R & E Kitchen

St Johns Nursing Home

Inspection report

Rownhams Lane
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Date of inspection visit:
15 January 2018
16 January 2018
19 January 2018

Date of publication:
09 March 2018

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 15, 16 and 19 January 2018 and was unannounced. The home provides accommodation for up to 38 people with nursing care needs. There were 32 people living at the home when we visited, some of whom were living with dementia. All areas of the home were accessible via a lift and there were three lounge/dining rooms spread across both floors. There was accessible outdoor space from the ground floor. Bedrooms were a mix between single and shared occupancy.

St John's Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager at the home. 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.

At our last inspection in December 2016, we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us an action plan detailing how they would make improvements in the areas of: ensuring the service obtained appropriate consent to provide people's care, and ensuring there were sufficient numbers of trained and qualified staff in place. At this inspection we found the provider was still not meeting the requirements of these regulations and we also found concerns in other areas.

There was no clear management structure in place. The provider did not have management or supervisory staff in place who were able to assume roles in overseeing the quality and safety of the service. As a consequence, there were deficiencies in key areas of the running of the service, which resulted in the compromised safety and wellbeing of people. The registered manager had worked hard in their role to make improvements, but told us they often did not have the resources to fully implement or imbed improvements.

People's medicines were not managed safely. The medicines management system in place did not ensure effective, ordering, storage, administration, recording or disposal of people's medicines. This put people at risk of harm as there were examples where people received the incorrect medicines or it was not clear which medicines they were prescribed to receive.

Risks to people's individual safety were not managed effectively to reduce the risk of harm. Systems and plans to protect people in the event of an emergency were either not completed or did not fully consider the most effective action to take in order to keep people safe. Where risks had been identified around people's health conditions, monitoring and management plans were put in place in order to manage these conditions. However, the actions and recordings related to these plans were not always clearly followed,

which resulted in confusion about the support people had received and how effective treatment plans were. There were ongoing safeguarding concerns in relation to people's health and wellbeing which the registered manager was investigating at the time of inspection.

There were enough staff working in the home, but staffing levels were maintained only with the addition of agency staff. The registered manager told us they were in the process of recruiting staff, but the service had experienced a high turnaround of staff leaving since our last inspection. Staff's ongoing training and development needs were not closely monitored. Many staff required training updates to ensure their knowledge was current and following best practice.

People did not always receive personalised care. Care plans did not contain sufficient detail to enable staff to understand people's behavioural and communication needs. Handover information between staff was not always sufficiently accurate to ensure that staff had all the information required to meet people's needs. Guidance for some people was not clear about the support they required when eating and drinking. This resulted in confusion within the staff team about the appropriate levels of support people required. People had access to healthcare services, but documentation did not always make it clear about the healthcare interventions which people required in order to promote healthier lives.

Staff did not always follow legislation to ensure they complied with legal requirements where people lacked capacity to consent to their care. Where people were unable to make specific decisions about their care and treatment, staff did not follow best practice guidance to ensure that the decisions were proportionate and in people's best interests. The registered manager had not fully assessed or taken steps to ensure that people's accommodation arrangements were fully supportive of their rights and freedoms. The registered manager did not always inform CQC when people had authorisations granted in relation to their accommodation when they lacked the capacity to consent to care arrangements. This was a statutory requirement.

The system of audits and quality assurance were not effective in monitoring the quality and safety of the service. Audits were completed, but they did not identify where issues around medicines or emergency equipment needed remedial action.

People were not always treated with dignity and respect. There were examples where staff not fully respectful of people's wishes or right to privacy. People told us there was a distinction in the quality of staff between permanent and non-permanent staff, who were not always familiar with their needs. People said they were consulted about their care, but staff could take a long time to action requests.

The registered manager sought feedback from people about the service and dealt with complaints in an open and consistent way. Team meetings were used as a platform to discuss issues and make improvements, but they were not always effective in proving a catalyst to positive change.

The service was clean and there were systems in place to reduce the spread of infections. The provider had made adaptations to the building to make it suitable for people and specialist equipment was in place to support people around their health and mobility. There was a programme of activities in place, which people spoke positively about.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made

significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

We identified seven breaches in six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The systems to ensure people's medicines were safely managed were not effective or robust and put people at risk of harm.

Risks to people's safety were not mitigated to reduce the risk of potential harm.

Incidents were not always fully investigated to promote reflection, learning and drive improvements.

