with the provider and the manager told us about the plans to improve the process. We saw monthly checks of peoples care records had also taken place. However, we found shortfalls in practice throughout the inspection, which showed that some practice issues were not being identified by these quality audits. These included, shortfalls in medication practice, daily records of people's care, obtaining consent to care and treatment, and effective communication to ensure people were kept safe. While we saw that audits had taken place they were not always effective, and failed to identify issues that had been noted during the inspection.

There were daily staff meetings to discuss care practice and ideas that would improve the service. Staff also shared information in a variety of ways, such as summary sheets which were discussed during handovers between shifts. These meetings were an important part of the manager's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service. We found that lots of processes and meetings took place but they were not effective in all cases. Staff had not received regular supervision and did not always support people in a respectful or dignified manner. We found that outcomes for peoples care and support was not always good.

The lack of an effective system to assess, monitor and improve the quality of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager and provider were very open and honest during the inspection process and told us that the home aimed to operate in a way that included and empowered people as much as possible. The manager had a clear vision of how the home could improve and had implemented several recommendations from a report that had been commissioned externally to improve the quality of life for people living with dementia. We looked at the report and saw that much more work was needed to achieve the final desired outcomes. The manager was aware of the need for further improvements. The manager told us they would not accept poor quality care and were in the process of performance managing some staff because of quality issues. There was a clear commitment towards standards of care being driven upwards.

At the time of our inspection the home manager was in the process of registering to become registered manager of this service. Staff comments about management were all positive. One staff member said "I love it here, and the manager has been really helpful." The manager was skilled and experienced in the provision of social care. We saw staff and people who used the service were comfortable approaching them and were given time and attention. We found the manager offered leadership and was a visible presence within the home.

Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. There are required timescales for making these notifications. The manager had informed us about any incidents and from these we were able to see

appropriate actions had been taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not always treat people with respect while supporting them with their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effective and failed to ensure that risks to the care and support people needed would be identified and acted on.