Jasmine Care Holdings Limited

Jasmine House Nursing Home

Inspection report

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Reading
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29 July 2020

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Jasmine House Nursing Home is a residential care home providing personal care, accommodation and nursing care to up to 79 people aged 65 or over. There were 35 people living at the service at the time of our inspection, some of whom were living with dementia. The service comprises of two units, Hawthorne and Jasmine each of which has separate adapted facilities.

People's experience of using this service and what we found
People were not always protected from a risk of harm and we found concerns about risk management and medicines. People were not always protected in an event of an evacuation. The provider's system to identify safeguarding concerns, monitor accidents and environmental safety needed improving.

We received mixed feedback about staffing levels with some people commenting they at times needed to wait to be supported. The provider followed safe recruitment practices.

Although we recognised the changes implemented by the new management team and further improvements planned, we found the provider's governance remained ineffective. We took this into consideration when making judgement to ensure the most proportionate regulatory response to the concerns identified.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 18 December 2019) and there were multiple breaches of regulation. We issued a warning notice in relation to breaches of regulations relating to safe care and treatment and good governance. The provider was required to be compliant with the breaches of the regulations relating to safe care and treatment and good governance by 5th January 2020.

At this inspection we found improvements had not been made and the provider was still in breach of regulations around safe care and treatment and good governance. Additionally, we identified another breach around not notifying us of incidents of suspected abuse.

Why we inspected
We undertook this focused inspection to check the provider was compliant with the regulations and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions: Safe and Well-led, which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service remains requires improvement. This is based on the findings at this inspection. This is the second

consecutive requires improvement rating for the service.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Jasmine House Nursing Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. We were unable to inspect the service as initially planned. We wrote to the provider requesting evidence to be sent to us. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We will continue to work with our partner agencies and to monitor the service through the condition we have already placed on their registration which requires them to send us monthly updates in respect of their quality assurance processes to ensure this improvement is sustained.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not always well-led.

Details are in our well-led findings below.

Jasmine House Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by three inspectors, a medicines inspector and 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.

Service and service type
Jasmine House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was no manager registered with the Care Quality Commission. The provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a one-day notice of the inspection as we needed to check if anyone at the service had Covid-19 symptoms. The management ensured no people or staff had symptoms and we knew from our ongoing communication with the operations director they have remained outbreak free for several weeks. The site visit took place on 28 July 2020.

What we did before the inspection

We reviewed information we had received about the service since the last inspection as well as the information shared with us by the local authority, such as details of the safeguarding concerns that had been raised. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
On the first day of the inspection, which was the site visit we spoke with one person who used the service, the provider, the operations director, the clinical lead, two nurses, one care staff and the maintenance person. We reviewed a range of records. This included four people's electronic care records and medicine records for 17 people. We looked at four staff files in relation to recruitment. A variety of records relating to the management of the service including accidents records were also viewed. On the second day we telephoned five more staff and spoke with three. The Expert by Experience telephoned three people living at the service and five relatives and spoke with two people and three relatives.

After the inspection
We continued to seek additional evidence from the provider. We contacted three external professionals involved with the service to seek their feedback. We also spoke with three ancillary staff members to gather their views.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was a risk that people could be harmed.

The purpose of this inspection was to check if the provider had met the warning notice we served after our last inspection and which required the provider to be compliant by 5th January 2020.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. These issued formed part of a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 12.