There were enough staff in place; however, agency staff were not always familiar with people and their needs.

There were systems in place to reduce the risk of spread of infections.

The registered manager had investigated safeguarding concerns when alerts were raised.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have access to ongoing training and support in their role.

The service did not always ensure that people's rights and freedoms were assessed or respected.

People were not always given appropriate support to encourage them to eat and drink and their nutritional care plans did not always reflect the support they required.

The provider had made some adaption to help ensure the environment met people's needs.

There were assessments in place to help formulate appropriate care and treatment plans for people. However, guidance from these assessments was not always followed.

People had access to healthcare services, but the service did not always work in partnership with other organisations to promote healthier lives for people.

Is the service caring?

Requires Improvement

The service was not always caring

People were not always treated with dignity and respect.

Most staff were caring and familiar with people's needs, but some staff who were new to the service did not always display these values.

People told us they were given choices about their care, but often changes took time to implement.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not always include sufficient or accurate details in order to fully reflect people's needs and preferences.

There was a complaints policy in place and people told us they were comfortable in raising concerns.

People were involved in decisions about their care arrangements at the end of their life.

Is the service well-led?

Inadequate

The service was not well led.

There was not a clear management structure in place and

support available to the registered manager to monitor key aspects of the service was inadequate.

The auditing and quality assurance systems were not effective in identifying key areas of concern.

The service did not demonstrate it could implement and sustain improvements.

The service was open to work in partnership with other stakeholders.

The registered manager sought feedback from people to try to make improvements.

St Johns Nursing Home

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.

This comprehensive inspection took place on 15, 16 and 19 January 2018 in response to information of concern. CQC was aware there had been ongoing quality monitoring visits by the local authority after concerns were raised about the quality and safety of the service. Prior to the inspection we spoke to four social workers and attended a quality monitoring meeting held by the local authority which the registered manager attended.

One inspector, a specialist advisor, who had a background in nursing, and an Expert by Experience, carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection was unannounced.

As this inspection was brought forward due to information of concern, we did not request a Provider Information Return (PIR) or ask for questionnaires to be sent out to people who receive a service. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke to 12 people or their relatives. We spoke to the registered manager, the administrator and nine staff. This included a range of permanent and agency staff.
We looked at care records relating to seven people who used the service. We looked at other records in relation to the management of the service. This included recruitment files, training records, complaints, quality assurance records and audits carried out by staff.

We last inspected the service in December 2016, where the service was rated requires improvement.

Inadequate

Is the service safe?

Our findings

The systems to ensure people received their correct medicines were not effective. We found repeated instances where people were given incorrect medicines by staff. In one example, a person made the inspection team aware that staff were administering the incorrect dosage of their medicines. Staff were not able to explain why the correct dosage of the person medicines had not been administered. In other examples, one person had been administered insulin mistakenly and another person had been administered tablets incorrectly. In both these cases, these medicines were prescribed to other people. This resulted in one person requiring treatment in hospital and another required monitoring by their GP. This meant there was a risk of serious harm effect on these people's health and wellbeing as a result of not receiving medicines as prescribed or the incorrect medicines. In a further case, one person did not receive one of their prescribed medicines for a period of six days in December 2017. Staff initially did not realise the omission in administration. After staff realised the error, they were slow to act to ensure the person's medicines were obtained quickly to minimise the risk of harm to the person. The person did not suffer any long terms effects from not receiving these medicines, however, the systems in place to ensure people received medicines as prescribed had failed to work effectively.

The systems in place to ensure people received their medicines at the right time were not effective. On the first day of inspection, two agency nurses were carrying out the morning medicines round. The medicines round was severely delayed as there were discrepancies in two people's medicines which the agency nurses struggled to resolve. In one case, a person did not have medicines available which were indicated as required on the medicines administration record (MAR). In another case, a person had medicines available, but there was no accompanying MAR, so nursing staff were not clear how much medicine the person had been prescribed. The registered manager was eventually able to assist nursing staff to clarify each person's needs. However, the delay and confusion put people at risk of not receiving the correct medicines or not receiving medicines within a timeframe which was prescribed to meet their health needs.

The systems in place to record the medicines people were administered were not robustly followed. The registered manager had recently returned 18 flu jabs to the pharmacy as they were not aware of who had been given the flu jab and who had not. No records of administration could be found and at time of inspection, it was still unclear who had received the flu jab. We checked the medicine administration records. Some people's medicine administration records were either missing or had gaps in staff signatures. Therefore it was unclear whether some people had received their medicines as required.

