Rushcliffe Care Limited

Jasmine Court Nursing Home

Inspection report

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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 responsive?	**Requires Improvement**

Summary of findings

Overall summary

Jasmine Court is a nursing home which provides support for up to 66 older people with age related needs, nursing needs and dementia type illness. The service comprised of three floors. We carried out an unannounced comprehensive inspection of this service on 3 and 4 November 2014. After that inspection we received information about concerns in relation to people's needs not being met due to low staffing levels and lack of staff support. As a result we undertook a focused inspection on 18 February 20016 to look into those concerns.

You can read a summary of our findings from both inspections below.

Comprehensive inspection of 3 and 4 November 2014.

This inspection was unannounced. At our inspection on 17 June 2014 we asked the provider to take action to make improvements. We asked them to improve practices in relation to people's consent to care and treatment, people's care and welfare needs, cleanliness and infection control, staffing levels, supporting staff and the systems for assessing and monitoring the quality of the service. Following that inspection the provider sent us an action plan to tell us the improvements they were going to make. We found that this action had been completed in our inspection on 3 and 4 November 2014.

People who used the service including relatives we spoke with, made positive comments about the care and treatment provided. We saw staff treated people with dignity and respect and involved them as fully as possible in decisions.

People were supported by staff who had received training on how to protect people from abuse. Safeguarding procedures were in place and appropriate action was taken if concerns were identified. Risk assessments had been completed where appropriate for people who used the service, staff, visitors and the environment. People received their medicines safely and as prescribed by their doctor.

There were sufficient numbers of staff available to meet people's needs and keep people safe. Staff had the right skills and experience and received an initial induction and on-going training and support. Recruitment practices were safe and relevant checks had been completed before staff commenced work.

People's human rights were protected because staff were aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This is legislation that sets out the requirements that ensures where appropriate, decisions are made in people's best interests when they are unable to do this for themselves.

People's nutritional and dietary needs were assessed and people were supported to eat and drink sufficient amounts to maintain their health. The home made appropriate and timely referrals to health care professionals and recommendations were followed. Support was also provided for people to attend routine health checks.

People told us that they felt included in discussions and decisions about their care and treatment. Information was available that advised people about independent advocacy services and information about the service including the providers' complaints procedure. The service provided personalised care and treatment, people had been asked what was important to them in how they wished to be cared for. This information was reflected in their plans of care.

People who used the service, relatives and staff were positive about the leadership and said improvements had been made to the service. The registered manager regularly assessed and monitored the quality of care by completing audits and seeking feedback from people who used the service.

18 February 2016 Focused Inspection into Concerns

Following our inspection of 3 and 4 November 2016, we undertook a focused inspection after receiving information of concern about the service. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk.

The inspection took place on 18 February 2016 and looked into concerns about people's needs not being met due to low staffing levels. On the day of our visit, they were 60 people using the service. Most people in the three floors required nursing care, and had high dependency levels with their general health including mobility, mental health and communication needs. During the visit, we found that:

Staff were knowledgeable of what would constitute abuse to people. However, they did not feel always confident to report these issues.

The service did not have sufficient numbers of staff to meet people's needs safely or promptly. People did not have always have access to equipment that met their needs in a safe manner.

Staff did not receive supervision support from their manager. Staff did not understand the relevance of Mental Capacity Act (2005) to their role.

People did not receive the support they required to meet their nutritional needs in a timely manner.

People had prompt access to health care professionals.

People did not receive care that was personalised and reflected their individual needs and preferences.

The service provided opportunities for people to make complaints.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see 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 consistently safe.

People who used the service were being put at risk because:

There were insufficient numbers of staff to meet people's needs and keep them safe from harm. Staff did not feel confident to report issues when they were concerned about people's safety.

People did not always have access to equipment that met their needs in a safe manner.

However, people received their medicines as prescribed by their doctor.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always communicate effectively with people.

People's nutritional needs were not met well enough because they were not enough staff to provide the support they required.

People had access to health care professionals.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not receive personalised care that reflected their individual needs and preference and their care plans did not always reflect the support that they actually received.

People had opportunities to raise any concerns or complaints.

