Inspection Report

Beaumont Villa

Care Home Service

Rue de Craslin
St Peter
Jersey
JE3 7HQ

8 & 9 August 2023

[1] The Care Home Standards and all other Care Standards can be accessed on the Commission's website at https://carecommission.je/Standards/

INSPECTION PROCESS

This inspection was unannounced and took place on 8 and 9 August 2023. Two Regulation Officers attended on both inspection dates.

The Care Home Standards were referenced throughout the inspection.[1]

This was a focused inspection which concentrated on the following lines of inquiry:

- **Follow up on issues raised following a recent safeguarding enquiry**
- **Follow up on communications received directly from, staff and relatives**

Prior to our inspection visit, all of the information held by the Commission about this service was reviewed. This included the previous inspection report, notifications, safeguarding inquiries and recent communications with the home.

During the inspection, opportunities to obtain the views of people who use the service was limited due to their diagnosis of dementia. However, the Regulation Officers were able to observe staff and care receiver interactions during the visits.

Before the inspection visits, recent feedback on the home had been received into the commission from a combination of, relatives and staff which was taken into consideration.

The inspection was facilitated by the Interim Manager. The Regulation Officers spoke directly to five staff members who held various roles within the home to receive their feedback.

During the inspection, records including policies, risk assessments and a sample of care records and care plans were reviewed.

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At the conclusion of both inspection visits, the Regulation Officers provided feedback to the Interim Manager about the inspection findings. Written feedback was also provided outlining the areas of improvement, with an opportunity for the Provider to respond. There was one further opportunity to discuss the inspection findings with the provider at a meeting held on 6 September 2023, before the inspection report was issued.

This report sets out our findings and includes areas of good practice identified during the inspection. Where areas for improvement have been identified, these are described in the report and an improvement plan is attached at the end of the report.

INSPECTION FINDINGS

This is a focused inspection report which sets out the findings for Beaumont Villa Care Home. The home is owned and managed by Aria Healthcare Group Limited. The report references the Jersey Care Commission, Care Standards, Care Homes (Adults), throughout[1].

A previous focused inspection was carried out in May 2023, two areas of improvement were identified during the inspection. The areas of improvement related to ensuring notifiable events are provided to the Commission, and an updated completion plan of the refurbishment works was to be submitted to the Commission, this was due to the delay in the commencement of the refurbishment. It was positive to find that both areas of improvement had been addressed. The Regulation Officer for Beaumont Villa had seen an improvement in the timely notifications being shared with the Commission since the inspection in May. The refurbishment of the communal areas of both Beaumont Villa and its sister home L'Hermitage had been completed prior to this inspection.

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This inspection was focused and unannounced following several concerns raised to the Commission. During the two inspection visits, areas of enquiry included recruitment, induction, training and management oversight of the home, maintenance of clinical equipment and pressure area care.

The inspection was completed over two days and took place on 8 and 9 August 2023. Two Regulation Officers on each day attended the home to complete the inspection.

Based on the findings of this inspection it was evident that there were nine identified areas of non-compliance to the standards.

The home has capacity for 24 care receivers; on the days of the inspection, there were 18 care receivers living in the home. The Interim Manager was available to facilitate the inspection. The Regional Director, Quality Support Manager and Chief Executive Officer for Aria Care were also available onsite. The Regulation Officers met with the Interim Manager at the beginning of the inspection, at intervals throughout, and at the end of the inspection to provide immediate feedback.

There was also an opportunity to see the completion of the recent refurbishment of Beaumont Villa and the sister home L'Hermitage. The Interim Manager facilitated a full tour of the home.

Feedback from four members of the care staff was collected during the inspection. Each staff member was seen individually in a private room. Feedback was also received from one member of the catering staff. Due to this being a focused inspection, the Regulation Officer's did not attempt to receive feedback from relatives. During the inspection, care receivers were approached to offer comments when asked about living in the home, it was difficult to receive feedback due to the nature of their diagnoses of dementia.