The arrangements for storage of medicines were not always secure and in line with best practice recommendations. Some medicines require refrigerated storage in order to maintain their effectiveness. The service had a medicines fridge but it had been unavailable for use since early January 2018. Since this time some medicines were stored in a refrigerator in the service's kitchen. The fridge was not lockable and was in easy access to staff, visitors and people as it was near a busy walkway. The National Institute for Health and Care Excellence recommends in its publication, 'Managing medicines in care homes' that arrangements for managing people's medicines should include, 'secure storage with only authorised care home staff having access.'

The failure to operate systems for the safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks associated with the home's environment and people's personal safety were not always managed safely. On the first day of inspection, an alarm fitted to a ground floor fire exit was tested. Upon testing, the registered manager told us the alarm had been set to sound 20 to 25 seconds after the door was opened. This meant that people were potentially at risk of leaving the service and being in the vicinity of a main road before staff were alerted to them leaving.

Personal evacuation plans for people were not always fully completed. One person's plan did not detail that they mobilized with a wheelchair. The plan did not instruct staff where to evacuate to or the correct procedure to follow in the event of an emergency. This meant that the risk to people's personal safety in the event of an emergency had not be fully considered or mitigated.

Risks associated with people's health and wellbeing were not always managed safely. Some people had been assessed as being at risk of dehydration and therefore needed their fluid intake monitoring. There were examples of incomplete records where entries were missing for long periods of time or totals of fluids offered were not tallied. This meant that it was not clear if the levels of fluid people received were being reviewed and monitored. We looked at records of one person's fluid monitoring between 7 and 13 January 2018. On three of the seven days sampled, there were significant gaps of seven hours or more throughout the day between recordings of fluid offered. In one case there was only one recording for the entire day. On four of the seven days, the total fluid offered and taken was not measured. This meant that the person was potentially at risk as staff would find it difficult to monitor or assess the effect this had on the person's health and wellbeing.

Another person required the daily use of a cough assist machine due to a medical condition. Staff were asked to record daily after each use of this machine to help ensure that the machine's use and effectiveness could be monitored. The person suffered a complication in relation to their medical condition in January 2018. There were no documented recordings of this piece of equipment use in the dates between 2 and 11 January 2018. The registered manager was unable to confirm if use of this machine took place on every occasion required. This meant that medical professionals were unable to monitor the person's health condition effectively as accurate records of their treatment were not maintained.

Communication was not always effective. The handover documentation used by staff to pass information onto incoming staff was not effective in ensuring important information was passed over. The inspection team were given two examples of handover documentation. Both examples contained inaccurate information. There were examples where people had the incorrect room number assigned to their name, some people who no longer were at the service were still on the handover document and one person was omitted from both examples and no handover information was available. One agency member of staff was unaware of who one person was as they were not listed on the handover sheet. They were unable to confirm the person's room number, whereabouts, medical conditions or risks related to their safety. This posed a risk that people's information about health and wellbeing would not be reliably communicated between staff and therefore it would be difficult for staff to provide safe care in line with their needs.

The failure to put effective measures to mitigate risks to people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views about whether they felt safe living at St Johns Nursing Home. One person said, "I don't know." Whilst another person told us, "I am happy living here."

There were sufficient staff available to meet people's needs. The registered manager told us how the service had experienced shortages of permanent nursing and care staff. The registered manager was in the process of recruiting new staff at the time of inspection. In the meantime, agency staff covered staffing shortages. The registered manager said, "The agency use has gone down over the last month or so. At one point last year it was very high." One person said, "There are always different staff here all the time." A second person commented, "Sometimes there is a bit of a quick change over [of staff]." A third person remarked, "The staff change a lot." Staffing levels were determined by assessments of people's needs. There were enough staff available to meet people's needs, but some agency staff were not always aware of the support people required around their personal care or nutrition and appeared quite rushed throughout the course of carrying out their duties. In one example an agency member of staff told us, "It's not always clear what you need to do with each person. The guidance could be better and it's a bit disorganised here."

The service made the appropriate recruitment checks on staff before they started working at the service. These checks helped to ensure that candidates had appropriate experience, skills and character to suit their role.

