Summary Report

L'Hermitage Care Home

Care Home Service

La Route de Beaumont
St Peter
JE3 7HH

Inspection Dates:
15, 16, 19 May and 3 June 2025

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SUMMARY OF INSPECTION FINDINGS

The following is a summary of what we found during this inspection. Further information about our findings is contained in the main body of this report.

The home has met four of the five areas for improvement identified in the last inspection carried out on 19 September and 3 October 2024. However, it is concerning to note that the home continues not to meet the required standards regarding staff supervision and appraisal.

Staffing levels have improved since the previous inspection, albeit relatively recently. There is less reliance on the use of agency staff and a reduction of staff regularly working more than 48 hours per week. However, regular gaps were noted in the staffing rotas, meaning staffing levels fell below the minimum ratios set out in the Home Care Standards. In addition, the requirement for 50% of care staff on duty to possess a Level 2 Diploma in Adult Social care (or equivalent) has not been met, although seven staff began this training in May 2025. Recruitment processes were found to be safe and compliant with the Standards.

The home maintains an effective maintenance programme and health and safety practices, including fire safety, Legionella prevention, and infection control. Medication management requires improvement in respect of controlled drug record-keeping and transcribing practice.

Pre-admission assessments lead to comprehensive risk assessments and the development of a range of person-centred care plans, which are subject to regular review. Quality assurance activity takes place regularly, and the effectiveness of care delivery is monitored; however, information sharing and communication in the home require improvement.

Opportunities to provide care receivers with choice and control in the care they receive are promoted, alongside an offer of varied in-house and community-based activities. Feedback mechanisms, such as surveys and a "You Said / We Did" board, encourage engagement.

Leadership has been strengthened with the addition of a deputy manager and a community relations manager; however, this is relatively recent. A detailed Continuous Improvement Plan is in place.

Staff have access to regularly updated policies and procedures online. Improvements are required in the supervision of care staff undertaking their induction and in ensuring that all staff are compliant with mandatory training. Records for individuals under Significant Restriction of Liberty (SRoL) are current and well-managed.

Overall, there have been some positive recent improvements regarding staffing. However, seven areas for improvement were identified during this inspection.

IMPROVEMENT PLAN

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

Area for Improvement 1 **Ref:** Standard 3.9; Regulation 17 (4) (a) **To be completed:** by 19/08/2025	The Registered Provider and Registered Manager must always ensure that there are adequate care staff to meet the minimum ratios set out in the Care Home Standards. **Response by the Registered Provider:** Rotas are planned to reflect at least minimum ratios Set out in the care home standards. In addition to planned numbers which are recorded in the electronic HR system, the weekly rota is reviewed by the Registered Manager and recorded to detail actual numbers provided. These are also monitored by Regional Director and Senior Leadership colleagues through a weekly reporting system, and any variances scrutinised. The system used was demonstrated to the Inspector, and subsequently a revised recording schedule of staffing and deployment shared – this was confirmed as acceptable by email on 23 July 2025. Any instances of staffing levels falling below the minimum ratios are recorded and reported to the JCC. There is an ongoing recruitment campaign to fill current vacancies and in addition to the existing, permanent staff team. L'Hermitage uses long term agency colleagues to provide consistency of care and support.

Area for Improvement 2 **Ref:** Standard 3.12; Regulation 17 (1) (a) **To be completed:** by 19/11/2026	The Registered Provider and Manager must ensure that at least 50% of the care staff on duty at any time have the required Level 2 Diploma in Adult Social Care (or equivalent). **Response by the Registered Provider:** There are 37% care staff with or working towards the required Level 2 Diploma, and four more colleagues are required to commence this. Two colleagues are booked onto the next cohort in September 2025, and the remainder will be booked on the April 2026 cohort. This excludes any new starters who will be booked on the next available course from their start date, unless they already have this. In addition to the colleagues in progress (Level 2) there is also: 1. Two colleagues holding and one working towards Level 3 2. One colleague working towards Level 5

Area for Improvement 3 **Ref:** Standard 6.7; Appendix 9 Regulation 14 (2) **To be completed:** With immediate effect	The Registered Manager must ensure that record-keeping in the controlled drugs register is compliant with best practice guidance and that procedures for returning controlled drugs and other prescribed medications are aligned with this guidance. **Response by the Registered Provider:** A full review Controlled Drugs medication administration was completed by 19 May 2025 and amendments to the daily checking of drugs and documentation implemented – this added checks by

	both day and night colleagues, and twice weekly handover checks by nursing staff. New CD books replaced and implemented from 1 June 2025. This included simplifying content and clarifying type of medication, strength and preparation. The CD register was adapted to highlight active pages by folding back expired pages to minimise error and provide ease of compliance checks. Returns of medication now logged on daily CD checklist. "Returns" documentation enhanced with weekly sign-off by the Community Care Manager, and monthly review by Registered Manager. The Medication Policy was reviewed to include reference to specified CD guidance for Jersey and this included pharmacy input. The new policy was shared with the Commission on 19 June 2025.

