INSPECTION REPORT

Lakeside Care Home

Care Home Service

La Rue de La Commune
St Peter
JE3 7BN

15 October and 17 December 2020

THE JERSEY CARE COMMISSION

Under the Regulation of Care (Jersey) Law 2014, all providers of care homes, home care and adult day care services must be registered with the Jersey Care Commission ('the Commission').

This inspection was carried out in accordance with Regulation 32 of the Regulation of Care (Standards and Requirements) (Jersey) Regulations 2018 to monitor compliance with the Law and Regulations, to review and evaluate the effectiveness of the regulated activity and to encourage improvement.

ABOUT THE SERVICE

This is a report of the inspection of Lakeside Care Home. The service is situated in St Peter and is within proximity to another care home, also operated by the same service provider. Lakeside Care Home provides nursing and personal care services to people over the age of 55 years of age.

Accommodation is provided over two floors with communal facilities provided on both floors. The ground floor accommodation primarily supports care receivers who have personal care needs and the first floor for those with nursing care needs. To the rear of the home is a large lake which most of the bedrooms overlook. The front of the home is currently laid with tarmac for parking and the home is fully wheelchair accessible.

Since the last inspection, the provider has appointed an interim manager and a new deputy manager. Plans are underway for a permanent manager to be appointed.

Registered Provider	Lakeside Residential Home Limited
Registered Manager	Rosie Goulding (interim manager)
Regulated Activity	Care home for adults
Conditions of Registration	Nursing care can be provided to 35 care receivers Personal care can be provided to 31 care receivers Category of Care is Old Age Age range of care receivers is 55 years and over
Dates of Inspection	15 October 2020 17 December 2020
Times of Inspection	8:40am – 11:45am 1:00pm – 4.30pm
Type of Inspection	Unannounced on 15 October 2020 Announced on 17 December 2020
Number of areas for improvement	None

At the time of this inspection, there were 58 people accommodated in the home.

SUMMARY OF INSPECTION FINDINGS

A focused inspection was undertaken to check whether the provider had taken action to meet the areas for improvement that were identified during the inspection in July 2020. This inspection was completed over two separate visits and concluded on 17 December 2020.

The first was an unannounced visit carried out by one Regulation Officer and Senior Pharmacist employed by Health and Community Services on 15 October 2020, and the second announced visit took place on 17 December 2020. The interim manager was given less than 24 hours' notice that the second inspection was to take place, which was in view of the vaccination programme that had taken place in relation to the Covid-19 pandemic. The Regulation Officer gave due consideration to the home's infection control measures which were necessary due to Covid-19.

The Standards for care homes were referenced throughout the inspection[1] and the Regulation Officer focussed on the following areas:

- the service's Statement of Purpose and Conditions on registration
- safeguarding (adults)
- complaints
- monthly quality reports.

Since the last inspection, there have been some changes to the home's managerial arrangements. An interim manager and deputy manager have been appointed and the provider has given an assurance that a permanent manager will be appointed at the earliest opportunity. The provider has maintained contact with the Commission since the last inspection. The interim manager is providing leadership and guidance to the staff team and is familiar with the home and the provider's policies and procedures.

Arrangements for safeguarding care receivers is a strong feature of the home. This was evidenced by improved and sustained improvements in relation to practices around medication management. The practices relating to the management of medicines that were evident during the previous inspection, have significantly improved. Nursing staff explained that medication administration processes have been a key focus of attention over the last few months to improve and maintain the safety of care receivers.

Appropriate and adequate infection prevention and control procedures are in place in relation to the Covid-19 pandemic and during both inspection visits, all staff were observed adhering to infection control principles. At the time of the second visit, visiting had been suspended due to Government of Jersey advice. Staff spoke of the ways in which care receivers had maintained contact with their representatives

[1] The care home standards can be accessed on the Commission's website at https://carecommission.je/standards/

and expressed compassion and empathy in respect of the difficult circumstances the visiting restrictions had brought.

During both visits to the home, care receivers were observed making use of the communal areas and interactions heard were noted to be good humoured, respectful and caring. On the second inspection visit, the home had been pleasantly decorated with Christmas decorations and care receivers were noted to be enjoying a party in the lounge, with physical distancing measures in place.

Nursing staff described the efforts that have been taken to ensure that a good quality and safe service is provided and the approach to quality monitoring has positively affected care receiver's health and wellbeing. There were noted reductions in the incidence of pressure ulcers in the home and evidence that care receiver's wishes and preferences in relation to managing and directing their care completely respected.

There are no areas for improvement identified from this inspection.

INSPECTION PROCESS

Prior to the inspection visit, information submitted to the Commission following the last inspection in July 2020, was reviewed. This included any notifications and all correspondence submitted to the Commission from the provider. A review of the findings from the previous inspection, which was completed on 8 and 16 July 2020, also formed part of the pre-inspection preparation and planning. Written correspondence between the provider and the Commission since the last inspection took place, and communications between the interim manager and Regulation Officer were also reviewed in preparation for the inspection visit.

Commission staff met with the provider's representatives at the Commission's offices on 23 September 2020 to discuss the July inspection outcomes, the recruitment for a new manager and the progress of the investigation of a complaint that was underway.

