Chengun Care Homes Ltd

St John's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service:

St John's Nursing Home is a care home situated in the town of Boston, Lincolnshire. The home is registered to provide accommodation for up to 37 older people, some of whom live with dementia and complex physical health needs. There were 31 people living in the home at the time of our inspection.

People's experience of using this service:

The registered provider had failed to ensure risks to people's health, safety and welfare had been effectively identified, assessed or managed, which placed people at risk of harm. Specialist healthcare support had not always been sought in a timely manner. Some vulnerable people had received treatment in hospital as a result of poor care practices.

The registered provider had failed to ensure people were supported to eat and drink enough to maintain good health. Furthermore, they had failed to ensure people's continence and skin integrity needs had been effectively assessed and managed. The registered provider had not followed the advice of healthcare professionals regarding essential care to meet people's needs.

The registered provider had failed to implement effective infection prevention and control control practices which placed people at risk. Some people had developed infections that had not been recognised or appropriately managed by staff which subsequently required medical treatment.

The registered provider had failed to recruit and retain the required numbers of staff to provide consistent care for people. This meant there was a reliance on the use of agency staff who did not know people well or fully understand their care needs.

The registered provider had failed to ensure that staff had the right knowledge and skills to care for people safely and that they understood their responsibilities. This meant that people did not receive the essential care they required. Furthermore, they had failed to accurately assess the levels of staffing required to keep people safe and meet their needs.

The registered provider had failed to ensure people received the right medicines at the right times because arrangments for the ordering and monitoring of medicines did not support good practice.

The registered provider had failed to ensure effective governance and leadership systems were in place. This meant there was no clear oversight of the quality of care provided for people and opportunities for learning and improvements had been missed due to poor governance and leadership arrangements.

Why we inspected:

This was the first inspection of St John's Nursing Home since the registered provider registered the location with CQC in November 2018.

We brought forward the inspection due to information we received from partner health and social care agencies regarding serious risks and concerns for the health, safety and welfare of people who lived St John's Nursing Home. They had been carrying out regular checks of the care provided at the home over the course of the previous month. The inspection focused on two key questions; Is the service safe? and Is the service well-led?

Enforcement:

The services provided for people met the characteristics of an inadequate rating in the key questions: Is the service safe? and Is the service well-led?

We urgently removed the location from the provider's registration to ensure regulated activities could not be carried on from there.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

St John's Nursing Home

Detailed findings

Background to this inspection

The inspection:

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This focused inspection was prompted by information we received from partner health and social care agencies regarding their serious concerns for risk to people's health, safety and welfare.

The information shared with CQC also indicated potential concerns about the management of risk and leadership. This focused inspection examined areas of potential risk, including infection prevention and control, nutrition and hydration, continence management, medicines management and the use of pressure relieving equipment.

Inspection team:

The inspection was carried out by two inspectors and one assistant inspector.

Service and service type:

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. The service provides accommodation and personal and nursing care for up to 37 older adults and people living with dementia.

St John's Nursing Home had a manager registered with the Care Quality Commission. This means that they and the registered provider are legally responsible for how the home is run and for the quality and safety of the care provided.

Notice of inspection:

This inspection was unannounced.

What we did:

Prior to the inspection we reviewed information we had received about St John's Nursing Home. We sought feedback from local authority commissioners and safeguarding adults team and other health care professionals who worked with the service.

During the inspection we gathered information by observing the care that people received. We reviewed the care records for 6 people. We looked at records in relation to the management of the home such as quality audits.

We spoke with the registered manager, three registered nurses and 4 members of care staff. We also spoke with a visiting local GP, local authority representatives and clinical commissioning group (CCG) representatives.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Preventing and controlling infection; Using medicines safely; Learning lessons when things go wrong:

