St John's Nursing Home Limited

St Johns Nursing Home Limited

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 caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

St Johns Nursing Home provides nursing care and support for up to 45 older people, some of whom are living with dementia.

Our inspection took place on 26 and 27 November 2014 and was unannounced. At our last inspection in October 2013 the service was meeting the regulations inspected.

The service had a registered manager and they had been in post since 2011. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their relatives told us they felt safe at the service. Staff knew how to recognise signs of potential abuse and followed the right reporting procedures. Staff positively supported people when their behaviour challenged the service and clear guidance was written for them in people's care records. Staff made sure people were safe by identifying and taking steps to reduce risks.

Summary of findings

People had access to healthcare services when they needed it and received on-going healthcare support from GPs and other healthcare professionals

Staff communicated with people in a kind and sensitive way. They were attentive while supporting people at mealtimes to ensure people had sufficient amounts to eat and drink. People and their relatives were positive about the food at St Johns Nursing Home and the ways in which the service involved people to make choices about the daily menu. Special dietary requirements were catered for and people's nutritional risks was assessed and monitored.

During our inspection we observed that staff were caring. They showed people dignity and respect and had a good understanding of individual needs. There were lots of different activities for people to be involved in and we heard about ways the service tried to involve everyone in activities to stop people from feeling lonely or isolated.

The service was accredited with the Gold Standards Framework (GSF) for end of life care which ensured staff were trained to provide appropriate care, in accordance with people's wishes, when they were nearing the end of their life.

People and staff were asked for their views on how to improve the service. Staff felt listened to and supported by their manager.

The provider had a number of audits and quality assurance systems to help them understand the quality of the care and support people received. Accidents and incidents were reported and examined. The manager and staff used information about quality of the service and incidents to improve the service.

Staffing was managed flexibly in order to support the needs of people using the service so that they received care and support when needed. However, not all staff had received the training or skills they needed to deliver safe and appropriate care to people.

People received their prescribed medicines at the right times, these were stored securely and administered by registered nurses. We found some records that related to people who took their medicines covertly were not always complete.

The provider was aware of the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) that ensured people's rights were protected. However, we found mental capacity assessments were incomplete and did not find any details recorded about how decisions were made in people's best interests. We have asked the provider to make improvements in the above areas.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

We have recommended that the provider consults the NICE Guidance on Managing Covert Medicines in Care Homes.

Summary of findings

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 safe in most areas. However, some medicines records were not complete so staff did not have the written information they needed to administer medicines covertly.

There were arrangements in place to protect people from the risk of abuse and harm. People we spoke with felt safe and staff knew about their responsibility to protect people.

Staff helped make sure people were safe at the service by looking at the risks they may face and taking steps to reduce those risks.

The provider had effective staff recruitment and selection processes in place and there were enough staff on duty to meet people's needs.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. The manager had sought and acted on advice about the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected. However, where decisions had been made with respect to people's capacity the rationale for making the decisions were not clearly documented.

Not all staff had received the training or skills they needed to deliver safe and appropriate care to people.

People were supported to eat and drink sufficient amounts of nutritious well-presented meals that met their individual dietary needs.

People's health and support needs were assessed and appropriately reflected in care records. People were supported to maintain good health and access health care services and professionals when they needed them.

Is the service caring?

Good

The service was caring. People were happy at the service and staff treated them with respect, dignity and compassion. Staff knew about people's life histories, interests and preferences. The care records we viewed contained information about what was important to people and how they wanted to be supported.

Staff had a good knowledge of the people they were supporting and they respected people's privacy and dignity.

Staff were trained to provide good care, in accordance with people's wishes, when they were nearing the end of life.

Summary of findings

Is the service responsive?

Good

The service was responsive. People's care records were person centred and focused on people's individual needs, their likes and dislikes and preferences.

A range of meaningful activities was available and people were supported to follow their interests. Efforts were made to prevent people from feeling isolated or lonely.

People and their relatives felt able to raise concerns or complaints and knew how they should complain. The service responded to and investigated complaints appropriately.

Is the service well-led?

