

Mrs A Shiels

Jesmund Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Inadequate ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 9 August 2016 at which breaches of six regulations were found. These related to providing person centred care, treating people with dignity and respect, the need for consent, providing safe care and treatment, suitability of premises and good governance. Warning notices were issued in regards to the breaches of regulations in relation to safe care and treatment, premises and good governance. The provider had until 19 September 2016 to make the necessary improvements to meet the requirements as detailed in the warning notices.

We undertook a focused inspection on the 7 December 2016 to check that they now met legal requirements relating to the three breaches where we issued warning notices. We will follow up the other breaches at future inspections. This report only covers our findings in relation to this inspection. You can read the report from our previous comprehensive inspection, by selecting the 'all reports' link for 'Jesmund Nursing Home' on our website at www.cqc.org.uk.

Jesmund Nursing Home provides accommodation, personal and nursing care to up to 25 older people. At the time of our inspection 22 people were using the service. Most of the people using the service had a cognitive impairment and some were living with dementia.

A registered manager was 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 worked closely with the registered manager to provide the day-to-day management of the service.

At this inspection we found the provider had not taken sufficient action to address the requirements of the warning notices issued. The environment continued to be dirty and unpleasant and there were no cleaning schedules in place. Carpets were heavily stained and there were stains on the walls. Furniture in people's rooms were ripped and covered in food debris. Some of the bathrooms had cracked floors and broken bath panels meaning they could not be adequately cleaned.

The provider had still not addressed all of the environmental risks to people's safety. They had not undertaken a full health and safety risk assessment and there were not always plans in place as to how risks to people's safety were being mitigated. The provider had begun work on covering radiators and installing window restrictors but this had not been completed and there were no clear plans as to when the work would be completed or how the risks were being managed in the meantime. Some broken equipment continued to be held together with electrical tape.

The provider did not have proper quality assurance systems and clear improvement plans about how they were addressing the concerns identified at this and our previous inspections. There were no processes or systems in place to monitor and review the safety of the environment. Checks on the cleanliness of the

service were ineffective and did not address each person's bedroom.

The provider remained in breach of the regulations relating to safe care and treatment, premises and good governance. Following our inspection and as part of our decision making process for enforcement action against the provider, we wrote to them requesting a plan outlining what actions they had taken since our inspection and what further action they planned to take in order to meet the breaches of regulations summarised above. We received an action plan within the timescale requested. This showed that the provider had addressed or was in the process of addressing our most urgent concerns. We have requested weekly updates from the provider on the action they are taking and will continue to monitor the provider's action plan. On this occasion we are not taking further enforcement action but we will consider taking further enforcement action if when we inspect again, we find that adequate improvements have not been made to the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service continued not to be safe. The provider had not made the necessary improvements to ensure a clean and pleasant environment was provided to people.

Whilst some improvements had been made to the environment the provider had not taken sufficient action to ensure a safe environment was provided. Risks to people's safety had not been fully considered and mitigated.

Inadequate ●

Is the service well-led?

The service continued to have areas that are not well-led. The provider had not made the necessary improvements to their quality assurance processes. The quality assurance processes continued to not identify concerns to the quality and safety of care delivery and had not addressed concerns identified at previous inspections.

Requires Improvement ●

Jesmund 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 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.

We undertook a focused inspection of Jesmund Nursing Home on 7 December 2016. This inspection was completed to check that improvements to meet legal requirements planned by the registered provider after our comprehensive inspection on 9 August 2016 had been made. We inspected the service against two of the five questions we ask about services: is the service safe? Is the service well-led?

The inspection was undertaken by two inspectors. Prior to the inspection we reviewed the information we held about the service including the statutory notifications received. These are notifications about key events that occurred at the service. We liaised with a representative from the local authority about their experiences of the service and the findings from recent contract monitoring visits.

During the inspection we reviewed the environment, we looked at five care records and management records relating to health and safety and cleanliness of the environment. We also spoke with the provider and the registered manager.

Is the service safe?

Our findings

At our previous inspection on 9 August 2016 we saw that many areas of the environment were dirty and not well maintained. We observed dried brown stains on walls, carpets and equipment. Furniture in people's rooms were ripped and covered in food debris. We saw that commodes and urine bottles were not always cleaned appropriately in-between use. Equipment was dirty and covered in dust and food debris. Many of the bathrooms had ripped flooring and broken bath panels meaning they could not be adequately cleaned.

At this inspection we found that areas of the environment remained dirty and there continued to be stains on the carpets and walls. This included dried brown stains. In addition there was liquid staining on some bedroom carpets and on the day of our inspection some of the carpets were wet and this had not been cleaned. The provider informed us some people were known to express behaviour that led to spills on the carpet but was unable to give a reason as why it had not been cleaned. Some people's furniture in their rooms remained ripped and covered in food debris. Some of the bathrooms continued to have ripped flooring and broken bath panels meaning they could not be adequately cleaned. This meant that people were continuing to live in an unpleasant environment where the cleanliness was not being maintained adequately.