The service did not always reflect on incidents to promote learning and development of working practice. The registered manager kept a log of all incidents which took place at the service. This included medicines errors, falls or other incidents involving people and staff. Some incidents were followed up with records of investigations and action, but in the case of other incidents, there was no clear record of any comprehensive investigations that took place, or any learning points that came as a result of reflection. In one case, a member of staff made a medicines error. The registered manager's investigation and subsequent action was not documented. The same member of staff made another medicines error in December 2017. Therefore it was not apparent that any training, learning or support had been offered to the member of staff in order to mitigate the risk of this reoccurring.

Staff were aware of their responsibilities to safeguard people from abuse and harm. Staff had received training in safeguarding, but nine of the 10 permanent care staff were overdue a training update in this area. The registered manager kept a log of all safeguarding concerns and had raised alerts to the local safeguarding bodies when appropriate. There were records of investigations made in relation to these concerns which outlined the steps the service had taken in order to keep people safe. At the time of inspection there were two ongoing safeguarding alerts that the registered manager had been asked to investigate by the local safeguarding team.

There were systems in place to ensure people were protected against the risk of spread of infections. Staff had received training in infection control. However, all of the 10 permanent care staff were overdue a training update in this area. Staff were able to describe the steps they would take to in order to minimise risk of infection by use of appropriate hand washing and personal protective equipment, such as using gloves during personal care. All staff were aware of systems and processes to promote good hygiene when carrying out cleaning and laundry duties at the service. The service had also received a five star rating from the food standards agency. This judges that the level of hygiene and cleanliness was 'very good' .This helped to ensure that people were protected against the risk of infections.

Requires Improvement

Is the service effective?

Our findings

The registered manager did not have a clear oversight into the ongoing training needs of staff. On the first day of inspection, the training matrix in place did not contain current information about the training staff had attended and required. As there was no current information available, the registered manager arranged for a new training matrix to be produced in time for the second day of inspection. This demonstrated that there was a lack of ongoing monitoring of staff's training needs and development.

Upon reviewing the most current staff training information, significant numbers of care staff were overdue training updates in key areas of their role. Out of 10 care staff (excluding newly recruited staff), nine staff were overdue an update for their safeguarding training, infection control and fire training. Eight care staff were overdue a training update in health and safety and seven staff's moving and handling training was past due. In one example, a staff member had not received a training update in the safeguarding of vulnerable adults since September 2015. The service's training records said the staff member was due a training update in this area in September 2016.

The failure to ensure staff received appropriate support, training or professional development to enable them to carry out their role effectively was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's legal rights were not protected as the staff did not always follow the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. The registered manager had documented some decisions which had been made in people's best interests but there were other decisions that had been made about people's care and treatment without following a process in line with the MCA. In one example, one person had the use of bed rails. In their care records it was documented that the person was assessed to lack capacity to consent to their care and treatment. However, the registered manager confirmed that there had been no capacity assessment or best interest's process in relation to the specific decision for the use of bed rails. As bed rails are classed a physical restraint, there needed to be due processes in line with the principles of The Mental Capacity Act 2005 to ensure these actions were necessary and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the MCA, and if any conditions on authorisations to deprive a person of their liberty were being met. We found the system to monitor the applications for authorization under the Deprivation of Liberty Safeguards was not effective in identifying the people who had applications for authorizations sent, granted and those who required assessments to determine whether they met the criteria for this. During our inspection the registered manager identified six people who would likely require applications to the supervisory body, but

no assessments or applications had been made. This meant that some restrictions to people were in place which had not been assessed as being least restrictive in line with the principles of The Mental Capacity Act 2005. The registered manager told us, "This was something I was really worried about and I know we have to sort it out."

The failure to act in line with The Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked the food at the service and were given a choice about what to eat. One person said, "The food is absolutely fine." A second person commented, "If I don't like it I say so and they take it away and bring me something else." The support people required around their fluid and nutrition was detailed in their care plans. Where people required adapted or specialised diets the kitchen staff were aware of the individual's requirements.

People were not always given sufficient support and encouragement during mealtimes. Some people required support to eat their meals. We observed lunch times during three days of inspection and found that there were occasions where staff often became distracted with other tasks whilst helping people with their meals, or did not provide care in line with guidance in their care plan. In one person's care plan it detailed how staff needed to be aware the person was accustomed to having a specific drink before their meal. We observed that this was not offered by staff. The person was reluctant to eat and received limited encouragement or support from staff. When staff eventually offered support, the person's food was cold and they were not keen to eat it. The person was offered more support around eating their desert and as a consequence they ate their entire portion. The person's care plan did not indicate they needed support whilst eating. We brought this to the attention of the registered manager who agreed to review the person's nutritional care plan without delay.