Jasmine Court Nursing Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Jasmine Court on 18 February 2016. We carried out an unannounced comprehensive inspection of this service on 3 and 4 November 2014. After that inspection we received concerns in relation to people's need not being met due to low staffing levels and lack of staff support. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to this topic.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.'

This inspection took place on 18 February 2016 and was unannounced. The inspection team consisted of two inspectors, and a nurse specialist advisor.

Before our inspection visit we reviewed information we held about the service. This included previous inspection reports, and notifications sent to us by the provider. Notifications tell us about important events which the service is required to tell us by law.

We spoke with four people who used the service, relatives of seven other people who used the service, a GP who visited the service, nine members of the care staff, a catering assistant, a student nurse and the registered manager. We looked at the care records of nine people who used the service, nine people's medication records, and the provider's complaints documentation. We reviewed records of staff rotas to determine if there was enough staff deployed to meet people's needs. Each member of the inspection observed care and support in communal areas on each of the three floors.

Requires Improvement

Is the service safe?

Our findings

Some relatives told us that people were safe at Jasmine Court. One relative said, "[Person using service] is difficult to manage but I feel they are safe here. They [staff] let us know if any health concerns, if [person] had a fall they let me know." Another relative said, "Yes, they are safe, [person using service] hasn't absconded." They went on to say that they had absconded when they had been in hospital. Staff told us that they felt that people were safe at the home because they cared for them. One member of staff said, "Yes, we look after them well, we all communicate with each other." Staff we spoke with were knowledgeable about the signs of abuse. However, some staff were not confident to report abuse because they were not confident that their identity would be protected. One person said, "There is no whistleblowing because everyone will find out who said it."

People were not supported by sufficient numbers of staff to keep them properly safe and to meet their needs in a timely way. A person using the service told us, "I am not doing very well at the moment. I call for people to come and they don't." Another person said, "They could do with more staff. They [staff] are always rushing around but never complain." Staff themselves had mixed views about staffing levels. One member of staff who frequently worked night shifts told us they felt staffing levels at night were adequate. Some staff said, "We can manage." referring to occasions when there were no replacement to cover staff absences. However, other staff told us that there were not enough staff to provide safe levels of care. One said, "Sickness is not covered by bank or agency [staff]. We are stretched to the limit. We are often asked to cover but we cannot because we are tired." Another said that "More recently we have lost some staff. Everyone is running around like headless chickens. It is worse in mornings; we have lots of falls and a lot of skin tears and bruises." And another member of staff said "We are severely understaffed for the clientele - the day shift on the ground floor needs at least six members of staff" and "More staff needed especially in ground floor."

The provider had determined the staffing level and mix that was required at Jasmine Court to meet people's needs but did not always ensure that this level was met. For example in the week prior to our visit this level had not been achieved on half of the morning, afternoon and evening shifts. However staffing levels on night shifts had been maintained at the level determined by the provider as had the number of registered nurses. To maintain the required level of registered nurses the registered manager needed to be available to provide nursing support on most days. .

People did not always receive the support that met their assessed needs. Staff told us that they were not always able to provide the support that people needed or support them in the way that they preferred to receive their support because they didn't have sufficient staff numbers to do this. One member of staff told us, "Few months ago, I worked on middle floor with two staff and we had two people who required 1:1 support."

One person required observation every 15 minutes to ensure that they were safe. On the day of our visit we noted that this person had not been observed for at least 45 minutes. We also saw from a relative's complaint that a person who was being funded for 1:1 care due to their very high sensory and mental health needs was not receiving this support when their relative visited. The provider had explained that there had

not been enough staff on that day to provide the required 1:1 care.

These issues and others related to the effectiveness of the service constitute a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's had individual risk assessments where they had needs that may have been associated with falls, developing pressure ulcers, nutrition and choking. There were also risk assessments for the provision of hot drinks and bed rails. Records we reviewed showed that staff took necessary steps to investigate falls and identify possible preventative actions. People's records included their personal emergency evacuation plans which identified people's support needs in the case of emergency evacuation of the building.