● There was not always evidence available that risks to people had been assessed, recorded and appropriately managed. One record showed a person developed a pressure area at the end of May. This person's care plan said the person's, "Skin and pressure areas remain dry and intact." This person's skin integrity care plan was due to be reviewed on 30 June 2020 however, this had not been completed. Additionally, this person's care plan stated they were not able to reposition independently, and staff needed to reposition the person regularly. The records did not evidence the person was being repositioned regularly. Another record dated 24 July stated the person needed to be repositioned every two hours, but the person's skin integrity care plan had not been updated to reflect this. Again, there was no evidence the person was being repositioned as required. After we raised this with the provider the person's care plan was amended.
● Another person used a pressure relieving mattress. Their skin integrity care plan had not been completed and was blank. This meant there was no information recorded around actions staff should follow to manage and mitigate the risks of the person developing pressure ulcers, such as ensuring the correct settings of the pressure relieving mattress.
● People's safety had not always been appropriately monitored. The provider's accident log showed there had been numerous incidents of people found with bruising, skin tear or skin flap. The 'investigation and follow up' section of these accident logs had not been completed.
● There was no information in people's risk assessments to guide staff monitor or manage side effects of high-risk medicines such as anti-coagulants (blood thinning medicine), anti-epileptic medicines or diabetic medicines. This meant there was a risk, staff may not be able to respond appropriately and take necessary action regarding these medicines and keep people safe.
● We found people's individual personal evacuation emergency assessments (PEEPS) contained conflicting information. For example, one person's PEEP stated the person used a wheelchair and was usually transferred by hoist as well as that the person was able to mobilise independently and would be able to walk to the point of evacuation. Another person's PEEP's stated the person lived in the Hawthorne unit but

did not specify the room number. However, this person had recently moved rooms to the other unit and their PEEPS had not been updated. This meant there was a risk in the event of an emergency the information available was not always correct and not always easily accessible to evacuate people safely.
● The service's fire risk assessment contained conflicting information. For example, it stated that, "Service users may smoke in their rooms" and yet there was a "No smoking policy in the home." During our inspection we observed the fire door into the laundry which had a clear sign on the door saying, "Fire door, keep shut" was propped open.
● There was an up to date gas safety certificate in place and water safety test had been carried out earlier this year. However, there was no record to show regular maintenance, such as cleaning of the shower heads took place. The person identified by the provider to manage water safety informed us they had not received training to develop their competence to do so, they said, "They have never told me how to do it. I have never had training."

The above issues form a part of the continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
At our last inspection the provider had failed to ensure safe medicine management. This was part of a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 12.

● We found gaps in the temperature monitoring records for the medicine's storage room and the medicines refrigerator. At times the temperature recorded was out of the required range. This meant the medicines could lose efficacy as they were not stored at temperature recommended by the manufacturer.
● Where people had been prescribed medicines to be taken on when required (PRN) basis, PRN protocols were not always in place. This meant there was no guidance when these medicines should be offered to people.
● People's care documents did not always contain details of people's medicines. One person's medicine care plan had not been completed. A staff member confirmed the person was prescribed various medicines. We asked the staff member why the medicine care plan had not been completed and they said, "We [are] just starting to do them". This meant there was a risk staff may not be able support people's medical and health needs safely.
● On the day of our visit there was no evidence staff competencies around medicines management had been monitored as required by the national good practice standards. A staff member told us they worked at the home for a few years and had not had competencies checked. Following our inspection, the operations director told us staff have received their competencies.
● We observed staff giving medicines to people, they gained people's permission and signed for each medicine on the Medicine Administration Record (MAR) after the person had taken it. MAR had been fully completed. Medicines including controlled drugs (CD) were stored securely.

The above issues form a part of the continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Safety concerns were not always proactively identified. The local authority shared with us a log of safeguarding concerns and where some concerns had been substantiated these could have been prevented from escalating to a safeguarding concern should the staff identified these promptly.

● We found staff needed better understanding to prevent and manage behaviours that may challenge. For example, we saw the record one person was non-compliant with the support and the person was labelled as 'rude'.
● Not all staff we spoke with were able to recollect attending safeguarding training. None of the people or relatives we spoke with were aware of the provider's safeguarding policy and as a result what to do if any concerns noted. However, one relative commented they were getting informed by the new management about concerns. They said, "There have been so many issues in the past. The good thing is that new manager [name] and other seniors are very hot on the fact that when there is an incident the family needs to know".