People had access to healthcare services as required, but some people's health needs were not fully assessed or known. People had access to a range of healthcare services including doctors, dentists and chiropodists. Details of their health needs were documented in their care plans. However, not everyone's health needs were fully met. In one person's care plan it detailed how they were required to wear hearing aids. We observed that the person was not wearing hearing aids throughout the inspection. When we spoke with staff about this, some were unclear as to whether the person required these. In the person's care records, there was no record of a referral to an audiologist or related appointments. The registered manager told us they would investigate this to determine whether these hearing aids were required.

There were a range of assessments that staff made to determine an appropriate care and treatment plan. These were nationally recognised tools in order to assess; people's staffing needs, risks of malnutrition and dehydration and the risk of skin break down. This assessment helped to formulate people's care plans and action staff needed to take in order to keep people safe. However, although assessments were made, staff did not always comprehensively follow or record agreed actions, which meant it was sometimes unclear about the level of care people received or the impact these interventions from assessments had.

The provider had made adaptions to the home to make it suitable for people. There was a passenger lift for ease of access to each floor. This helped people who struggled with their mobility access both floors of the service. There were lounges available on both floors of the service. On the ground floor there was a choice of communal spaces which could be used if people wanted quieter time or some privacy. There was access to outside space, but garden space was not enclosed and therefore people were only able to gain access to this with the help of staff. People had access to specialist equipment to help them with their mobility. This included a range of equipment, from adapted bathing facilities to aids to help them move from sitting

positions.
The registered manager did not have a clear oversight into the ongoing training needs of staff. On the first day of inspection, the training matrix in place did not contain current information about the training staff had attended and required. As there was no current information available, the registered manager arranged for a new training matrix to be produced in time for the second day of inspection. This demonstrated that there was a lack of ongoing monitoring of staff's training needs and development.

Upon reviewing the most current staff training information, significant numbers of care staff were overdue training updates in key areas of their role. Out of 10 care staff (excluding newly recruited staff), nine staff were overdue an update for their safeguarding training, infection control and fire training. Eight care staff were overdue a training update in health and safety and seven staff's moving and handling training was past due. In one example, a staff member had not received a training update in the safeguarding of vulnerable adults since September 2015. The service's training records said the staff member was due a training update in this area in September 2016.

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People were not always given sufficient support and encouragement during mealtimes. Some people required support to eat their meals. We observed lunch times during three days of inspection and found that there were occasions where staff often became distracted with other tasks whilst helping people with their meals, or did not provide care in line with guidance in their care plan. In one person's care plan it detailed how staff needed to be aware the person was accustomed to having a specific drink before their meal. We observed that this was not offered by staff. The person was reluctant to eat and received limited encouragement or support from staff. When staff eventually offered support, the person's food was cold and they were not keen to eat it. The person was offered more support around eating their desert and as a consequence they ate their entire portion. The person's care plan did not indicate they needed support whilst eating. We brought this to the attention of the registered manager who agreed to review the person's nutritional care plan without delay.

People had access to healthcare services as required, but some people's health needs were not fully assessed or known. People had access to a range of healthcare services including doctors, dentists and chiropodists. Details of their health needs were documented in their care plans. However, not everyone's health needs were fully met. In one person's care plan it detailed how they were required to wear hearing aids. We observed that the person was not wearing hearing aids throughout the inspection. When we spoke with staff about this, some were unclear as to whether the person required these. In the person's care records, there was no record of a referral to an audiologist or related appointments. The registered manager told us they would investigate this to determine whether these hearing aids were required.

There were a range of assessments that staff made to determine an appropriate care and treatment plan. These were nationally recognised tools in order to assess; people's staffing needs, risks of malnutrition and dehydration and the risk of skin break down. This assessment helped to formulate people's care plans and action staff needed to take in order to keep people safe. However, although assessments were made, staff did not always comprehensively follow or record agreed actions, which meant it was sometimes unclear about the level of care people received or the impact these interventions from assessments had.