The Regulation Officer did not directly engage with care receivers during the inspection visits on account of the pandemic, and to reduce unnecessary risks to care receivers, but was able to observe and listen to interventions and interactions between care receivers and staff. However, the interim manager, three registered nurses and two members of care staff were spoken with during both visits.

During the inspection, documents including, medication administration records, the medication policy, complaints log and a sample of care records were examined. At the conclusion of the inspection, the Regulation Officer provided feedback to the interim manager.

This report sets out the findings of the inspection and includes areas of good practice which were identified. There are no areas for improvement identified as a result of this inspection.

INSPECTION FINDINGS

The service's Statement of Purpose and Conditions on registration

The care home service's Statement of Purpose was reviewed prior to the inspection visit. The Standards outline the provider's responsibility to ensure that the Statement of Purpose is kept under regular review and submitted to the Commission when any changes are made.

The inspection found full compliance with the mandatory conditions on registration. The provider confirmed through correspondence with the Commission that the mandatory conditions of registration relating to the category of care are to remain unchanged.

During the meeting between Commission staff and the provider on 23 September 2020, the provider acknowledged the need to recruit and appoint a permanent registered manager. At the time of inspection, the interim manager explained that plans were underway to recruit and appoint a permanent manager.

Prior to the inspection, the interim manager informed the Commission of the successful recruitment of additional registered nurses into the staff team. Their employment into the home has been delayed to some extent, which has been due to travel restrictions imposed by the pandemic. Since the last inspection, a new deputy manager who is a registered nurse has been appointed and was present during the second inspection visit. There is one vacancy for a registered nurse for which recruitment is ongoing.

A discussion with two registered nurses during the second inspection confirmed that they had full knowledge of their roles and responsibilities and described the importance of overseeing aspects of care delivery and of supervising health care workers. They spoke positively of the provision of care to care receivers and the efforts made in terms of improving medication practices. They described regular assessments of care receivers' needs that had resulted in some care receivers transferring into nursing care so that their health needs could be better met.

Staff members who were spoken with, also described the efforts they had made as a team, in terms of focusing on ways to prevent care receivers from developing pressure ulcers. Staff confirmed that there were no care receivers with pressure ulcers at the time of inspection.

Staff also spoke of the efforts they had made in terms of establishing information about care receivers' past life events to build personal biographies to include as part of their care records. An example was provided which explained that one care receiver's level of communication and interaction with staff had improved as a result of staff having a better understanding of their life story.

During both inspection visits, the Regulation Officer observed care receivers being supported by staff with various aspects of their care. During the second inspection visit, which coincided Government of Jersey guidance which advised that visitors

should not visit care homes, care receivers were heard laughing and joking with staff. It was also noted on that day a social event was held in the communal lounge which care receivers attended with physical distancing measures in place.

The care home service is, as part of the registration process, subject to the following conditions:

Conditions of Registration	<u>Mandatory</u> Maximum number of care receivers: 66 Number in receipt of nursing care: 35 Number in receipt of personal care: 31 Age range of care receivers: 55 years and above Category of care provided: Old Age Maximum numbers of care receivers that can be accommodated in the following rooms: Bedrooms 1 – 12 and 14 – 28 to provide personal care - one person Bedrooms 31 – 69 to provide personal or nursing care – one person <u>Discretionary</u> There are no discretionary conditions.

Safeguarding (adults)

The Standards for care homes set out the provider's responsibility to ensure that care receivers feel safe and are protected against harm. This means that service providers should have robust safeguarding policies and procedures in place which are kept under review. Staff working in the service should be familiar with the safeguarding arrangements and should make referrals to other agencies when appropriate.

Prior to the inspection, the Commission received a copy of a safeguarding alert that had been raised by an external health professional which provided details about one care receiver in the home. The nature of the concerns had in fact been identified some weeks earlier by the interim manager, at the time of the care receiver's admission to the home. The interim manager notified the Commission of the care receiver's health condition and physical condition at that time. The safeguarding alert was not progressed through the safeguarding route. The Commission has been provided with the outcome of the clinical nurse specialist for tissue viability's overview which concluded that the home provided relevant and appropriate care to the individual.

During the inspection, the opportunity was taken to review the care receiver's care records which showed that, on admission to the home, assessments were recorded, and clinical photographs taken to evidence the care receiver's physical condition. The care records also showed that the care receiver's contribution to managing their

health and requests for treatment were fully respected and acknowledged. This was reflected in the summary provided by the clinical specialist nurse also.

The Commission received concerns from an anonymous source detailing allegations of poor care practices in November 2020. These concerns were shared with the interim manager, who explained that they had not been made aware of such allegations. The interim manager investigated the concerns and provided the Commission with a comprehensive response, which refuted the allegations. The Regulation Officer was satisfied with how the concerns had been explored.

