Westfield Care Limited

Jubilee 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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Jubilee Court Nursing Home is a care home which provides residential and nursing care for up to 100 people. Care is primarily provided for older people, some of whom are living with dementia. At the time of this inspection 68 people were using the service.

People's experience of using this service and what we found
Robust systems were not currently in place to ensure that when an accident or incident occurred, the registered manager had enough oversight to review whether actions taken by staff were effective. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff training was not fully up to date. The registered manager's understanding of duty of candour legislation was limited.

We have made a recommendation to the provider to improve their understanding of the management of people's medicines within a care home setting.

People received care and treatment that kept them safe. The risks to their health and safety were appropriately assessed and acted on. Detailed and robust processes were in place to reduce the risk of people developing pressure sores. People were protected from the risk of abuse and neglect. Staff were recruited safely and there were enough staff in place to keep them safe. Where an incident occurred, staff acted quickly to make people safe. Robust procedures were in place to reduce the risk of the spread of infection.

People felt able to discuss any concerns they had with staff and the management. Staff understood the requirements of their role and they felt supported by the management. Effective working relationships had been formed with other health and social care agencies. They worked together to provide safe care and treatment that met their individual needs.

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

Rating at last inspection
The last rating for this service was Good (published 3 July 2019)

Why we inspected
The inspection was prompted in part by notification of a specific incident. Following which a person using the service died. We inspected this service at the request of the Nottinghamshire Coroner to ensure that there was no on-going risk of harm to others. The information CQC received about the incident indicated concerns about the management of pressure care and accidents and incidents. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the Well-Led section of this full report.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.
You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our safe findings below.

Jubilee Court 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors and a specialist advisor (nurse).

Service and service type
Jubilee Court 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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.

Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We asked them if they held information about this service. We used all this information to plan our inspection

During the inspection
We spoke with three people who used the service and asked about their experience of the care provided. We spoke with 16 members of staff including, the registered manager, home manager, deputy manager, nurse, senior care workers, care workers, head of housekeeping, domestic assistant, activities coordinator, cook and kitchen assistant.

We reviewed a range of records. This included parts of or all care records of 13 people; we also looked at the medication records for 23 people. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
The home manager provided additional records as required. These were sent to us within the required timeframe. We reviewed these documents such as training data and quality assurance records away from the home and used these to support our findings of the inspection.

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 good. At this inspection this key question has now changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- The system for recording the support people received with their medicines was not consistent and increased the risk to people's health.
- Records showed that three people received medicines that were prescribed on 'as needed' basis. These people had received these medicines every day up to the maximum dosage for two continuous weeks. A review of their medicines and care plans had not been completed to establish if alternative methods could have been used rather than the continued use of these medicines. It is important to ensure that alternative options are considered, to ensure that people are not medicated unnecessarily. The registered manager told us they would address this.
- Where people received their medicine via a transdermal patch there was a rotation chart in place for staff to record the administration site. This is important to ensure that the same site is not used repeatedly as this can reduce the effectiveness of the medicine. The actual number of sites to be used for full safe rotation was not stated. The chart also required staff to record the removal of the previous patch to avoid the risk of overdose. This had not been completed. After the inspection we received a revised version of the records used to record this process. This will help to reduce the risk to people's health.
- We reviewed the records of three people who received their medicines covertly. There was a letter from the GP attached to their medicine administration records which stated that medicines had been authorised to be given covertly. However, there was no assessment of the person's capacity and best interest decision documentation had not been completed. This is important to ensure the person's rights are respected and decisions made on their behalf are appropriate.
- After the inspection we received a revised process which showed that MCA assessments had been completed for those that needed them and would be completed for others when required.
- We also found no evidence that a pharmacist had been consulted on the appropriate and safe method for covert medicine administration. This is important to ensure that staff prepare covert medicines in a way that does not alter their effectiveness.
- Medicines were not always stored appropriately. We noted 'Thickener' was stored in an unlocked cabinet and did not have the person's name on. Eye drops and liquid medicines were not always dated when opened. Medicines were stored in a locked room; however, some medicines were stored in unlocked cabinets within that room. It is best practice to secure all medicines within the locked room as an extra safety precaution. The registered manager told us they would address this.