The provider had made adaptions to the home to make it suitable for people. There was a passenger lift for ease of access to each floor. This helped people who struggled with their mobility access both floors of the service. There were lounges available on both floors of the service. On the ground floor there was a choice of communal spaces which could be used if people wanted quieter time or some privacy. There was access to outside space, but garden space was not enclosed and therefore people were only able to gain access to this with the help of staff. People had access to specialist equipment to help them with their mobility. This included a range of equipment, from adapted bathing facilities to aids to help them move from sitting positions.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity and respect. Although most staff interactions we observed were positive we noted instances when this was not the case. One person requested to go upstairs as they were uncomfortable and wanted to lie down. We observed a member of tell the person they were too busy to this. Another member of staff intervened and called for the member of staff to assist. The first member of staff complained openly to the second member of staff in earshot of the person about how busy they were before eventually supporting the person out of their chair. This was not dignified or respectful towards the person requiring assistance.

Another person we spoke with had been sitting on their sling (mobility aid used in hoisting) on an armchair. They told us they had been waiting for staff to help them to move and that sitting on the sling was uncomfortable. They told us they did not enjoy being hoisted, "Yes it's pretty horrible. My legs and feet get knocked." When we asked if staff explain what they are doing during hoisting to make it more comfortable, the person said, "No, not really, but what can you do."

We spoke to another person and their relative. The person was receiving care in their room. At the time of our visit there were six wheelchairs which were placed in their room. Their relative told us how five of them were not their family member's but had been stored there for approximately a week. The relative confirmed staff had not asked the person's or family member's permission to store such a large amount of items in their bedroom. This demonstrated a lack of respect in relation to people's private spaces.

We brought these issues to the attention of the registered manager who told us they would look into these issues without delay.

The failure to ensure people were treated with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were involved in making choices about their care, but the service was not always responsive in promptly auctioning people's requests. Staff worked with people to identify their likes and preferences which then helped to formulate their care plans. One member of staff said, "When we have new residents I introduce myself to the families and discuss what people liked to do; do they have their own hairdresser or chiropodist. I fill out paperwork, [in regard to] likes and dislikes usually after about a week."

People and their relatives told us that they were consulted about their care, but sometimes suggestions took a long time to materialise. One person said, "They [staff] do listen, but I don't feel like things get done quick enough." Another person's relative commented, "I ask and ask, it feels like staff are taking it in, but the inconsistency means it takes a while to change things." A second relative remarked, "I have asked so many times for staff to change this light. It keeps going on and off and it drives me mad. I'm sure they will do it, but when I don't know, they seem too busy." This was in relation to a light outside their relative's room which was flicking on and off.

Permanent staff were caring and knowledgeable about people's needs. One person said, "At the end of their shifts the girls usually come and sit and chat." Another person said, "By and large the staff are very caring." Staff were dedicated to their role and told us how they spent time with people when possible to give them reassurance and comfort. One member of staff said, "I can tell if people are in a mood or need a lift or boost." Another member of staff commented, "[During] The first six months I took my time getting to know people. It is really important to try to understand the people you look after."

However, people also told us that non-permanent staff could vary in quality and not all of them understood their needs. One person said, "Quality of staff varies greatly. Some are not very respectful." Another person said, "Some might be a bit sharp but generally they are ok." Some staff appeared rushed or unfamiliar with the support people needed around their personal care or meal times. One temporary member of staff said, "I have been rushing around all morning, it's stressful."

Requires Improvement

Is the service responsive?

Our findings

People's care plans and information contained in staff handover documentation did not sufficiently reflect people's needs in relation to their health, wellbeing or communication and behavioural needs. This meant that there was a risk that staff would not have sufficient guidance in place in order to provide personalised care to people.

In one example, one person's care records referred to their 'behavioural problems'. The person's care plan did not identify what these behaviours were. The care plan did not reference any potential causes or triggers to this behaviour. There was no guidance in place for staff to adopt strategies to reduce the person's anxieties. This meant that staff were not given guidance about how to provide effective support for this person, reduce their anxieties or promote their wellbeing. In another example staff were observed to struggle to adopt a consistent approach to one person who was repeatedly vocalising about wanting food and drink. Staff we spoke with were unaware of potential reasons for the person's repetitive behaviour or effective strategies to adopt when working with the person. One member of staff said, "They are always saying they are hungry and thirsty. I don't know why, maybe it's because they are forgetful?" The person's care plan made no reference to the possibility that their hunger and thirst were common side effects from their medical condition and therefore could yield some explanation into an underlying cause to their vocalizations. This meant that staff had not adopted a consistent way to support the person or had considered reasons or underlying causes for their behaviour.