The provider told us since our comprehensive inspection they had a dedicated cleaner. They were not on duty on the day of our inspection and the registered manager told us when the cleaner was not on duty the care staff undertook the cleaning duties. However, the provider did not have effective arrangements to ensure that the premises were cleaned and maintained to a suitable standard. There was not a clear and documented cleaning schedule and there were no records kept of what cleaning had been undertaken and when.

The provider remained in breach of Regulation 15 of the HSCA 2008 (Regulated Activities) Regulations 2014.

At our previous inspection on 9 August 2016 the provider had not ensured a safe environment was provided. The provider had not assessed the environmental risks to people's safety and had not mitigated those risks. This included the risks of people scalding themselves on radiators, falling from height or cutting themselves on razors left in communal bathrooms. Fire exits and escape routes were blocked. Environmental hazards had not been assessed and mitigated, including access to rooms containing the hot water tank and hazards from loose wiring, uneven surfaces and unsafe equipment. We found call bells were not accessible to people. We also found that incidents were not being appropriately reported to the management of the home for them to take action to minimise the risk of similar incidents from recurring.

At this inspection the provider continued to not provide a safe environment and had not adequately assessed the risks to people's safety. Since our last inspection the provider had arranged for the radiators to be covered and we saw that the majority of radiators in communal areas and people's bedrooms had been covered. However, the radiators in bathrooms had not been covered and the provider had no management plan in place as to when this work would be completed and in the meantime how they were managing the risk of people burning or scalding themselves, if they came into prolonged contact with unguarded

radiators. Since our last inspection the provider had also arranged to have window restrictors installed. However, we saw these were not in place in three bedrooms and again the provider did not have a management plan in place as to when this work would be completed and in the meantime how they were managing the risk of people falling from height. We also saw that environmental risks including those to people falling due to uneven surfaces had still not been assessed or mitigated. We saw that one bed's controls and a light fitting continued to be held together with electrical tape which could pose a risk to people.

The provider remained in breach of Regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Since our inspection in August 2016 the provider had addressed some of the risks found at that inspection. Loose wiring had been fixed to the walls to reduce the risk of people tripping and falling. Rooms which were a risk to people's safety had locks installed so people could not access them, this included the sluice room and the room with the hot water tanks and controls. Call bells were accessible in each bedroom. A bed had been moved from blocking a fire exit and broken equipment and rubbish had been removed to provide clear fire escape routes. Incident reporting had improved and we saw that incident reporting processes were being followed.

Is the service well-led?

Our findings

At our previous inspection on 9 August 2016 we found the provider did not have effective quality assurance systems which covered all areas of service delivery. At the time of our inspection there were no processes in place to monitor and ensure a suitable environment was in place and there were no processes to monitor infection prevention and control or cleanliness. There were insufficient checks to identify and mitigate risks to people's safety. We also found that care records were not stored securely and the provider had not ensured that care plans were kept up to date and provided accurate information about people's care needs.

At this inspection the provider continued to not have effective quality assurance systems in place. The registered manager had introduced new systems to audit and review the cleanliness of the service. These audits did not cover infection prevention and control. They also were not detailed enough and did not specifically address the cleanliness of each room. The daily cleanliness checks were not effective as these checks had not identified the concerns we found including the fact that people's bedroom carpets needed to be steam cleaned. The provider and registered manager told us they were aware that certain people expressed behaviour that meant their carpets would need cleaning more regularly, but there was no evidence that action had been taken and this had been carried out. The provider and registered manager had not undertaken a full health and safety review in relation to the premises and the delivery of the service. Whilst the provider and registered manager told us they took responsibility for leading on health and safety at the service they had not adhered to good practice guidance, including the Health and Safety Executive's guidance on health and safety in care homes.

The provider and registered manager had not sufficiently addressed the findings from the previous inspection and did not have an improvement plan as to what actions they were taking in order to provide high quality and safe care to people.

The provider remained in breach of Regulation 17 of the HSCA (Regulated Activities) Regulations 2014.

Care records had been moved and were now stored securely. The care records we viewed contained more detailed information and we saw that care plans and risk assessments were regularly reviewed. However, we still found that some care plans contained information about people's behaviour but did not provide sufficient information about how this behaviour was to be managed and supported. For example, for one person at risk of falls the instruction in the person's care record was for staff to provide a safe environment but there was no information about how this was to be achieved.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	The registered person did not ensure the safety of service users by assessing and mitigating risks, and ensuring that premises were safe to use. (Regulation 12 (1) (2) (a) (b) (d))
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Diagnostic and screening procedures	The registered person did not ensure that all premises and equipment were clean, suitably for use and properly maintained. (Regulation 15 (1) (a) (c) (e))
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	The registered person did not ensure processes were in place to assess, monitor and improve the quality and safety of the service. They did not assess, monitor and mitigate risks to the health, safety and welfare of service users. (Regulation 17 (1) (2) (a) (b)).
Treatment of disease, disorder or injury	