

Quantum Care Limited

Jubilee Court

Inspection report

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Tel: 01438730000

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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 well-led?

Requires Improvement ●

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 30 September 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Regulation 12 of the Health and Social Care Act (Regulated Activities) 2014 Regulations.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Jubilee Court on our website at www.cqc.org.uk

This inspection was carried out on 24 May 2016 and was unannounced. At their last inspection on 30 September 2015 they were found not to be meeting all the standards we inspected. We found that people did not always receive safe care and treatment. This related to addressing health care needs and the management of medicines. At this inspection, although we found that some action had been taken to address the shortfalls, some issues still remained.

Jubilee Court provides accommodation and personal care for up to 91 people. They also provide an enablement and intermediate care service which means people stay at the home for short periods of time while they recuperate from ill health.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

There were shortfalls in relation to the record keeping at the service. This was in relation to the accurate recording of medicines and ensuring all information in relation to people's health was recorded clearly and consistently. We also found that systems implemented to address the previous breach of regulation needed further work to ensure they were effective. In addition, systems already in place, such as audits, were not always identifying issues.

Systems had been implemented to help ensure the safe handling of medicines. However, this required additional time to become consistently effective.

People's health care needs were responded to appropriately and managers were checking to ensure all actions were carried out.

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 safety.

Systems had been implemented to help ensure the safe handling of medicines. However, this required additional time to become consistently effective.

Is the service effective?

Requires Improvement ●

We found that action had been taken to improve effectiveness.

People's health care needs were responded to appropriately.

Is the service well-led?

Requires Improvement ●

The service was not consistently well led.

Action plans developed to address issues from our previous inspection were not always effective.

Audits and checks in place did not always identify shortfalls.

Jubilee Court

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Jubilee Court on 24 May 2016. The inspection was carried out by two inspectors. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 29 September 2015 inspection had been made. The team inspected the service against three of the five questions we ask about services: is the service safe, is the service effective and is the service well led. This is because the service was not meeting some legal requirements.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We reviewed the action plan they sent us subsequent to the previous inspection undertaken in September 2015 telling us how they would make the required improvements.

During the inspection we spoke with one person who used the service, five staff members, the deputy manager, the registered manager and the regional manager. We also received feedback from professionals involved in supporting people who used the service and reviewed the recent reports from service commissioners. We viewed information relating to eleven people's care and support. We also reviewed records relating to the management of the service.

Is the service safe?

Our findings

When we inspected the service on 30 September 2015 we found that people's medicines were not always managed safely. At this inspection we found that although action had been taken to try and address the shortfall, some issues still remained. However, this mainly related to the accurate record keeping of medicines and not poor administration of medicines.

There was a chart introduced that recorded a running total of medicines that were boxed rather than in a pre-packed system from the pharmacy. This was introduced to try and reduce medicine errors and ensure an accurate account of medicines. However, we found that this did not always tally with the medicine charts and quantity of medicines in stock and further review indicated it was as a result of inaccurate and poor record keeping. We also found that five of the 14 boxes we counted did not coincide with the quantities recorded and in one instance antibiotics administered that morning had not been signed for correctly by staff. In addition we observed on one unit a trolley being left unattended, with the key in the lock and medicines out on top of the trolley. Although at this time there was no one in the area this meant that medicines could be accessed by those not authorised should this happen again and people are in the area. The staff member was in a room nearby and when questioned by the registered manager stated they were watching it. However, the registered manager explained to the staff member that this was not acceptable practice.

We discussed these finding with the registered manager and the deputy manager and they agreed that the record keeping did not support the safe management of medicines and some practices needed further improvement. They told us that all staff had undergone additional training in medicines since our last inspection and had also all received competency assessments by the deputy manager who had a good understanding of safe medicines management. However, this remained an area that required further and sustained improvement.

Is the service effective?

Our findings

When we inspected the service on 30 September 2015 we found that people's health care needs were not always responded to in an appropriate timeframe. At this inspection we found that the issue had been addressed.

Following our inspection the registered manager implemented a health care log sheet which set out any health concerns and actions to be taken to address them. This was then reviewed by care team managers and the deputy manager to ensure all health needs were addressed safely and effectively.

People's health care needs were responded to appropriately. We saw that where a person had a healthcare concern, this was logged and the appropriate health care professional was contacted. We spoke with a person who had a health condition that required following up. They said, "The nurse came out to see me, and I think they are due again." A health care professional told us that staff were responsive to instruction and were proactive in raising concerns on behalf of the people who used the service. The professional went on to say that they had no concerns in relation to the health of people who lived at Jubilee Court.

We reviewed the health care log sheet and saw that actions were recorded. We also saw that a member of the management team had signed it off when they were satisfied all actions were complete. This helped to ensure that people's health care needs were identified and resolved appropriately.

Is the service well-led?

Our findings

Following our last inspection on 30 September 2015 the registered manager sent us an action plan setting out how they would address the issues relating to the safe management of medicines and people's health care needs not being met. The action plan dated 13 November 2015 stated that all actions had been completed. We found that although the documentation developed to address the issues had been introduced, it was not always effective.

The system in place to address the breach in relation to medicines was not used effectively. We saw that the log sheet used to record boxed medicines did not correspond with the medicine charts. We also found that the record of medicines received into the home did not always tally with the amount of stock held and number of tablets administered. For example, one box was recorded as having 24 tablets in the home. However, when we counted these there were 32 tablets. An audit had been carried out, along with weekly checks by care team managers (CTMs) and they had not identified this issue. We found this to be the case for five of the 14 boxes of medicine we counted. The deputy manager told us that they only audited a sample of medicines and checked that the spot check sheet was signed by CTMs. They told us that CTMs counted boxed tablets randomly and there was no system in place to ensure that all boxed medicines checked. We were also told that the night manager carried out checks on stock held by the service and these had not identified any issues. This meant that had we not identified these issues during our inspection they may not have been identified for a number of weeks if at all.

In regards to health care information, although we felt that people's needs were met, we did note that not all information was recorded consistently. For example, information in relation to a person becoming disorientated was not recorded in their daily notes even though one staff member told us that this had happened. We saw that this was reported to enable a GP to attend but the information was not recorded so that it could be communicated to all staff. We spoke with different staff members on the unit the person lived and they did not know they had these symptoms. This was also the case for a follow up test for another person's possible infection and a record of support requested by the home for nursing input. This meant that the health care log sheets were not used effectively.

Records were not always stored securely. During our inspection we found personal and sensitive information stored in communal areas on top of recently installed locked cabinets. Some of this information was extremely private and related to issues such as end of life care for a person, sore areas on their body and deprivation of liberty explaining their mental health needs. This information should not have been accessible to those not authorised to do so. We informed the registered manager at the time of the inspection who went around the home and removed it.

We tried to review a care plan for a person but staff were unable to locate it. We asked a staff member who told us the person had moved units but didn't know when. We asked staff on the person's new unit for their care plan. They told us that the plan had not yet been transferred to their unit and they had not seen it. We spoke with the deputy manager who told us it was on the unit but had been removed it to add a new folder and staff would have been accessing it to complete daily records. However, this was another example of

ineffective records management.

Therefore due to the ineffective audit system in relation to medicines, the action plans not yet being fully completed and the records being accessible and inconsistent, this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems in place to ensure the quality of the service were not consistently effective and records were not always accurate or secure.