Care Quality Commission

Sage Care Homes (Jasmin Court) Ltd

Jasmin Court Nursing Home

Inspection report

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Date of inspection visit: 12 June 2015
Date of publication: 26/10/2015

Overall summary

We last carried out inspections under the Care Quality Commission's old methodology on 23 September 2014 and 4 December 2014, during which we found a number of breaches of regulation. This, focussed, inspection took place to look at whether any improvements had been made since those inspections.

This report only covers our findings in relation to this topic. You can read the report from our last inspection by selecting the 'all reports' link for Jasmin Court on our website at www.cqc.org.uk

We undertook this focused inspection to determine people experienced a service which was well led and effective. We have not yet carried out a comprehensive inspection to provide a rating for this service under the Care Act 2014

Jasmin Court is located in the city of Sheffield, approximately two miles north of the citry centre in the suburb of Pitsmoor. The home is a purpose built building set in its own grounds with parking facilities. The ground floor has lounges and dining areas, and the bedrooms are a mix of those with ensuite bathrooms and some without.

The home had a registered manager, however, they had left their post several months before the inspection. They had not yet applied to the Commission to cancel their registration. There was also a new manager in post, but they had not yet applied to be registered with the Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

At this inspection we found, while most people said they were happy with the home, we identified a number of concerns. Our observations and the records we looked at did not always match the positive descriptions some people gave us. We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in that people did not receive care which met their needs, and the systems in place to monitor and assess the quality of the service were not always effective.

Parts of the premises were in a poor condition, and some areas had been damaged. Repairs had not taken place to address this, despite the provider's action plans stating that this work had been completed.

We identified incidents which the provider was legally required to notify the Commission about, but they had failed to do so, and the provider's complaints policy contained incorrect information. This had been identified in previous inspections, but the provider had not addressed this.

The arrangements in place for acting in accordance with people's consent, and assessing people's mental capacity, were inadequate. Where people lacked the mental capacity to make decisions about their care and welfare, the correct legal procedures were not followed.

Summary of findings

One person had a notice in their file stating that resuscitation should not be attempted, which was in direct contradiction of their expressed wishes. A CQC inspector referred this matter to the local authority's safeguarding team after the inspection.

Staff had not all received sufficient training to undertake their roles effectively. A number of staff had not received training in relation to safeguarding, mental capacity or moving and handling. The home's manager contacted us after the inspection to tell us that the training records were incorrect.

The home's management team had devised a wide range of audits in order to monitor and improve the quality of service people received, however, these audits did not always reflect an accurate picture of the home, and were not always carried out at the frequency they were intended to be carried out at.

We are taking action against the provider, and will report on this at a later date.

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 effective?

The service was not effective. Staff had not received all the training they required, and this had a negative impact on people using the service.

The arrangements in place for gaining and acting in accordance with people's consent were poor. Where people lacked the capacity to consent to their care and treatment, the correct legal procedures were not always followed.

Is the service well-led?

The service was not well led. The provider had failed to make certain legally required notifications to the Care Quality Commission.

There were systems in place to audit people's care and the quality of the service, however, these systems had not identified shortfalls in the way people's care needs were assessed or recorded, and had not recognised where improvements were required in relation to staff training or the condition of the premises.

Jasmin Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was to determine people received effective care, and whether the service was well led. We inspected this service against two of the five questions we ask about services; is the service effective; is the service well led?

This inspection took place on 12 June 2015 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before our inspection we reviewed information we held about the service. The provider had not completed a provider information return (PIR) as we had not requested one. The pre-inspection information pack document is the provider's own assessment of how they meet the five key questions and how they plan to improve their service. We checked records we hold about the service, and checked action plans that the provider had supplied to the Commission, setting out how they intended to improve the service. We also held a meeting with the provider earlier in the year in which they told us about their planned improvements.

At the time of our inspection there were 25 people living in the home.

We carried out a physical check of the premises, including some people's bedrooms, communal bathrooms and lounge areas. We spent some time looking at documents and records that related to people's care, including care plans, risk assessments and daily records. We looked at seven people's support plans, and checked records relating to the management of the home and how the service was audited. We spoke with five people living at the home about their experience of receiving care, and carried out an observation of care taking place.

During our inspection we also spoke with six members of staff, which included care workers, domestic staff and members of the home's management team.

Is the service effective?

Our findings

We spoke with two people using the service about the food available to them at Jasmin Court. They both told us they enjoyed it. We observed a mealtime taking place, and saw that the food was plentiful, and where people needed support to eat, this was provided. However, we observed that staff did not always practice good food hygiene techniques when supporting people to eat. We saw that in between handling food, staff were touching people's hair, moving and handling equipment and people's clothing, without changing their gloves or washing their hands.