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Management arrangements

The home has an interim management arrangement in place, following the resignation of the Registered Manager in June 2023. A Regional Support Manager has been placed to oversee the operational running of the home. This position will be referred to as the Interim Manager throughout this report. A new Registered Manager has been appointed and is due to commence at the end of September 2023.

The Interim Manager has been present in the home from Monday to Friday. The Regional Director and Quality Support Manager have also been present intermittently to offer management support.

The Regulation Officers requested reassurance of management cover including, the weekends, up until the new Registered Manager commences their post.

A management rota was requested from the senior management team. This has recently been presented as additional information attached to the general staff rota.

Management Oversight

During the inspection it was recognised that there had been a lack of clinical oversight from the interim management team in some instances. This led to some care planning outcomes not being met.

Staff raised unresolved issues with some of their communication aides in the home. The Regulation Officers explored the concerns raised and found that a maintenance problem had not been resolved, this had temporarily created a barrier to care staff members being able to communicate between the two residential floors.

These incidences have highlighted that improvements in management oversight are required, specifically concerning communication and escalation. Standard 12.3 has not been met.

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Staffing

On the second day of the inspection, the Regulation Officers were informed that due to unforeseen staff sickness, three care staff were available that morning. Standard 3.9 of the Care Home Standards states that sufficient numbers of care/support workers will be available to meet the care and support needs of people in the accommodation. A staff member from the care team at L'Hermitage was redeployed to cover the shift and ensure that the minimum staffing levels of four carers was achieved. Reassurances were given that this did not impact the staffing levels at L'Hermitage.

During the inspection, it was highlighted that a number of the care staff on duty were required to also cover catering duties due to staff shortages affecting the catering staff, including the Chef and Kitchen Porters. It was confirmed by the Interim Manager that care staff had been covering duties such as washing up and serving food, additional to their caring roles. This arrangement impacted the wellbeing of the care staff, who reported feeling under pressure, and unable to concentrate on the tasks of their caring role while covering duties within other departments.

Furthermore, the Regulation Officers received feedback that additional tasks given to staff members who reported struggling to cover their own care work due to low staff numbers, was causing stress. This has the potential to impact adversely on the provision of care.

The Commission acknowledges that in exceptional circumstances, it may be necessary to see irregular practice; however, such practice should not become a regular occurrence.

Maintenance of Clinical Equipment

Part of the recent concerns highlighted to the Commission were that the medical equipment in use may not have been working correctly. At the time of the

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inspection, the management team could not evidence if regular maintenance checks had been completed on all medical equipment.

It was reported to the Regulation Officers during the inspection that the provider was finding it difficult to commission a contractor to maintain equipment in the home. This has the potential to affect the health and safety of both care receivers and staff. Standard 6.6 and 4.6 is not met.

Pressure Trauma Care

A recent incident raised questions about the clinical management of care receivers who have developed pressure ulcers. During the inspection the Regulation Officers sought evidence on how risks of harm from pressure trauma is minimised, managed, and monitored to achieve the best outcomes for the care receivers affected. The Regulation Officers inquired whether the home had adopted the 'Island Wide Pressure Ulcer Prevention and Management Framework'. The management team provided conflicting information as to whether this framework was utilised. It was not clear to the Regulation Officers how pressure trauma is assessed, managed, and how associated care is planned and delivered. Standard 4.7 is not met.

Escalation Processes

During the inspection the Regulation Officers sought evidence on the communication and guidance available to care staff to support escalation processes, and for staff to have an increased knowledge of recognising a deterioration in health care needs and conditions. It needed to be clarified to the Regulation Officers what actions the management team had taken to escalate the requested assessments of a particular care receiver. There was no evidence of the home having raised their concerns to relevant health professionals. Standard 6.2 is not met.

Care planning and Record Keeping

Care plans and record keeping were reviewed during the inspection. The home uses an electronic recording system for record keeping, including individual care

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plans for the care receivers. The Interim Manager advised that an essential care plan in place for a care receiver had not been completed for several days. This meant there was no recorded evidence of the required care having been delivered. While there was no evidence that the necessary care had not been undertaken, there was also no evidence that the specific care action had taken place. In this instance the lack of adequate recording, suggested that there was no indication that care staff and management responded to deficits in either care provision or care recording. Standard 2.7 is not met.