The service was well-led. People and their relatives spoke positively about the care and attitude of staff and the manager. Staff told us that the manager was approachable, supportive and listened to them.

Regular staff and managers meetings helped share learning and best practice so staff understood what was expected of them at all levels.

The provider encouraged feedback about the service through regular meetings and staff and relative surveys.

Systems were in place to regularly monitor the safety and quality of the service people received and results were used to improve the service.

St Johns Nursing Home Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check 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.

Our inspection took place on 26 and 27 November 2014 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with four people who used the service, 10 friends and relatives, nine members of staff and the manager. We also spoke with three healthcare professionals who were visiting the service at the time of our inspection. We observed the care and support being delivered and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at 13 care records, four staff records and other documents which related to the management of the service such as training records and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe at the service. One person told us, "I'm OK here" and a relative said, "They wouldn't be here if they were unhappy." Staff knew what to do if there were any safeguarding concerns. It was clear from discussions we had with care staff that they understood what abuse was and what they needed to do if they suspected abuse had taken place. This included reporting their concerns to managers, the local authority's safeguarding team and the CQC. Managers and staff we spoke with knew about the provider's whistle-blowing procedures and had access to contact details for the local authority's safeguarding adults' team.

Some of the people at the service were living with the later stages of dementia and we observed staff positively support people when their behaviour challenged the service. Guidance for staff was contained within people's care records; this included individual information on what may trigger the behaviour and strategies for managing it. For example, one person would sometimes become angry when offered their medicine. There was clear guidance for staff on how to support that person when this happened. One relative told us about the strategies used by staff when their relative was upset they told us, "Staff know them well enough to leave them alone when this happens but still keep an eye on them."

People's care records had risk assessments in place such as moving and handling, falls, nutrition and pressure area care. We saw some good examples where a risk had been identified and a management plan had been put in place. For example, one person's records had detailed guidance for staff on how to assist and reassure them when mobilising. Where people were at risk of developing pressure sores, regular monitoring and assessments took place. Regular body map assessments, Malnutrition Universal Screening Tool (MUST tools) and food and fluid charts were completed in people's care records. Where people were identified as having developed a pressure sore, appropriate pressure relieving equipment was used and checked. Turning charts and notes from visiting tissue viability nurses were in place.

The premises and equipment were maintained to keep people safe. One member of staff told us, "The maintenance man is around all the time and responds quickly if something needs fixing." A book of all maintenance issues was kept at reception and it evidenced that they were addressed within a couple of days. Regular fire drills were conducted and each person had a personal evacuation plan in place detailing the risk to each person and their mobility needs.

People using the service, relatives and staff we spoke with felt there were enough staff available in the home at all times to meet people's needs. One relative said, "There always seems to be staff around and nothing is too much trouble for them." The manager told us they had a flexible approach to arranging staffing levels and would regularly employ an additional member of staff when necessary. For example, when new staff started and needed supervision, additional staff would cover shifts and when one person became more active at night, an additional member of staff was allocated to the shift to attend to their needs. Duty rotas confirmed the staffing levels at the service.

The service followed safe recruitment practices. We looked at the personnel files of four members of staff. Each file contained a checklist which clearly identified all the pre-employment checks the provider had obtained in respect of these individuals. This included an up to date criminal record check, at least two satisfactory references from their previous employers, photographic proof of their identity, a completed job application form, a health declaration, their full employment history, interview questions and answers, and proof of their eligibility to work in the UK (where applicable).

People received their prescribed medicines at the right times. All medicines were stored securely and administered by registered nurses. Protocols for 'as required' medicine were in place, giving guidance to staff on the type of medicines to give and when people needed to receive them. We found no recording errors on any of the medication administration record sheets we looked at. We were shown the medicine audits that were carried out on a rotation system.

Some people were receiving covert medicines. Covert is the term used when medicine is administered in a disguised way without the knowledge or consent of the person receiving them. Records contained a 'medicines agreement' with reasons for administering covert medicine and the signatures of the GP and nurse who had made the decision. However, when we looked at people's care records we did not always see that a mental capacity assessment had been completed in respect of people's

Requires Improvement

Is the service safe?

covert medicines. Staff clearly explained how they gave people their covert medication, but we did not find this guidance recorded in people's care records. Staff told us they had consulted with the pharmacist for their advice and agreement but this was not always recorded. Recording this information was necessary because adding certain medicines to food or drink can alter the way they work or how they affect people.