The provider did not ensure that equipment people needed was safe for their use and that it was used in a safe manner. One person required a special pressure relieving mattress to ensure safe wound management. Without this mattress there was a high risk to their physical health following a hip replacement. This mattress had been recommended by a specialist tissue viability nurse and the risks to this person were clear in their care records. The mattress was fitted with an alarm which would be triggered if it was faulty or if it was not maintaining the right settings to support the person correctly. This person was in bed when we arrived for our visit, the alarm was sounding and the unit was registering a fault. This person was still in their bed and the mattress alarm was still sounding four hours later and we noted that the mattress was flat in the area which was designed to support this person the most.

This person also required observation every thirty minutes due to a risk that they may have harmed themselves. Records showed that hourly observations had been carried out in the four hours that the alarm had been sounding but staff had not responded to the fault with the mattress. This person's care plan clearly recorded that the mattress required checking to ensure that it was not faulty and was in proper working order and the risks associated with it not being in good working order were also clear in the records. The provider had failed to ensure this person's safety. We brought this to the attention of the registered manager who arranged for the mattress to be repaired and for the person to be moved to a chair.

We observed that sensor mats were in place in a large proportion of the twenty three rooms on the top floor and that these were plugged into the call bell unit. There were no adaptors in place to allow a call bell to be used in addition to the sensor mat. The registered manager told us that there were adaptors available to ensure these people could use their call bell as well as sensor mats. However, we did not observe any were in use in people's bedrooms. This meant that the people who had sensor mats that were plugged in were unable to use the call bell if they required staff assistance.
We also saw that a person who spent most of their time in their bedroom did not have their call bell plugged in or within reach to be able to call for assistance. They told us, "I have to wait for staff to pass and I call out if I need support." This meant that this person was at risk due to not being able to call for assistance when they required it. We brought this to the attention of the registered manager who checked and plugged in the call bell.

People received their medicines as prescribed by their doctor. We saw that people's medicines were stored safely and disposals were completely following current guidelines. The provider has effective systems for managing and administrating people's medicines. The provider had good practices to ensure that people had sufficient supply of medicines. Only nursing staff administered people's medicines and they used a 'communication board' to pass information to other nursing staff about any changes in people medicines.

Requires Improvement

Is the service effective?

Our findings

Staff received training prior to commencing their role. They told us that they completed a three day mandatory training which included safeguarding and meeting the needs of people with dementia. They also had additional training in manual handling to support people with their mobility needs. Some staff told us the training was sufficient for their needs. Other staff told us that they required further support with training.

Staff did not always have the necessary support they required to carry out their roles. Staff told us that they did not have access to supervision meetings with their manager for support to discuss their practice. At supervision meetings, staff and their manager can discuss the staff member's on-going performance, development and support needs, and any concerns. One member of staff told us, "I haven't had one [supervision] in over a year. I was supposed to have an appraisal but that didn't happen." Another staff member said, "I've been here two years and have not had any appraisal or supervision." The registered manager was not able to provide records of any formal staff supervision although there were records referencing that concerns had been dealt with through staff supervision. They said the supervisions referred to in those records were verbal support to staff.

We observed a variation in staff skills to support people's mobility needs and to communicate with people with behaviour that may challenge others. We saw some staff were measured in their support to people and communicated effectively with them. We observed other staff who did not engage with people and they responded to them either with little or with abrupt communication. On the top floor, we observed staff use unsafe techniques while supporting a person to transfer from a chair. We saw other staff in the ground and middle floor support people safely with their mobility needs. We also observed that people were moved between the lounges across each unit at every meal time. Staff we spoke with did not understand why they were required to do this. One member of staff said the system was implemented whilst they were on leave and did not understand why. One staff member told us, "[Moving people between lounges] upsets and agitates the service users, this tires the staff out as well." After our inspection, we spoke to the registered manager about this and they said this system was to give people a change of scenery. They said that they would cascade their reasoning for this down to staff.

The provider could not be assured that people's care and support were provided in line with legislation and guidance. The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. We reviewed records that showed that staff had received training in MCA. However, staff we spoke with had a poor awareness of it and how it related to their roles. They told us that they were unsure as to the extent of their responsibilities when someone was refusing care. Records we reviewed showed inconsistency in how staff recorded their assessment of people's mental capacity to make their own decisions. For example, one person's records included evidence of a mental capacity assessment and best interest checklist for the use of a sensor mat. Other peoples' records included mental capacity assessments which covered the whole of a

person's care and support needs and although a best interest checklist had been completed the actual decision was not documented.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The provider had made DoLS applications for people who required them.