Safe Recruitment Practices

The Regulation Officers reviewed the recruitment files of care staff members recruited through a UK agency. The information provided by the Interim Manager did not evidence that safe recruitment processes had been followed. There was no accompanying evidence or indication that due diligence associated with safe recruitment practices had been satisfied. Several days post-inspection, the Interim Manager was able to provide information that gave some reassurance that the care workers had received safe recruitment checks through the agency. However, concerns remain that the management team needed to satisfy their obligations regarding safe recruitment before allowing the care workers to deliver direct care to the care receivers at Beaumont Villa. Standard 3.2 sets out the 'core set of data' required by the employer before an employee can commence a care worker role. Standard 3.2 is not met.

Induction Processes

The Regulation Officers sought assurances from the Interim Manager that the agency staff members had been supported through the home's full induction programme. Although some induction processes had been completed before the care workers delivered direct care, no evidence was provided that the entire induction programme had been accomplished. This included care competencies and the completion of mandatory training required for the role. The Standards set out that all 'care/support workers will complete a structured induction programme

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assessing their competence to work in the accommodation'. Standard 3.10 is not met.

Training Appropriate to Role

Records of staff training were requested during the inspection process. The Regulation Officers were made aware of a staff member who was working as a senior carer and who had been placed in charge overnight to take responsibility for the home. The Regulation Officers requested evidence of an appropriate care qualification and medicines management qualification. The Standards stipulate that a person placed in a senior care position should have completed a relevant level 2 Diploma and have completed or be working towards a level 3 Diploma. Additionally, if administrating medications, Standard 6.7, Appendix 9- Medicines Management, stipulates that 'the administration of medicines will be undertaken by trained and competent care/support workers' 'who have completed an Accredited Level 3 Medication Administration Module'. The requested evidence was not provided to the Regulation Officers. Standard 3.12 and 6.7 is not met.

Information Sharing and Working Together

It was recognised from a safeguarding incident that when health professionals from outside the home provide care to care receivers of Beaumont Villa, the communication and information sharing are not robust. These professionals are required to record their interventions in a generic handwritten file and not on the individual record of the care receiver. The consequence is that information can be missed, compromising the care delivered. Standard 2.8 is not met.

Refurbishment

A planned refurbishment of Beaumont Villa and the sister home L'Hermitage, has been completed for both homes. The communal areas have undergone full redecoration with much needed replacement of carpets and furnishings. This has improved the look and feel of the home in the communal areas. There has been no refurbishment of the care receivers' rooms; however, the Regulation Officers have

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been informed that six rooms have been identified for the first planned refurbishment stage before the year's end. This will include the replacement of carpets, redecoration, and new furniture.

Maintenance and essential repairs

There continue to be delays in the maintenance and repair work required in parts of the home. The focused report completed by the Commission on 10 May 2023, highlighted a maintenance issue in an occupied care receiver's 's bedroom. It is acknowledged that efforts have been made to organise reparation for the damage to the room, however the identified work remains uncompleted. Standard 4.6 is not met.

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IMPROVEMENT PLAN

There were nine areas for improvement identified during this inspection. The table below is the Registered Provider's response to the inspection findings.

Area for Improvement 1 **Ref:** Standard: 3.10 **To be completed by:** With immediate effect	**Induction Processes:** Staff members employed through an agency should receive a full induction programme, including the completion of all identified mandatory training specific to the role. Care staff should not be working unsupervised until the induction competencies are completed.
	Response of Registered Provider: Actions agreed to evidence staff recruited through an agency are inducted appropriately and receive the identified mandatory training for their roles were included in the action plan sent with the response to the inspection report. Specifically – 1. Check all agency staff have completed or have mandatory training in progress. 2. Revise Agency Induction Checklist to reflect Jersey standards. On 11.08.23 the interim Home Manager met with agency supplying staff to the service to verify all mandatory training had been completed. On 13.08.23 Agency staff were included in the face to face training scheduled for permanent staff 6-9 September 2023, and all sessions were completed by agency staff being used at the time. On 01.09.23 A new Agency Checklist was developed with Neuven

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	(neutral vendor) who book any agency staff on our behalf. This was reviewed and on 15.09.23 this was updated to include a specific item on CSDL. On 9-16 October HRBP audited files as compliant. .