We recommend that the provider should consult the NICE Guidance on Managing Medicines in Care Homes for covert medicines.

Requires Improvement

Is the service effective?

Our findings

Staff felt they received enough training to care for people and meet their needs. Staff told us about the induction they had received when they first started working at the service and how it helped them support people. The induction covered an overview of the service, training regarding the gold standard framework, manual handling and fire safety. After three months the staff member would meet with the manager to discuss their training and competency.

Staff training records were kept centrally at the service and the manager confirmed that mandatory training should be completed every two years. The manager explained that there were 40 staff working at the service, this included maintenance and catering staff. She told us that not all staff required training in all areas. However, we noted many staff required refresher training as previous courses had been attended over two years earlier. For example, nine staff had received infection control training in 2013, but the remainder had no training in this area since 2011. Food Hygiene was last attended by staff in 2011 and only four staff had received training in in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) during 2014. The manager was aware that training staff was an issue and we were shown minutes from a managers' meeting in November 2014 where staff training had been discussed. We were told the provider had three homes and the managers intended to work together so all staff received and renewed their mandatory training. In the meantime, however, we were concerned that some staff may not have the training or skills to deliver safe and appropriate care to people. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010. The action we have asked the provider to take can be found at the back of this report.

The service had policies and procedures in relation to the MCA and DoLS. The provider was aware of the implications that followed the Supreme Court judgement in relation to DoLS. They were in liaison with the local authority to ensure all staff received the appropriate training in the future and knew that assessments should be undertaken to ensure people who used the service were not unlawfully restricted. Records indicated that four staff had received training in this area.

People's records contained mental capacity assessments, however, it was not always clear if they lacked capacity or not, as this section had not been completed. We did not always see the recorded rationale behind some of the decisions made in a person's best interests. For example, there were no mental capacity assessments or evidence of best interest's decisions regarding people's covert medicines. Although there was evidence of GP and nurse involvement the reasons why the decisions had been made and date the decision was due to be reviewed had not been recorded. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010. The action we have asked the provider to take can be found at the back of this report.

People were supported to have sufficient amounts to eat and drink and maintain a balanced diet. People and their relatives were positive about the food and their comments included, "The food smells delicious", "The food is lovely and plentiful" and "The food is mostly alright." Throughout our visit people were regularly offered hot and cold drinks by staff. We looked at the food menu for the week, which was available in the dining room. We observed lunchtime and noted staff were kind and attentive, supported people when they needed assistance and the atmosphere was relaxed. People who had special dietary requirements were catered for. For example, people with diabetes were provided with alternative puddings and snacks were available throughout the day and night. People's weight and fluid intake were monitored and where necessary nutritional screening tools were used to identify people's needs and involve other healthcare professionals as necessary.

We observed people were offered a choice of food and drink at meal times. We spoke to the cook who explained that alternatives to the menu were available for people and we were shown the process that had been put in place to order different options. The service asked people about the menus in place and if they would like changes. We noted menus were discussed at resident and relative meetings and people's views were sought via resident surveys. The manager told us about the 'British food' day they held in the Summer. The cook had prepared small 'tasters' of different food to gauge what people liked. The service identified that people liked curry, sausage rolls and hotpot so included this on the menu.

Requires Improvement

Is the service effective?

Relatives told us the nutritional needs of their relatives were met. They told us "[my relative] was underweight when they came but the home has got them eating again" and "[my relative] has put on weight since they have been here, they really care." Care records included information about people's food preferences and nutritional risk assessments. Details of people's food and fluid intake were recorded over 24 hour periods.