People's care plans contained contradictory and sometimes inaccurate information. In one person's care plan it documented how the person was unable to use their call bell to signal for staff's assistance. However, the care plan also instructed staff to ensure the person had their call bell with them at all times. We asked the person if they were able to use their call bell and they were able to demonstrate how and why they would use it. Some staff also told us that the person was able to use the call bell system effectively to call for assistance if required. However, other staff told us that the person did not understand how to use the call bell system. This meant that this person's care plan contained inaccurate information about the their abilities and staff were not always aware of the appropriate support people required.

We brought these issue to the attention of the registered manager, who told us they were planning to review all people's care plans to help ensure they contained accurate and detailed guidance in line with people's needs and preferences.

The failure to provide a plan of care that met people's needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they enjoyed the activities that took place in the service. One person said, "The singers that come in are wonderful." A person relative commented, "The staff take the trouble to get people out of bed so they can join in. It's stimulating for them. I think it's good the staff take the trouble." The service had an activities coordinator in place, whose role it was to design a programme of activities suitable for people. They told us, "We have entertainers every Monday; they are loved by the residents. We try to get everybody

as involved as possible and we don't want people to miss out." We looked at records of activities provided in January 2018. There were regular externally based singers and entertainers that came in, coffee mornings, quizzes, beauty and wellbeing sessions and regular time dedicated to people who were receiving care in their bedrooms due to their health conditions. We observed that the activities co-ordinator took time to engage people in informal chats and activities throughout the day. People told us they enjoyed the time that staff were able to spend with them, but they often appeared quite rushed. One person said, "I love talking to the staff, but they are always running off because they are busy."

There was a complaints policy in place and people told us they were comfortable in raising concerns. One person said, "If I had a complaint I would speak to the boss [registered manager]." A second person commented, "If I had a problem I would raise it, it's not telling tales, it's fact." The registered manager kept a log of all complaints that had been raised. These records included investigations into concerns raised and outcomes from what was found. The registered manager wrote to people with the outcome of their investigations. This helped to ensure that people were given the opportunity to review all the information at hand to ensure they were happy with the outcome.

There were plans in place to help ensure people's wishes were followed when they received care at the end of their life. People and their families were consulted about how they would like to receive care and treatment in their last days and after they had passed away. Where people had made advanced decisions about their care and treatment, these were documented in their care records. This helped to ensure that healthcare professionals were instructed as to how people wished to receive care in the event they were not able to communicate this at the time.

Inadequate

Is the service well-led?

Our findings

Audit and quality assurance systems were ineffective in assessing the quality of the service and did not identify key areas where action was required to keep people safe. An external fire safety audit was carried out on 18 January 2018. This audit was carried out by a fire safety professional. The audit identified that nine of the 25 emergency lights at the service required replacing. It also identified that a fire door did not shut properly and therefore would not be effective in keeping people safe during an emergency. A designated member of staff carried out weekly health and safety audits which included checks on emergency lighting and fire doors. On the last audit carried out on 12 January 2018, no issues were identified in relation to these two areas. Therefore, these internal audits were not effective in identifying where action was needed in order to maintain a safe environment. The registered manager acknowledged there were deficiencies in the quality of these audits and told us after the inspection, "We are also interviewing for the maintenance staff with someone who has fire experience."

Audits of the medicines management system were not effective in ensuring people received their medicines safely and as prescribed. We looked at medicines audits which were carried out weekly. These audits were designed to identify if there were any issues with the ordering, administration, storage and disposal of medicines. We looked at medicine audit records from October 2017 to December 2017 and found that although medicines errors had occurred, there was no evidence that these audits picked up any errors or discrepancies. Therefore these audits were not effective in monitoring the safety and effectiveness of medicines records.

There was a significant lack of support around the registered manager. There was a lack of a management structure in place, which meant that key aspects of ensuring the quality and safety of the service were compromised. The registered manager told us how the clinical lead had left the service in November 2017 and there were no designated senior staff to carry out audits or checks on the quality and safety of the service at the time of inspection. The registered manager told us that in the absence of a clinical lead, agency nurses would carry out audits of medicines or people's care records. There were clear failings in the safe management of people's medicines, which the lack of suitable supervisory staff contributed towards. As agency nurses were not permanent, they did not have the continuous insight and overview of the service required in order to implement systems which promoted effective and safe working practices. Therefore, when issues with the ordering, storage, administration and disposal of medicines arose, there was no consistent governance or oversight in place to put the necessary remedial actions in place to prevent errors from reoccurring.