We observed staff interacting with people using the service, and saw that their communication skills were variable. Some staff communicated well with people, but on some occasions communication was not done well, and we observed that this had a negative impact on people. For example, we observed one person being moved from one area of the home to another. They appeared to be distressed and anxious. The staff member who was supporting them was speaking to them from behind, and carrying out some care tasks without telling the person what they were doing. We checked this person's care plan, and saw that staff were directed to speak to the person directly to their face, to enhance the person's ability to understand what was being said to them. We saw that when another staff member did speak to the person in the way they had been assessed as requiring, it alleviated their anxiety. Another person told us that the TV remote control in their bedroom didn't work. They said that they had told staff about it, but staff had not told them how or when it was going to be rectified.

We checked seven people's care records. Each person had a detailed assessment of their needs and preferences, however, these were not always accurate. For example, we observed one person to be supported in a wheelchair, however, their mobility assessment did not record that they used a wheelchair. The home's manager told us that the person often used a wheelchair, and agreed that their assessment was not accurate. Another person's file had been regularly reviewed, but the reviews had not identified changes to the way care was provided to them. People's files held documents which calculated the risk that issues such as falls or malnutrition presented to them. Two of the documents we looked at had not been calculated correctly, so the risks people were vulnerable to had not been accurately assessed.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked whether people had given appropriate consent to their care and where people did not have capacity to consent, whether the requirements set out in the Mental Capacity Act 2005 had been adhered to. The Mental Capacity Act 2005 sets out how to act to support people who do not have the capacity to make a specific decision, and also sets out the legal framework in which a person who lacks capacity can be deprived of their liberty. We found that the provider had not made appropriate arrangements to ensure that consent was legally obtained. In one person's file, we found that the provider had obtained consent from a person's relative in relation to providing their care and treatment. Another person had been assessed as having the mental capacity to make decisions about their care, but they had not been consulted about a decision which was made not to resuscitate the person should the need arise. One person's file contained information stating that they wished to receive resuscitation, however, there was a "Do Not Attempt Resuscitation" document in their file, and no evidence that they had consented to this. A CQC inspector referred this matter to the local authority's safeguarding adults team after the inspection, and subsequently a social worker and the person's GP reviewed this matter to ensure that this decision was made legally.

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff training records, and found that many staff had not received the training that the provider's Statement of Purpose says that its staff have received. A Statement of Purpose is a legal document that all providers are required to produce and keep under review, which sets out the type of service provided, its aims and objectives and details about the company.

We checked a list of staff training and cross checked it with the staffing rota. We found that on some days, a third of the staff on duty had not received safeguarding training. Many staff had not received moving and handling training, and the staff member responsible for maintenance had not

Is the service effective?

received training in health and safety or fire awareness. A recent medication error had resulted in a person being given twice the correct dosage of medication by a staff member who had not received training in handling medicines. Following the inspection, the manager contacted the Commission by telephone to say that the training matrix was incorrect in relation to moving and handling training, and that a named staff member had, in fact, received training but this had not been recorded.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service well-led?

Our findings

Arrangements had been put in place to involve people in making decisions about the home, and a meeting had recently taken place for people's relatives to attend, however, this was a new development and had not yet been embedded. People we spoke with told us they knew who the manager was, and in our observations we saw that the manager and the deputy manager routinely spent time in the communal areas of the home and were available for people to chat with or raise any issues.

The home's manager had implemented a large number of new audit systems, including daily and weekly audits of care and records. However, these audits did not always recognise or address shortfalls, and were not always carried out at the provider's required frequency. For example, a system had been devised to carry out a weekly audit of any pressure ulcers people had, but this had only been completed once in May. Daily audits were in place to look at issues such as staffing, infection control, training and fire safety, but they were not being undertaken on a daily basis.

There was a weekly audit of the premises. The most recent one we checked recorded that all equipment and hoists were "clean and fit for purpose." However, when we checked the equipment we found a bathroom support device was rusted, meaning it could not be cleaned properly, and we also saw two ripped pressure relieving cushions, which, again, meant they could not be cleaned properly. The daily audit looked at whether staff training was up to date. The audit records we checked recorded that "no action" was required in relation to staff training, but we identified a number of staff training requirements, including one staff member who had not received training in infection control, food hygiene, safeguarding, mental capacity or first aid, and a large number of staff that had not received training in the protection of vulnerable adults.

There was information about how to make complaints in the communal area of the home, however, it did not direct complainants to the correct external agencies if they wished to complain about the home. We had raised this matter during our inspection of the home in September 2014, and in the subsequent report which was published in November 2014, but the provider had failed to address this.

In response to the findings of recent inspections, the provider had developed a "Home Improvement Plan." This document set out the improvements that were intended to be made, and actions that had been undertaken. The document recorded that all care plans had been audited and were in good order, however, the care plans we checked contained errors and omissions, including conflicting information and inaccurate assessments. The audit of these care plans had failed to identify or address this.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked records of incidents and accidents in the home, and found that the provider had failed to make certain, legally required, notifications to the Commission about incidents and accidents, including an incident where the police were called, and another where part of the home could not be used. We discussed this with the home's manager on the day of the inspection.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Registration) Regulations 2009.