People had access to healthcare services and received on-going healthcare support. People's relatives told us that they felt confident that medical treatment would be sought promptly. One person said, "If [my relative's] behaviour changes, the staff check their urine in case they have an infection and need antibiotics." Another said, "The GP comes in regularly, but if anything is wrong they call them. " We spoke with a chiropodist visiting the home, they explained they had been called in especially to see one person who was in discomfort and needed to be seen before the next scheduled visit. Staff told us the GP visited the service every Monday and more regularly if required. Care records confirmed regular visits from healthcare professionals.

Good

Is the service caring?

Our findings

People using the service and their relatives told us they were happy with the level of care and support provided at the home. They also said staff were always kind and caring. They said, "I can't fault the place", "There's a certain feeling when you walk in 'Home from Home', "The staff are extremely friendly" and "The other week I saw [my relative] joining in and chatting and laughing with the staff, before they came here they were so reserved."

People's diversity was respected, for example, people's spiritual needs were understood and supported. Staff told us, "We have strong links with the local churches," and "One person has communion in their room." People's cultural and spiritual preferences were recorded in their care records.

We observed staff were patient when speaking with people and understood and respected that some people needed more time to respond. During lunch one person did not eat their meal and staff asked if they needed help. The person was then offered alternatives and decided on a sandwich. Another person sat with their relative during lunch but was not eating. They could not understand why their relative was not eating. Staff provided a meal for the relative and this provided reassurance to the person who then started to eat their meal.

Staff respected people's privacy and dignity when they were supporting people with personal care. They told us, "I close the curtains and the door to respect the person's privacy and dignity when they are getting dressed", "We try our best to show people dignity and respect" and "I try to treat everyone how I would treat my parents or grandparents." In the dining room there was a relative's board where people were invited to comment on any element of the service. Comments included, "When I visit the home is a happy place, staff take time to chat even though they are busy. There is always laughter" and "When I visit [my relative] they are always dressed well and staff go to the trouble of putting their jewellery on". One relative told us, "The staff never look like it's a bother to cater for [my relative], they treat them like they are a relative."

Relatives told us they were able to visit whenever they wanted and there were no restrictions. One relative told us, "We can come in any time and that gives you some confidence." Another relative explained when their loved one was feeling poorly they had been able to stay overnight with them.

The care plans were centred on the person as an individual and their preferences and views were reflected .We spoke to the friend and healthcare professional of one person who had recently moved into the home. The friend had previously had experience of the service and spoke highly of the staff and of the care they gave. They said "[My friend] couldn't do better." The healthcare professional confirmed this was their first visit to the home but everything relating to that person's care appeared to have been followed.

St Johns Nursing Home was accredited with the Gold Standards Framework (GSF) which is a system of training and accreditation in end of life care which enables front line staff to provide a 'gold standard' of care for people nearing the end of life. We looked at examples where people's end of life care needs were considered and recorded and staff had worked with relevant professionals to make sure people's wishes were respected. Information and requests from people and their relatives were recorded including information about people's religious and cultural beliefs, where they wanted to be and who they wanted to be with them. A GFS board was in the main dining room with photographs and memories of previous residents. A remembrance and memorial day was held for families, friends and staff to remember and celebrate the lives of people who had passed away whilst at St John's. One visitor told us how her husband had been a resident, and had been very happy. When he died the service had arranged to have a gathering after the funeral. They told us, "The home was brilliant, I would recommend this place to anyone."

Good

Is the service responsive?

Our findings

People who used the service and their relatives felt they were involved with the assessment and planning of care. We were told, "Staff work around [my relative], they know them well. If [my relative] wishes to stay in bed longer they can", "Staff tell me things about [my relative] and the care they are getting" and "If there are any problems [the staff] phone and tell me."

Staff were clear about the handover routine and told us the notes helped them meet people's immediate needs. One staff member told us, "We are given written information each day on handover which helps us to quickly identify what each person's support needs are." A summary of people's daily needs were provided at each handover. For example, one person required increased regular monitoring following a fall earlier that day and there were details of an appointment with the chiropodist for another person.