The registered manager told us they were solely responsible for the majority of key areas of running the service. This resulted in them working long hours. As a consequence of the lack of supporting managers or supervisory staff, the registered manager had struggled to maintain effective oversight into key areas such as; Deprivation of Liberty Safeguards, staff training and development, ensuring people's care plans were current to their needs and following up on incidents. This had resulted in a deficiency in the quality of the records kept in relation to key areas of people's health and care planning, meaning that people were potentially at risk from not receiving appropriate care and treatment. The registered manager told us they

were unable to access emails and some records related to the service. This meant that people's health, wellbeing and safety were at times compromised.

There was no support system in place for the registered manager from the provider. There were no documented provider led quality assurance procedures that ensured that there was adequate oversight of the registered manager and the quality and safety of service provision. The registered manager told us that the registered provider regularly visited the service, but these visits did not coincide with times the registered manager was at the service. The registered manager confirmed they had not received a formal supervision or appraisal in their role and they were unclear about who to turn to within the provider for support or guidance.

Our findings from this and previous inspections have shown a history of non –compliance with regulations. The past three comprehensive inspections have resulted in Inadequate or Requires Improvement ratings. The breaches in regulation have covered a range of areas and where improvements had been made, these were not sustained. The service was first put in special measures after receiving a rating of inadequate after a comprehensive inspection in February 2016. At that inspection there were multiple breaches in regulation. After our comprehensive inspection in December 2016, the service received a rating of requires improvement and was taken out of special measures. Although there had been improvements at that inspection, the service was still in breach of two regulations at that time. At this inspection, we identified seven breaches in six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. This further demonstrates that the service was not able to implement and sustain a consistent model of high quality care

As at other inspections, a number of the shortfalls related to matters which had been brought to the provider's attention on previous occasions. These related to key aspects of the service, such as; safe care and treatment, staffing , consent, good governance, person centred care and dignity and respect. At our previous inspection in December 2016, we identified breaches in Regulations 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, around consent and staffing. The provider sent us an action plan telling us how they were planning to meet the requirements of these regulations. Their action plan informed us they would be compliant by February 2017. At this inspection we found continuing breaches in these regulations and in addition other areas of concern, highlighted earlier in this report. This demonstrated that the service was unable to implement and sustain the changes and improvements necessary to meet these regulatory requirements.

The failure to implement systems and processes to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Providers are required by law to notify CQC of significant events that occur in care homes. This allows CQC to monitor occurrences and prioritise our regulatory work. We found that St Johns Nursing Home did not inform us when four people's authorizations under Deprivation of Liberties Safeguards were granted.

The failure to notify CQC of the people's authorizations under Deprivation of Liberty Safeguards was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People gave mixed feedback about the management of the service. When asked how effective the management of the service was, one person said, "The manager is a nice person." However, another person commented, "I couldn't tell you who is in charge." However, staff told us that the registered manager was hard working and supportive. One member of staff said, "The registered manager has been very supportive.

They have really worked hard to try to make things better."

The registered manager sent surveys to people and relatives to gain feedback about the quality and safety of the service. The surveys asked for feedback about a range of areas including staffing, quality of food, quality of environment at the service and feedback about the management. Out of 15 people who completed the last survey, there was strong positive feedback about access to healthcare services but very negative feedback about staffing levels at the service. The registered manager used the findings of these surveys as topics for discussions in regular team meetings. Team meetings were used to discuss and reflect on incidents and events. However, these discussions were not always effective in driving improvement. In a recent staff meeting in November 2017, the registered manager discussed with staff where improvements were needed in people's care and health records. As we found gaps and inaccuracies in people's health records, the discussions at these meetings did not act as a catalyst to implement improvements.

The registered manager was open to taking feedback and working in partnership with other stakeholders. In 2017, they had arranged for an external pharmacy to carry out an audit of the services medicines management system. In light of recent concerns, the registered manager told us they were arranging for the pharmacy to carry out another audit in order to make recommendations to improve their system and working practices.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC of the people's authorizations under Deprivation of Liberty Safeguards

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to provide a plan of care that met people's needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to act in line with The Mental Capacity Act 2005