Area for Improvement 2 **Ref:** Standard: 4.6, 6.6 **To be completed by:** With immediate effect	**Maintenance of Clinical Equipment:** There should be regular servicing of all clinical equipment used in the home. A record of servicing should be maintained, and equipment should be clearly labelled with date of last servicing check.
	Response of Registered Provider: As per the action plan sent specific actions : 1. Review maintenance checks for mattresses and related equipment and confirm frequency of checks. 2. Implement external servicing and maintenance of beds, air mattresses and pumps. 3. Provide information and training for staff to understand use and operation relevant to their roles. Mattress Checks continue to be done twice daily as a minimum and 2 hourly checks implemented where this is required for specific residents (where this is the case it will be recorded in their care plan). External provider contracted to undertake annual checks of all equipment and this includes labelling service checks. The service contract was implemented on 18 September 2023 and servicing completed 20 September (a copy of the initial report was sent to JCC). All residents who require

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	equipment have a suitably working model in place which has been serviced. Training and guidance information shared from 23.09.23 through to 31.10.23

Area for Improvement 3 **Ref:** Standard: 3.2 **To be completed by:** With immediate effect	**Safe Recruitment Practices:** Safe recruitment practices need to be followed for all newly recruited members of staff. The management team should be able to satisfy themselves that agency staff members have evidence of safe recruitment before they are placed to work in the home.
	Response of Registered Provider: An initial review of files on 26.08 23 highlighted additional reference information was required and this was completed on the same day. 31.08.23. All personnel files reviewed as complete including 8 agency staff files. Follow up review done on 09.10.23 and all files compliant.

Area for Improvement 4 **Ref:** Standard: 3.11, 3.12 **To be completed by:** With immediate effect	**Mandatory Training:** The management team should ensure that staff members complete mandatory training appropriate to their roles and remain compliant. Senior care workers are required to hold a level 2 care qualification and working towards a level 3. Senior roles should not be assigned to care workers that do not meet this minimum requirement.

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	Response of Registered Provider: Revision to Agency Profiles to clarify that no senior care staff are employed without level 2 care qualification and working towards level 3. Senior Carers who are required to administer medication will hold level 3 in medication and this is detailed in the agency profile checks.

Area for Improvement 5 **Ref:** Standard: 12.3 **To be completed by:** With immediate effect	**Management Oversight of the Home:** Clear management oversight of the home is required to ensure that staff are supported to provide safe care to the care receivers of the home. Escalation processes need to be clear and followed by management and staff members. The Management team should ensure that care workers are able to concentrate on their care roles without being assigned additional tasks outside of their care work.
	Response of Registered Provider: Actions Agreed – 1. Implement 7 day management cover 2. Clarify Escalation Processes – see specific section on Escalation Processes. 3. Clarify care staff are not expected to be assigned additional tasks when working a “care duty” and identify on rota if

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	care staff are uses in any other capacity where this is relevant. 1. Rotation management staff in place since 31.07.23 2. 14.08.23 – reviewed rota to confirm care staff are not assigned to other tasks and this is ongoing 3. 02.09.23 – rotas sent to JCC weekly to verify allocation of staff 4. 09.10.23 – rota audited and no issues noted of staff moving from care shifts. Where care staff have been utilised in other capacity this is where they have the training/experience and the role is noted on rota.