We recommend the provider reviews the National Institute for Health and Clinical Excellence (NICE) guidelines on managing medicines in care homes.

●We observed staff administer people's medicines safely.

Learning lessons when things go wrong
●Although accidents and incidents were investigated and acted upon to reduce the risk of recurrence the registered manager did not always have oversight of this.
●Basic analysis of the themes for each accident were recorded; however, it was unclear how this information was used by the registered manager to reduce on-going risks to people's safety.
●Where referrals were needed to specialist teams such as the Local Authority's 'Falls Team' these were completed quickly, and actions recorded to show progress.
●Where staff had made errors and lessons needed to be learned, these were discussed during supervisions and team meetings.

Preventing and controlling infection
●Measures to prevent the spread of infection including COVID-19 were robust and effective.
●Staff understood what was required of them to reduce the risk of the spread of infection.
●Sufficient numbers of domestic staff were in place and they were observed continually cleaning the home, particularly higher risk areas such as; door handles, handrails, tables and chairs. This helped to keep people safe from the risk of infection.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date

Systems and processes to safeguard people from the risk of abuse
●The risk of people experiencing abuse and neglect was reduced because the provider had processes in place to protect people from harm.
●Throughout the home people, staff and visitors were provided with information about how they could report concerns of abuse or neglect.
●Processes were in place to ensure that the local authority safeguarding team were notified of any concerns. Thorough internal investigations were completed where required to ensure any concerns were acted on to reduce the risk of people experiencing abuse or neglect.
●Most staff had completed safeguarding adults training. The registered manager told us they would ensure all required staff completed this training as soon as possible.

Assessing risk, safety monitoring and management
●The risks to people's safety were appropriately assessed and acted on.
●People told us they felt safe and that staff understood their health needs and how to reduce the risk of them coming to harm.
●Following the incident that had occurred in 2020 (as referred to in the 'Summary' section of this report), an improved process for identifying pressure sores early had reduced the risk of people experiencing avoidable harm. There was now a clear process that staff followed to act quickly when pressure care risks were

identified. Staff spoken with understood this process.

●Documentation was now in place to help staff to identify a wound, assess it and to put appropriate measures in place to reduce the risk of it worsening. All records viewed showed this process was effective and pressure care management was completed well, reducing the risk of people experiencing avoidable harm.

●Individualised evacuation plans were in place to help staff and emergency services to evacuate people safely. These documents were stored within each person's care records. We highlighted that it would be good practice to store copies of these together to enable staff and emergency services to have quick access to all people's records in an emergency. This was completed during the inspection.

●Fire risk assessments, servicing of gas installations and testing of electrical equipment was carried out within the required timescale. The home was free from obvious hazards. Equipment was stored safely, and the outside spaces were well kept and safe. This helped to keep people safe.

Staffing and recruitment

●People told us there were enough staff in place to provide the care they needed.

●We observed were enough suitably experienced and qualified staff were in place to keep people safe. When people required support in their bedrooms, communal areas or walking around the home, there were enough staff in place to do so.

●Staff responded quickly to call bells. Analysis of call bell response times for the six weeks prior to the inspection showed over 95% of calls were responded to within three minutes. Our observations throughout the inspection supported this. The timely response to call bells helps to keep people safe.

●Robust recruitment procedures were in place to reduce the risk of people being cared for by inappropriate staff.