There were not enough staff to meet people's needs in a timely way and keep them safe from harm. Before our inspection, we received information of concerns that people's needs were not met at Jasmine Court due to low staffing levels. Relatives told us that the service required more staff especially at meal times. They all told us that people did not receive the required support to meet their nutritional needs. They said that they visited the home to support their relatives to have their meals because they were not enough staff to offer them this support. One relative said, "Staff are so busy and running around." They went on to say that they came in at lunchtime each day to assist their relative with their meal as they took a long time to eat their meal and they felt staff did not have sufficient time to spend with them to make sure that they had enough to eat. Another relative also told us they visited daily in order to feed their relative. They said, "I come in to feed [person using the service] because I know staff haven't got the time. I can't have a break, I'm burned out."

People did not receive the support they required to meet their nutritional needs in a timely manner. Due to the complex needs of the people using the service, we were only able to speak to one person about their meals. This person said that they liked the food. One relative said, "I worry about [person using service] getting enough nourishment. I come in to feed [person] because I know staff haven't got the time to feed him. It takes me up to 40 minutes to feed him and I know that they don't have the time to do that. The food has been atrocious sometimes, carrot soup on day one and on day two they had mashed potato with yesterday's carrot soup." Another relative said, "They [staff] do their best. I don't think there is enough of them, there's a lot of people who require feeding. They [people using service] have a variety [of food]. It's what I would call school meals.

Staff and relatives told us that they were not confident that people who required a vegetarian or pureed diet received nutritionally balanced meals. A member of staff told us, "I think they need to change the menu because the service users get bored, one week they had three casseroles, different meats! A lot of the times, the pureed diet is pureed beans or mash potato." A member of the kitchen staff told us, "one [person using service] is vegetarian – liquidised, we do carrots and green beans and vegetarian gravy – this is where protein is from." We asked if other forms of protein were used to prepare vegetarian meals, and they replied "No." One the day of our inspection, one relative had brought in a meal for their loved one. They said that they did this because their relative was a vegetarian and they were not confident they were always given vegetarian food. They required a pureed diet and they said they had been told the gravy was vegetarian. They said there was little variety and they appeared to have mashed potato and gravy most days.

We observed that most people required support to eat their meals. We saw that there were not sufficient numbers of staff to provide this support. We saw that although there were some relatives supporting their loved ones with their meals, other people had long periods of waiting for staff to be available to support them. During lunch and tea times, we saw that some people waited for up to 50 minutes before staff were able to support them with their meals. Some people had their food in front of them without the necessary support to eat the meals. Others waited for staff to be available before their meal was served. A relative said, "At meal times food is put in front of them [people using the service] but not enough time is spent with them to help them." They went on to say, "[Person using the service] pick what they want. I was there one day

when [person] didn't want what they had chosen, and they went without a meal. Staff said they would get them a sandwich later but I don't know when this would have been." Staff told us that they struggled to provide the support that people required. In relation to providing adequate support with meals one member of staff said, "Sometimes it gets too much." Another staff member said, "We are still feeding breakfast past 10 am and then lunch is by 12, and they wonder why people are not eating."

This meant that there was a risk that people, especially those without additional support from their relatives, would not always have adequate support that they required to meet their nutritional needs.

People's records included nutritional risk assessments and care plans of support they required to maintain their nutrition. We saw that speech and language therapists and dieticians had been involved when concerns were identified. The care records of people we reviewed showed people had been weighed regularly and there were no sudden changes in their weight. The kitchen staff we spoke with told us the nurses completed a 'likes/dislikes/allergies/type of diet' sheet which guided them when they prepared people's meals. They gave us examples of how they applied this information. They said, "One resident on ground floor can't have much cream – so we do her soup first, then do rest.