• The processes for identifying, assessing and managing risks to people's health, safety and welfare had not be carried out effectively. In some instances, although risks had been identified, assessments had not been carried out to ensure people were cared for safely. In addition, some risk management plans and advice from healthcare professionals were not followed by staff. Throughout the inspection we observed numerous instances of these issues, examples of which are detailed below.
• One person was identified as being at risk of malnutrition. Their risk assessment indicated that they should be weighed weekly and they had lost a significant amount of weight between January and February 2019. The person was not weighed again until the end of March 2019 when a further significant weight loss was recorded. There was no evidence available to show that action had been taken to provide appropriate support, such as a referral to a nutritional specialist or the person's GP, and the person's risk assessment had not been reviewed or updated.
• One person was assessed as requiring full assistance with eating and drinking to prevent malnutrition and dehydration. Care records showed the person had poor food and fluid intake on the two days prior to the inspection and they had also vomitted. Partner agency health professionals had raised concerns about this with the registered provider and registered manager at the time. However, during the inspection we observed the person's breakfast had been left uncovered and untouched in their bedroom for over three hours. The person's care plan said that food should be re offered after 15 minutes if declined and there was no evidence in care records to show this had been done. In addition, we observed that fluids in the person's room were out of reach and records showed they had only drunk 150mls of fluid in in the previous 12 hour period. When we raised this with staff, an agency nurse said they were told the person was able to eat and drink independently.
• Where people had been assessed as being at risk of skin damage specialist mattresses for their beds had been provided. However, six of the mattresses we checked were not set to operate effectively. One mattress alarm was sounding as a leak had occurred. Three mattresses were set to a static mode which meant they would not alternate the pressure on vulnerable parts of people's body. The weight settings on two mattresses were set incorrectly for the people using them. For example, one person's weight was recorded as 36.9kg and the mattress was set for a weight of 110kg. Incorrect use of pressure relieving mattresses increased the risk that people would experience skin damage.
• Furthermore, when the issues with specialist mattresses were brought to the attention of staff they did not know how to reset the mattresses correctly due to lack of training.
• We spoke with the registered manager about the monitoring of people's weight to enable appropriate nutritional and pressure area care to be provided. They told us, "I have no idea who is at risk."
• Risks arising from continence needs, such as skin damage, infection and loss of dignity had not been

effectively assessed or managed. Only one type of continence product, in varying sizes, was available to people regardless of their individual needs or preferences. During the inspection we observed four people, although wearing continence products, experienced the indignity of being in wet clothes and unsupported in communal areas having had an episode of incontinence. Two of the people had clearly indicated their need to use toilet facilities which had not been recognised by staff. When we indicated to staff that another person required assistance with continence needs they attempted to take the person for a cup of tea. This was despite the person's clothing being visibly wet from their waist to their ankle.

• Throughout the day of the inspection there was an unpleasant odour in corridors, the entrance hall and the main lounge area resulting from unmanaged continence needs. Housekeeping tasks had failed to address the odour. This increased the risk of infection and did not support people's dignity.

• During our inspection we found that staff had not always followed advice from healthcare professionals to manage risks to people's health. One person's care records showed they had been diagnosed with a urinary tract infection (UTI) and were at risk of recurrent infections. They had been visited by a healthcare professional on three separate days in March 2019 who had advised staff to monitor the person's fluid intake and output as part of the management of the infection. Records showed that staff had not completed the monitoring as advised.

• One person's care plan recorded that they had seen a speech and language specialist in March 2017 and they advised that the person needed to have a modified diet to minimise the risk of choking. However, a risk assessment regarding the potential for choking, which was completed in January 2019, indicated that the person was not receiving a modified diet thus increasing risk for the person.

• Prior to the inspection partner agency healthcare professionals made us aware of four people who had been recently admitted to hospital from the home. One person had an untreated infection and had been diagnosed with dehydration and malnutrition on admission to hospital. As a result of partner agency healthcare professionals seeking medical support regarding concerns for two people, those people had also been admitted to hospital with infections. Partner agency healthcare professionals told us they had identified that a fourth person was at risk of developing cellulitis (a common but potentially serious bacterial skin infection) and immediately brought this to the attention of the registered provider. After four days the partner agency healthcare professionals noted a deterioration in the persons condition and this resulted in admission to hospital where the person was diagnosed with cellulitis.

• Prior to the inspection we were made aware that local authority infection prevention and control staff had decommissioned a number of armchair cushions as they were heavily stained and presented an infection control risk. During the inspection we observed that several of the cushions had been stored in the clean area of the laundry room, increasing the risk of cross infection. Staff told us that they had been instructed by the registered provider to attempt to clean the cushions and make them available for use, despite the earlier decommissioning. Following the inspection the registered provider said they had not issued these instructions to staff.

• We observed that items of personal clothing and bed linen, although having been laundered, were heavily stained and presented an infection control risk. In addition, we observed the material on an armchair in one bedroom was torn which meant it would be difficult to keep clean.

• In the main lounge area we observed a brown substance stuck to the ceiling near to a dining table. A staff member told us this was part of a pudding served the previous day and had not yet been cleaned away.

• In one bathroom we observed a cushion was stored on top of a toilet, increasing the risk of cross infection. In addition, the flooring in the bathroom was in need of repair which meant it would be difficult to keep clean.