Requires Improvement

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 good. At this inspection this key question has now changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems that were currently in place to review accidents and incidents were not fully effective.
- We carried out a review of all documentation relating to incidents that had taken place during November and December 2020. We noted an incident form had been completed by the staff member involved and then actions were put in place to reduce the current risk to the person and to reduce further recurrence.
- On each form there was a section for the 'manager' to complete to show they had reviewed the form and to sign it to say they agreed with all actions. 37 forms were looked at during the inspection and all 37 had not had manager sign-off. This meant that whilst staff had acted, their chosen action had not been reviewed, as required on the provider's form. This could increase the risk of inappropriate actions being taken by staff and increase the risk to people's safety.
- In light of the circumstances regarding the incident referred to in the 'Summary' section of the report, this was a missed opportunity for robust oversight and management of incidents that had occurred at the home.

The failure of the provider to ensure that sufficient reviews of incidents was carried out and recorded has resulted in a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After the inspection the registered manager showed us the revised process which will ensure that all incidents received a robust and recorded management review.
- Positive action had been taken to address the risks related to the incident in 2020. A new position of a 'Unit Manager' was now in place. On each unit of the home the Unit Manager was responsible for the day to day management of their respective units, reporting concerns to the registered manager where required.
- The registered manager told us this extra level of management had significantly helped with the reviewing of care plans and risk assessments as well as giving staff an additional person they could refer concerns to. This was especially effective at weekends, when there were occasions when senior management were not at the home. This meant action was taken quicker to reduce the impact of any emerging risks to people's safety.

Continuous learning and improving care

- Staff received a regular training programme in courses deemed mandatory by the provider to enable them

to carry out their roles safely and effectively. We did note there were some gaps in some areas of training such as; 'deprivation of liberty safeguards', 'react to moisture' and 'record keeping'. The registered manager assured us they would address these gaps with staff concerned immediately

●Action was taken to ensure that the provider, management and staff continuously sought ways to learn and to improve the quality of care people received.

●Regular staff meetings were held to enable staff to raise concerns but also discuss positive performances and actions by specific staff members. Staff were encouraged to participate fully in structured supervisions and feedback was provided on how performance could be developed and improved. Outstanding staff performance was rewarded with a certificate and a gift voucher.

●Weekly 'unit manager meetings' were carried out to ensure that any issues identified within each unit were discussed with senior managers. Actions were in place to ensure that recommended actions following these meetings were completed.

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

●The registered manager and home manager had a limited understanding of duty of candour legislation. During the inspection we discussed this with them and reminded them of their responsibility to ensure that if mistakes occurred, they investigated them fully and apologised to the people affected.

●The registered manager told us they did do this but would review policies and procedures to ensure that documentation was in place to carry out this legal requirement where needed.

●This will help to improve people's experiences of the service and to assure them that their concerns were acted on

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

●People told us they enjoyed living at the home. They liked the management and felt empowered to raise any concerns they had. They felt issues raised would be appropriately acted on.

●People were encouraged to give their views about their care. People told us they felt comfortable discussing their care with staff who listened and were genuinely interested in what they had to say.

●Our observations throughout this inspection found people were well cared for, well presented and were cared for by knowledgeable staff.

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

●The provider had made efforts to provide people, relatives and staff with suitable forums to give their views about the quality of the care and areas for improvement and development.

●A 'resident' meeting was held regularly. Minutes of recent meetings showed the impact of COVID-19- had been discussed with people; ensuring they were kept fully informed of the actions being taken by staff to keep them safe. Safe visiting procedures were in place to enable people to see their relatives in a COVID secure environment.

Working in partnership with others

●Effective working relationships were in place with other health and social care agencies.

●A weekly meeting was conducted with the local GP, district nurse and the community matron, to discuss people's care and actions that could be taken to maintain a high standard of care.

●Regular meetings were held with social workers, the local Clinical Commissioning Group and family members. These meetings review people's care to ensure that the appropriate funding was in place to continue provide them with the safe care and treatment they needed.

●System were in place that ensured during the COVID-19 pandemic, these meetings could continue by using appropriate technology. This meant people's care was not affected as a result of the pandemic.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The failure of the provider to ensure that sufficient reviews of incidents was carried out and recorded has resulted in a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17 (1) (2) (c)