Learning lessons when things go wrong
● Jasmine House Nursing Home had been previously found in breach of regulations in relation to protecting people from the risk of harm, medicine management and good governance. We previously issued the provider with a warning notice, but we found repeated concerns around medicine management, people's safety and governance at this inspection. There was no evidence of learning from events to improve safety as the provider did not ensure the necessary improvements had been made, sustained and lessons learnt where necessary.
● The provider did not comply with patients' safety alerts. These alerts require action to be taken by providers to reduce the risk of death or disability. There was no evidence of information such as medicines alerts being acted on. When we raised this with the provider, they said they received and read these but had not passed on to the team at the service to action if necessary.

Staffing and recruitment
● We received mixed feedback from staff about staffing levels. Comments included, "There is enough staff at present. When we work in pairs as there are some double ups and there it's a stretch, sometimes it feels like a bit rush" and "There is enough staff on duty, we're managing."
● People said at times they needed to wait a long time to be assisted. One person said they waited for help with toileting, "Quarter of an hour at least, it's too long to hold on, they understand that, but they can't do anything about it. They always say they are short staffed".
● One relative said, "There seem to be quite a lot (staff) milling around in the lounge, but I never saw many when [person] was confined to their bedroom, nobody seems to be patrolling those rooms". Another relative said, "The staff level fluctuated quite a bit, after the last CQC (inspection) previous manager said she would increase staff, in fact, it went down, it was impossible finding someone if you needed them."
● The provider followed safe recruitment procedures when employing new staff.

Preventing and controlling infection
● The environment was clean and tidy. There was no malodour and hand sanitizers were available in reception.
● Staff praised the provider and the management team who supported them well during the outbreak and ensured they had sufficient personal protective equipment (PPE).
● People told us staff wore PPE and the service was clean. Comments included, "They always wear their masks and aprons, they have gloves as well, the place is perfectly clean, it's the cleanest I've seen it" and "They keep it very clean. I'm aware they wear all these garments too. They're more careful now, I think." One relative said, "Since [operation director's name] there is a monthly deep clean in all the rooms, it's given me a lot of confidence."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. The leaders at the service were in a progress of improving the culture to assure the delivery of high-quality care. However, there still were widespread and significant shortfalls in the provider's governance processes.

The purpose of this inspection was to check if the provider had met the warning notice we served after our last inspection which required the provider to be compliant by 5th January 2020.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection we found the provider had failed to have systems or processes in place to ensure that the quality and safety of the services provided was being monitored effectively and used to drive service improvements. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of regulation 17.

● There was no registered manager at the service. The operations director who started working at the service at the end of January 2020 acted as a home manager. They shared with us they spent significant time addressing the culture at the service and personnel related concerns. Since commencing her employment, the operations director appointed a new head chef, administrator and a clinical lead. She was aware of the improvements needed and said, "Feels like commissioning the home from scratch, but with staff and residents in". This demonstrated the provider had not met the warning notice which required them to be compliant with governance by 5th January. Had they done so the improvements could have been embedded during the months before the lockdown and an outbreak which inadvertently affected the service delivery.
● The provider's oversight and governance was not effective. The provider's policy around their quality assurance stated 'The service has in place a programme for auditing all the standards and key procedures'. The repeated concerns we found demonstrated the provider was not operating accordingly to their own quality assurance policy. We saw two audits carried out by the provider in June and July 2020 which showed the provider sought feedback from staff, people and carried out visual observations at the service. However, many areas, such as safeguarding concerns, accidents, medicine management, risk assessments, submitting statutory notification had not been incorporated into these audits at all. Additionally, these audits were not always effective, for example, June audits under 'complaints' stated 'none'. We have been made aware of two complaints made to the service during this time. The 'Up to date' comments had been entered in both, June and July 2020 audits under the 'Fire Safety' section. We however, found concerns around people's PEEPS which we reported about in above section of this report.