• The registered manager told us the registered provider had made changes to the way in which medicines were ordered and delivered. The new system required the registered provider to send prescriptions to a pharmacy based in London (over one hundred miles away from the home) who then delivered them to the home. The registered manager described how the new system had created "Total confusion," and he could not always guarantee that all of the required medicines would be delivered in a timely manner as he had no

control of the system.
• We noted that the new monthly prescription cycle was due to commence on the morning of Friday 5 April 2019 which meant medicines would need to be delivered to the home by 4 April 2019 in order to be checked and recorded. On the day of the inspection, 2 April 2019, the London based pharmacy had informed the registered manager that some prescriptions were missing from the regular order. This meant the registered manager had to review what medicines were needed, organise further prescriptions from the local GP, inform the registered provider when they arrived at the home in order for them to picked up and sent to the London based pharmacy. This system increased the risk that people's medicines would not be available to them when required.
• There were no protocols in place to guide staff in the use of special medicines prescribed for people who were at the end of their life (known as anticipatory medicines). This increased the risk that people may not receive consistent symptom management. Protocols for the use of most other medicines people only needed at certain times, such as pain relief, were in place to guide staff as to how and when to administer them.
• During the inspection it was brought to our attention that a prescribed medicine intended for one person was available in liquid and tablet form, both of which were stored in the medicine trolley. The box of tablets contained a handwritten note, not dated or signed, to indicate the liquid form should be used. There was no indication on the person's medicine administration chart which form of the medicine the person should be or had been receiving. In addition, a check on the amounts of liquid and tablets left in the medicine trolley indicated that both forms had been used since the liquid had been prescribed.
• Some risk management plans and care plans contained contradictory information about the care needed to keep people safe. For example, one person's care records noted that they needed to be checked every half an hour at night to ensure their safety as they were unable to use the call bell. Another part of the person's care records noted that the person should be checked hourly. This increased the risk that the person' needs would not be met in a timely manner.

The failure to identify, assess and effectively manage risks to people health, safety and welfare; including the prevention and control of infection and management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The failure to ensure people received adequate nutrition and hydration to maintain good health was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment:

• Local authority and NHS clinical commissioners told us they were concerned that the registered provider's assessed staffing levels were not sufficient to meet people's needs. They had assessed the level of staffing needed to keep people safe and meet their needs and told the registered provider the level they needed to provide. As a result of this, on the day of the inspection, there were three registered nurses and 14 care staff on duty. However, only five members of care staff were permanently employed by the registered provider; the other staff being agency staff.
• The registered manager told us the registered provider had assessed that one registered nurse and nine care staff should be able to meet people's needs. However, they were unable to provide the tool that the registered provider had used to calculate these staffing levels so we were unable to validate this information on the day. Following the inspection the registered provider sent us a copy of their staffing level calculation tool. When we compared the rating for people's dependency levels with those recorded in their care plans we found there was little correlation. For example, one person's care plan had identified they had a high level of dependency whilst the staffing level calculation tool had identified their needs as low dependency. The lack of consistency in the way people's dependency levels were assessed meant that the registered

provider could not accurately determine the required staffing levels for the home.
• Two housekeepers had not arrived for work on the day of the inspection. The registered manager had been able to find one housekeeper to cover for part of the day and a registered nurse also carried out some cleaning duties. As a consequence of the housekeeping staff shortage, by mid-afternoon the home was running short of clean bed linen and care staff had to be released from supporting people so as to work in the laundry. It also meant that one registered nurse was not available to carry out nursing duties whilst engaging in cleaning.
• Our records showed, and the registered manager told us that since the home was registered in November 2018 there had been a high turnover of registered nurses, care staff and housekeeping staff. The registered manager said that at the time of inspection only two part time registered nurses were permanently employed. Despite an active recruitment programme the registered provider had not been able to recruit or retain sufficient numbers of registered nurses to cover the work rota. The registered manager told us about one example in which a registered nurse had been employed but had left after a short time. This meant there was a reliance on the use of agency nurses to cover the rota.
• The reliance on the use of agency nurses reduced the registered provider's ability to ensure a consistent, knowledgeable and person-centred approach to people's care. Agency nurses told us that they did not have the information they needed to support people safely. When they had arrived at the home they had only been given a list with people's names and room numbers. They had received no information about people's needs or the risks associated with those needs.
• Following the inspection the registered provider sent a copy of a handover sheet they had prepared for agency staff, intended to mitigate risk. However, we noted that, for example, for one person there was no indication that they needed pressure area care every three hours to help manage their skin condition. For another person it was noted they needed encouragement to eat while their care plan recorded that they were unable to eat independently. As the registered provider had failed to effectively communicate the identified risks to people's health and safety, agency staff would still not be able to effectively mitigate those risks.