People were promptly referred to health care services when they required this. Relatives we spoke with said staff identified people's health issues and obtained medical advice where necessary. They told us staff had informed them when their relative had become unwell which necessitated a visit from their GP. One relative said, "They have appointed leaders at each shift. They are very competent. The nurses are willing to listen. They call the doctors or nurses when necessary." Records we reviewed show that people were referred promptly to health professionals. There was good support to the home from health professionals. GPs from the local surgery visited people twice a week. We spoke to a visiting GP who told us that they also used their visits to identify any person whose health needs would require further monitoring over the weekend, and ensured that they made arrangement for weekend support to meet such needs. They told us that staff were good at taking observations and would make prompt referrals when people needed medical support. They said, "Staff will not only refer ill-health but will give 'obs' which is good." We spoke with a student nurse who was on a placement at the service. They said, "I have been involved in GP rounds and now to get to know medications. I'm really enjoying it here."

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that was responsive to their individual needs. Where individual needs and preferences were known they were not consistently responded to. Care plans we reviewed did not consistently include person centred information that reflected the needs of the person. We saw that some care plans were detailed and contained good information about the person and their preferences, and others didn't include such information. For example, one care plan was very generic and it was difficult to identify the person's actual needs from their care plan. There was no information about the person's preferences in relation to different aspects of their care.

Care plans had all been reviewed monthly. However, we saw that people's assessments were not always updated to reflect the care they required or received. For example, one person's records said they required the assistance of one staff to mobilise and when we talked with staff they said this person now required two staff to support them with their mobility needs. A male member of staff told us they worked on a night shift with only one female member of staff on shift. They said this meant that male staff had to provide support to people who had stated that they preferred to receive their support from only female carers. The carer told us that they raised this with senior staff who told them to go ahead and provide support to such people irrespective of their wishes.

We reviewed records of complaints to the provider which showed that people did not always receive the support that was reflected in their care records. One example was a complaint from a relative that said their relative's care charts indicated they had eaten one hundred percent of their pudding at a meal time. However, the record was made when the person was still eating their pudding.

We observed that there was limited interaction between staff and people who used the service. We saw that although most staff were kind to people, they engaged with people sporadically and provided support in a task orientated manner. We saw that the provider had provided a dementia friendly environment with a sensory room, sweet shop and dementia friendly corridor where people could reminiscence. However, people were not supported to use these facilities. We did not observe staff provide social stimulation to people. One relative told us that they visited the home daily, and that their relative was bored. They said, "They don't have activities. [Person using service] gets frustrated, they need to be doing something. Every time I come to visit, they are sitting in their room or in the lounge." Another relative told us, "I think they [staff] are caring. I think they get very stressed."

During our inspection, we saw that at tea time a member of the kitchen staff presented a person with a birthday cake to celebrate their birthday. However, this person said, "Oh dear, I am a Jehovah's Witness. I do not celebrate my birthday or Christmas. I never have since I was a child. It looks very nice can you give it to other people please." We observed that the person had repeatedly talked about their religion throughout the day. This meant staff did not apply people's information and history in the delivery of care and support and lacked understanding of people's diversity.

The provider had opportunities for staff and relatives to raise their concerns. We saw that the provider had

displayed their complaints procedure. Relatives told us that they would raise any concerns they had with staff or the registered manager. They said that staff sought to address their concerns. One relative said, "They [staff] have always been good and sorted it." Another said, "I think they all do remarkably well with staff they've got and diversity of residents." They went on to say that they would speak to the registered manager should they have any concerns. Another relative told us about an incident that had occurred which they were happy with the way the registered manager dealt with the issue. They said, "I am happy with how it was dealt with. Staff got fired."

Staff told us that if someone wanted to make a complaint they would ask them to speak to the manager. We reviewed records of complaints received since January 2016. We saw that the service had received ten complaints in that period. The records included responses to the complaints and they indicated that action had been taken to address the complaints.

Relatives and staff also had weekly opportunities to meet with the registered manager to discuss any concerns they may have. A relative told us there was a meeting every Friday from 4pm to 6pm and they could attend this if they had any concerns. They said, "The manager always says if there are concerns we can go and speak with her." We also reviewed records of relatives meetings. There were however mixed views on the value of this meeting. One relative who attended the meetings told us, "My opinion is that they are worthless. It's not been built as a forum between the relatives and the home. I'm not sure of the purpose of it. All they are doing is paying lip service. Just like they do at the office when you complain about staffing."

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 18 HSCA RA Regulations 2014 Staffing Staffing levels were not sufficient to meet people's needs. The provider had not ensured that staff received appropriate supervision and appraisal as necessary to enable them to carry out their duties.