The interim manager had good oversight of risks and awareness of care receivers' care and support needs. A discussion with one registered nurse, also confirmed that staff, including registered nurses and care staff, discuss significant changes or updates about care receivers during frequent handover. Two registered nurses, separately, in discussion reported they felt supported by the interim manager. Staff described an open culture of reporting and explained that they would not hesitate to bring any issues of concern to the interim manager's attention. Staff who were spoken with, had a clear awareness of the signs and symptoms of Covid-19 and identified a clear pathway to report any concerns they might have regarding care receiver's condition. The home is compliant in submitting incident and death notifications to the Commission as required.

One of the areas for improvement identified during the inspection of 16 July 2020, was in relation to improving certain aspects of medication practices. The Commission sent a letter of concern to the provider on 17 July 2020 informing them of the findings and requesting that the findings are addressed and that effective medication practices be implemented. The provider responded with an action plan to rectify the issues relating to medicine administration and gave an assurance as to how they planned to address the findings from the inspection.

The interim manager provided the Commission with updates regarding the action plan and submitted notifications where errors had been made in relation to medicine management.

An unannounced inspection was carried out on 15 October 2020 which focussed exclusively on medicine management. The inspection was carried out by one Regulation Officer and a Senior Pharmacist employed by Health and Community Services. It was positive to note the vast improvements in medicines management standards across the home in comparison to the findings in July. The records in place and discussions with staff at the time of inspection evidenced this. Care staff referred to the long-time taken to complete the morning medication round. This was raised with the interim manager who agreed to look into the issue.

During the December inspection, samples of care receivers' medication administration records were examined, which confirmed that there had been sustained improvements in medication standards in the home. This is encouraging to note and confirmed that medication administration arrangements are compliant with best practice and legislation. The interim and deputy managers explained that significant efforts had been made by all staff to ensure safe practice standards are in place. Staff advised the Regulation Officer that the timings of medication

administration are being discussed with some of the care receivers' GPs to ensure that they reflect individual preferences.

The home has not submitted any notifications relating to medication errors since 9 August, which would suggest that the home has made significant improvements in this aspect of care which correlates with the inspection findings.

During both inspection visits to the home, all staff were observed adhering to appropriate infection control measures including hand hygiene and the use of face masks.

On the second visit to the home, visiting had been suspended in line with Government of Jersey advice and robust screening protocols were in place upon entering the home, to reduce risks to care receivers. The Regulation Officer underwent a screening process on arrival at the home, which included temperature recording, showing evidence of Covid-19 status, and being requested to practice hand hygiene.

Complaints

The Standards for care homes set out the provider's responsibility to ensure that there are arrangements in place for the management of complaints. This means that care receivers should know how to make a complaint and what to expect if they need to make a complaint. The service's staff should be familiar with the complaints management procedures and service providers should closely monitor their implementation.

During the inspection in July 2020, the Commission had been made aware of a complaint that had been made regarding the care of a former care receiver. The provider investigated this complaint and acknowledged that some aspects of the care provided was below that which was expected and upheld the complaint and provided a response to the complainant. The investigation acknowledged that there were some actions identified in relation to improving performance. Progress with the completion of these action points was discussed with the interim manager during the December inspection, who confirmed that they had been actioned and addressed with the staff team.

A discussion with the interim manager during the December inspection, confirmed that they had identified an occurrence in the home where the provider's policy around the handling of personal possessions had not been adhered to. This happened before the interim manager took up post and whilst the care receiver's representatives had not raised this as a complaint, the manager recognised and identified shortcomings in the service provided. The interim manager had submitted a notification to the Commission when it was brought to their attention in October 2020 and was actively investigating the circumstances of the event at the time of inspection.

Monthly quality reports

The quality of services provided by this service should be kept under regular review. The Standards and Regulations set out the provider's responsibility to appoint a representative to report monthly on the quality of care provided and compliance with registration requirements, Standards and Regulations. The manager should be familiar with the findings of quality monitoring activity and any actions required to improve the quality of service provision.

The provider's system for regularly reviewing the quality of services was identified as an area for improvement during the July 2020 inspection. In view of the Covid-19 pandemic, the provider's review and verification of quality monitoring processes has been suspended due to travel restrictions. However, it is encouraging to note that the systems in place to monitor the quality and safety of the service are comprehensive and effective in identifying areas needing attention and improvement.

The interim manager explained that clinical and operational audits are used to monitor certain areas of care and support, some of which have led to improved outcomes for care receivers. One example was in relation to pressure trauma prevention where the outcome of recent review and analysis resulted in the provision of additional equipment necessary to prevent skin damage. The approach to quality monitoring has directly affected care receivers' health and wellbeing; there were noted improvements in the incidence of pressure ulcers in the home.

Assessments are completed to monitor weight loss, falls and skin integrity and the outcomes of these monitored by the provider's clinical governance team. The outcomes of these assessments are used to inform care planning.

As a result of the quality monitoring process in place, several carpets have been replaced and curtains in bedrooms identified in need of replacing. A discussion with the interim and deputy managers found that where harms occur, such as skin tears for example, discussions with the team will take place to identify and analyse whether there are any trends. The interim manager also maintains oversight of medication practices in the home.

IMPROVEMENT PLAN

There were no areas for improvement identified during this inspection and an Improvement Plan has not been issued.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of the Care Commission during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, Standards and best practice.

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