Area for Improvement 4 **Ref:** Standard 6.6; Regulation 14 (2) **To be completed:** With immediate effect	The Registered Manager must ensure that the transcribing of medication is compliant with best practice.
	Response by the Registered Provider: The Registered Manager received and implemented the transcribing guidance on 19 May 2025 and met with Pharmacy provider to clarify and agree the process of sending prescriptions and their receipt. Instances of transcribing are now to be recorded within the monthly medication audits, and a further review of medications receipts and how this is

	checked will be conducted when the home introduces an electronic medication administration record (EMAR) system later in the year. Within the admissions process for new residents, the GP to be contacted prior to admission to aid process of active MAR charts, to minimise use of a transcribed MAR.

Area for Improvement 5 **Ref:** Standard 12.4; Appendix 3 Regulation 19 (1) **To be completed:** With immediate effect	The Registered Manager must ensure there is an effective communication system in place to monitor, audit and review the quality of care within the home on a daily basis.
	Response by the Registered Provider: Within the process and systems to assess, monitor and review the quality of care in the home, the daily opportunities for this include: • "Flash" meetings in the morning involving all Heads of Departments (HOD) – these are recorded daily and actions reviewed on the following day. • "2@2" meetings take place in the afternoon to monitor progress against daily/weekly actions and provide the opportunity to check that colleagues on the floor have received and acted on information from handovers and dairy entries. It also provides the opportunity to highlight any additional or focus issues, e.g. fluid intake, repositioning, changes in resident condition and these are communicated at handovers.

	• A new “midnight catch up” with the same 2@2 principle was introduced for night colleagues. • An audit matrix for all HOD and required Audits timescales is shared at the beginning of the month and discussed daily at flash meeting – this can be cross referenced with the calendar schedule of all audits and proposed dates for completion • The Manager’s daily walkaround is used to bring observations and comments to individuals as they happen or collective sharing at Flash meetings. The walkaround also considers anything from 2@2 or midnight catch up from the previous days. • Daily Resident of the Day and Care Plan are completed for individual residents (schedule and names are published), and these are signed off by General Manager on the following day – any items arising from the process are communicated at Flash. Any consistent themes or significant feedback is also collated and shared at monthly colleague meetings. • The Community Care Manager relays any items identified or missing from the audits which have been completed to either daily flash meeting or weekly risk meeting before these are signed off by General Manager and uploaded to our electronic Care Management

	System (CMT) for review by the Regional Director.

Area for Improvement 6 **Ref:** Standard 3.14 Regulation 17 (4) (c) **To be completed:** 19/07/2025	The Registered Manager must ensure that all care staff receive regular supervision and appraisal in line with care home standards, with a minimum of four sessions per year.
	Response by the Registered Provider: There is a Supervision matrix in place, and this is now broken down into nursing, care and ancillary colleagues for ease of reference and monitoring. All outstanding sessions identified at the inspection (3 nurse and 2 induction) were completed by 1 June 2025 – the new matrix also more clearly identifies how many colleagues will have a one to one session over each quarter and specific when appraisals are due.

Area for Improvement 7 **Ref:** Standard 3.11 Appendix 7 Regulation 17 (4) (c) **To be completed:** By 19/08/2025	The Registered Manager must ensure that all care staff comply with this home's mandatory training requirements and those set out in the Care Home Standards.
	Response by the Registered Provider: The Aria “Ecademy” system is in place to track both mandatory and home specific training, and this is monitored weekly. A higher level monthly training report is provided to verify the percentage compliance against the target of 95% completion. L’Hermitage mandatory training is 89% and has set a

	target date of 95% by 22.08.25 – this is to take account of the availability of face to face training provision. Training through probation is monitored and reported separately, and this is reviewed at the end of each month.

The full report can be accessed from here.