Area for Improvement 6 **Ref:** Standard: 6.2 **To be completed by:** With immediate effect	**Escalation Processes:** There needs to be a clear policy and guidance to ensure that staff and the management team recognise when a care receiver has a deterioration in their health, and the situation requires escalation. Communication with professionals outside of the home requires improvement.
	Response of Registered Provider: Actions Agreed: 1. Review escalation processes in place. 2. Quality Support Manager review of PCS care plans to verify change or deterioration in care needs have been recorded and acted on. 3. Agree protocol for professional visits and how information sharing will be achieved (see Information Sharing and Working Together action) 1. HM met with senior carers and Deputy Manager to confirm escalation processes. Daily - handover, Flash Meeting, and daily checks on PCS. Weekly - Risk Meetings review - completed by DM and

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	reviewed by HM &QSM. Monthly - Clinical Governance meetings. All shift leads have RQF level 3 or above (included identification and escalation). 10.09.23 2. CP review with action tracker in place to monitor updates on PCS (see also Record Keeping Action) 02.10.23 Introduced the 2 at 2 meeting as additional escalation measure with all staff and RSM checked fluid watch and repositioning discussed.

Area for Improvement 7 **Ref:** Standard: 2.7	**Record Keeping:** There needs to be a review of the care plan record keeping and reassurances that care plans are being followed.
To be completed by: With immediate effect	**Response of Registered Provider:** Actions Agreed: Record keeping 1. Review all care plans to triangulate information observed and received for residents is reflected in care plans. 2. Implement full QSM review of all care plans and action tracker to monitor progress. 3. Share action tracker and monitor progress including review of preassessments, consents and update accordingly. 25.08.23 1. Review of care plans completed and actions agreed for improvement with QSM. 10.09.23 QSM review of all PCS care plans completed for 16 residents. 7 Stress/Distress to be updated and full review of HPPs for all 16 residents to be completed. This was completed om 02.10.23 Record keeping 1. Review all care plans to triangulate information observed and received for residents is reflected in care plans. 2. Implement full QSM review of all care plans and action tracker to monitor progress. 3. Share action tracker and monitor progress including review of preassessments, consents and update accordingly.

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	25.08.23 1. Review of care plans completed and actions agreed for improvement with QSM. 10.09.23 QSM review of all PCS care plans completed for 16 residents. 7 Stress/Distress to be updated and full review of HPPs for all 16 residents to be completed. 15.09.23 3 S/D to be completed and 4 HPPs done. 22.09.23 7 identified plans now complete and further 10 reviewed. 02.10.23 All Health Promotion Plans complete. 25.10.23 – Further review by QSM completed and care plan tracker in place and ongoing

Area for Improvement 8 **Ref:** Standard: 2.8 **To be completed by:** With immediate effect	**Information Sharing and Working Together:** There needs to be clear pathways for working together with other professionals to meet the needs of the care receivers. Communication should be clear and recorded in the care receivers record to prevent information being missed.
	Response of Registered Provider: Information Sharing and working together. System to be implemented and protocol agreed to make sure every visit by professionals is recorded, findings shared, and care plans updated and/or reviewed - senior carer will accompany community professionals when they are attending to dress/assess residents who have wounds. The senior will take a picture and gain feedback from the professionals which will be documented in our wound bundle. Notification of all GP and community visits to be reported to the home manager. FN and TVN to be invited to attend Clinical Governance Meetings. 01.09 - Meeting scheduled with SW (Safeguarding Lead) and with FN on 20 and 27 September 2023. 10.09 23 Protocol agreed and signed off by seniors, and is monitored by HM Meeting with family nursing held 27.9.23 agreed improved communication protocol that supports both

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	teams and actions agreed. Ongoing meetings in place

Area for Improvement 9 **Ref:** Standard: 4.7 **To be completed by:** With immediate effect	**Pressure Trauma:** The home need to follow the 'Island wide pressure ulcer- prevention and management framework', to ensure that there is safe practice around the management of pressure ulcers. **Response of Registered Provider:** Actions Agreed – 1. Island wide Pressure Area Care Framework shared again in the service. 2. Review of Policy and implement training/coaching sessions to embed this. 1. 01.09 Framework in place and reporting tool being used for notifications. Series of sessions organised by QSM between 18-30 September to cover Deputy and senior care staff. 2. 05.09.23 Learning and Development Team amended training on Pressure Ulcer Care to include the Framework. Aria Care Promotion and Management Tissues Viability Policy updated to reflect the Island Wide Framework 3. 27.09.23 QSM provided sessions for 3 seniors and 6 staff and 13 staff completed training by 09.10.23

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