● The operations director shared with us the '2020 audits' folder. The front page was a schedule of audits planned to be implemented, however, the file contained only one record. It was an audit of bed and bed rails carried out in July 2020.
● Care records were not always reflective of people's needs. One person's records showed 'Yes' was recorded under the question if the person was able to understand the purpose of bed rails. However, a staff member told us the person, "Lacked capacity to make the decision about the bed rails". We asked staff about the care documentation and one of the senior staff said, "Some of care plans are not great. They're not to the standards they should be". Another staff said they did not read care plans, "They say you must read care plans so you know what's going on, but we have no time really, I will have to start reading them." The feedback received from an external professional said, "We are aware that [electronic care planning system's name] training was delayed repeatedly and has only just been completed which has led to a delay in care-planning." We saw no evidence of care plans audits being completed and when we asked for it we were shown a blank audit tool.
● Some information to support performance had not been gathered at all. For example, we saw individual accidents had been recorded but there was no overview of these. One of the senior staff told us, "I am hoping to introduce a tracker to monitor accidents for trends".
● There were infection control and prevention audits and the new management team had introduced a falls tracker and infections tracker.

The above was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong. Continuous learning and improving care.
● At our last inspection we identified they failed to notify the CQC of an incident of potential abuse. At this inspection we found the provider continued to fail to notify us about incidents of potential abuse. An incident between two people occurred earlier this year we had not been notified about. The provider's own accidents log included the record of another, recent incident between people where one person pushed another person to the floor and they sustained a skin tear of which we had also not been notified about.
● We saw the record of the minutes of a meeting held a week prior to the above incident where the Duty of Candour had been discussed with the team and the responsibilities in relation to this requirement highlighted. The provider's own safeguarding policy stated, 'The care home requires its managers to take responsibility for notifying the Care Quality Commission of all instances of abuse, alleged or suspected abuse'. Despite this, the provided did not notify us.

This was a breach of Regulation 18 of the Care Quality Commission (registration) Regulations 2009.

Working in partnership with others
● The provider worked with a number of health and social professionals, this included the local commissioners and health professionals such as, the GP, the Speech and Language Therapist and the local care home support team.
● The feedback received from professionals showed they had not always been made welcoming as a result of them querying the standards of practices which should be seen as a part of standard professional conduct.
● The provider acted in a defensive way in response to the provisional feedback summary provided following our inspection. When we commented their quality assurance processes remained ineffective the provider said, "This sentence is both totally factually incorrect and libellous."
● External professionals complimented the improvements introduced by the new management team.

Comments included, "[The operations director's name and the clinical lead's name] are approachable and deal with any queries effectively" and "On my visits the management always assign a senior member of staff to support the visit."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff told us they felt the team work was good. One staff member said, "It's a nice atmosphere, I enjoy going to work."

● Staff felt the new management team listened to them. A staff member told us, "With the old management we were in the dark, they (new management) try to involve us as much as possible."

● People and their relatives gave us mixed feedback about their involvement. One relative told us when they spoke to the management recently about concerns, they were very sympathetic and understanding." Other comments included, "I have not had any problem with the new manager but I don't know for myself if what I ask for is happening because we haven't been able to visit during lockdown" and "When I told them about the call bell, I think they just don't listen, they don't do anything about it" adding they felt that any criticisms were not generally welcomed.

● The management team informed us they planned to carry out a satisfaction survey with people living at the service soon.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

● The operations director had implemented daily heads of departments meetings which were welcomed by staff and aided communication. A staff member praised these and said, "All staff catch up". We saw example of the records and areas such as update on people's needs, occupancy, catering and more had been discussed. Where the head of department was unable to attend a staff member was delegated to do so.

● One person's relative gave us an example of a positive change introduced by the new management. They said, "They have a 'Resident of the day' now. [Person] has had it twice now and treated like a queen. The cook comes out and asks if [person] would like something special to eat". Another relative said they believed the operations director was, "Keen to involve residents more." They added how the person was encouraged to get involved in a hobby they used to like and said this made them happy.

● Staff told us they could see the impact of the positive changes introduced by the operations director. One staff member also told us, "All of the changes that (operation director's name) made are residents orientated." Another staff member said, "(Operation director's name) is more home orientated. Changes she's made are for the better."

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to submit notifications of abuse and suspected abuse.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider did not ensure risks to people were managed safely.

The enforcement action we took:

Positive condition.

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	The provider did not ensured their governance remained effective.

The enforcement action we took:

Positive condition.