People's care records were person centred and focused on people's individual needs, their likes, dislikes and preferences. For example, one care record gave information about a person's history, the sport they played when they were younger, their employment, life history and experiences. Another record contained guidance for staff on how to communicate with a person who could be challenging to the service, this included being patient and listening to what the person was trying to say. Staff told us, "It's important to take time to get to know a person and what they like and dislike" and "[one person] can be aggressive sometimes but I explain what I'm doing and try to calm and reassure them. If they're still not happy, I will leave them for a short while and go back – they're normally happier then."

People were supported to follow their interests and take part in social activities. We spoke with the service's activities coordinator. They told us, "I spend time going round talking to people who like to remain in their rooms and try to encourage them to take part in different activities." At the time of our inspection a resident and relatives coffee morning was taking place. This was a weekly event and was very popular. The atmosphere was happy and vibrant with lots of chatting and laughing. During the afternoon people listened to music and played skittles in the lounge area. Other activities included watching films, games, arts and crafts and outings to the seaside, garden centres, pub lunches and shopping trips. Relatives of one person told us, "We like the wide range of activities the home organises for people and their families. We have recently been shopping, to the seaside and the garden centre." One person showed us their shoes they had brought during a visit to the garden centre.

We spoke with the hairdresser who was at the service at the time of our inspection. They told us they came in once every two weeks. They had noticed that there was always lots of activities for people and mentioned BBQs and summer fetes in the garden, coffee mornings and lots of outings to the coast and garden centres.

The service had a complaint procedure which clearly outlined the process and timescales for dealing with complaints. Complaints were logged and monitored. Records were kept of investigations into complaints, the actions taken and the outcomes achieved including the action taking to avoid similar occurrences. For example, a relative had made a complaint following one incident. The service had undertaken a full investigation and recorded outcomes. We noted the action taken by the manager to rectify the situation that included improvements in communication and changes in procedure.

Good

Is the service well-led?

Our findings

People were encouraged to have their say through regular meetings and surveys. Relative meetings were held four times a year. Agenda items included menus, GP services, staff and activities. We were given the minutes from the last two meetings and noted they had been well attended.

We looked at the results of a recent survey which covered issues such as food, staff, standards of care and asked for people's comments and suggestions. We noted most responses were positive and where suggestions had been made saw the actions that had been taken in response. For example, one person asked for a different choice of food in the evening and we heard how the cook had included this on the menu.

Staff felt well supported by their manager and colleagues. Team working was evident and staff told us the nurses and care workers worked well together. They told us, "The staff are lovely here. It's very handy that we all get on well together", "There is a nice friendly atmosphere here. People work together well as a team" and "The manager is brilliant she looks after us really, really well."

Staff said they felt able to raise concerns with the manager and felt listened to. They felt there was an openness and transparency at the service. They said, "The manager is very good at dealing with concerns" and "I know I can talk to the manager if I have a concern."

Regular staff meetings were held were held which gave staff the opportunity to discuss the needs of people who used the service, share information, raise any concerns and identify areas for improvement. The manager told us these were split into three weekly meetings around 10 to 15 minutes long, this enabled her to speak with all staff and ensure continuity of the information given. Records of each meeting and issues discussed were kept in the manager's diary. The manager explained that they were always learning from events and would reflect on these during staff meetings. Minuted quarterly meetings were held with the nursing staff at the service and discussions included people's medicines, records, communication and staff supervision.

The service had systems to manage and report whistleblowing, safeguarding, accidents and incidents. Details of incidents were recorded together with action taken at the time, notes of who was notified, such as relatives or healthcare professionals and what action had been taken to avoid any future incidents. For example, one person was experiencing regular falls. Records confirmed the persons relative and GP had been involved in decision about the persons medicine and how best to manage their stability.

Quality assurance systems were in place. Quarterly audits took place covering care plans, risk assessments, medication and health and safety. The provider carried out regular quality audits and where issues had been identified, recommendations were made and improvements monitored.

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 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not always have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided to them. This is particularly in relation to meeting the requirements of the Mental Capacity Act 2005 for those people who are unable to give their consent in relation to their care and treatment. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have arrangements in place to ensure all staff received the training and skills they needed to deliver safe and appropriate care to people using the service. Regulation 23 (1) (a).