The failure to accurately determine appropriate staffing levels, together with the failure to ensure all staff were sufficiently knowledgeable about people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse:

• The registered manager had a good understanding of the procedures for reporting and managing situations in which people were at risk of abuse. Our records showed that prior to the registration of the home under the new provider in November 2018 the registered manager and staff had identified, reported and managed such situations appropriately. However, since November 2018 the reporting of some concerns to the local authority safeguarding team had been delayed. In addition, concerns such as we have detailed earlier in this section of the report had not been identified and were not reported until partner agencies had raised their concerns. This meant that people were at continued risk of unnecessary harm resulting from poor care practices.

The failure to identify and report situations where people were at risk and take appropriate action to protect them from potential harm and improper treatment was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:

• Prior to the inspection the registered manager informed us they had resigned from their post and were working out a period of notice. They told us they were no longer able to carry out the role of registered manager effectively in line with their regulatory responsibilities. They added that new ways of working introduced by the registered provider; such as the removal of the deputy manager post and the expectation that the registered manager would cover nursing shifts; meant they had little time to complete management tasks.
• We found that quality assurance audits had not been completed since November 2018. This meant the registered provider and manager were not able to maintain effective oversight of the quality of the care provision or identify areas for learning and improvement. An example of this was mentioned earlier in this report where staff were unable to reset specialist mattresses correctly due to lack of training.
• The impact of ineffective governance as demonstrated earlier in this report showed that the registered provider and manager had, for example, failed to identify and manage risks to people's physical health; failed to review and improve medicines arrangements; failed to identify and manage infection control risks; and failed to ensure people received adequate nutrition and hydration.
• Following the inspection we raised our concerns with the registered provider relating to the immediate risks to people's health, safety and welfare. We asked them to respond with details of how they intended to address the issues and the time frame in which actions would be carried out. In their response, the registered provider failed to set out actions to address a number of the issues. In addition, we were concerned that the actions and time scales the registered provider set for other issues were not sufficient to mitigate the immediate risk to people's health, safety and welfare.
• On the day of the inspection three registered nurses and 14 care staff were on duty to care for the 31 people living in the home. This was in addition to the registered manager working in the home. However, the lack of effective delegation, clear team communication and oversight of care by senior staff meant that, despite adequate staffing levels, people needs were still not being met. On numerous occasions throughout the inspection inspectors and visiting partner agency healthcare professionals had highlighted shortfalls in care provision that had otherwise gone unnoticed. Examples of this were the lack of recognition and timely responses to people's continence needs; one person being care for in bed had become entangled in their duvet cover as it had been put on upside down. Another person sitting in their bedroom had been shouting out with no response from staff. When we checked we saw they had spilt their drink and were unable clear the table or change their clothes.

• People who lived in the home, those who were important to them and the staff team were not routinely involved in making decision about how the home was run. For example, the registered provider had not consulted with people about changes to the way medicines were managed or about changes to the provision of personal hygiene products. People had also not been consulted about a change of use for the dining room, which was now a cinema room.
• Staff members told us there had been no consultation when the registered provider reduced the number of activity support staff and changed the work focus of the one remaining activity co-ordinator. The activity co-ordinator told us the registered provider had set out changes their role to include supporting people to eat meals. Following the inspection the registered provider told us that the activity co-ordinator had asked if they could start their work earlier to help with breakfast. They were also instructed to ensure that films in the cinema room were changed at least three times during the day and that at least five people who lived in the home were to be present for each showing. The activity co-ordinator told us they felt "sad" doing this as most people were not interested in the films and it was not a meaningful activity for them.

The lack of effective governance and leadership was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Working in partnership with others:

• The registered manager told us that they had not had time to submit notifications to the CQC. Notifications are events which happen in the home which the provider is required by law to tell us about. For example, we had not been notified of alerts made to the local safeguarding authority when people were at risk of harm.
• The registered provider and manager had failed to understand their responsibilities in regard to The Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS). For example, one person had a condition on their DoLS authorisation which indicated they should be encouraged to take part in activities to reduce their isolation and loneliness. There was no evidence of the condition being applied. Care records noted only that the person liked to sit in their bedroom; we observed them sitting in their bedroom alone and at times shouting out.
• Some of the systems the registered provider had put in place impacted on the ability of the registered manager to manage the home. For example, the registered manager was no longer able to order any items which were needed for people's care such as continence products and disposable wipes used for personal hygiene support. This was now done by the registered provider. The registered manager told us, and information we had received from other anonymous sources indicated that at times there had been a shortage of this type of product as they had not been ordered in a timely manner. In addition, as mentioned earlier in this report, the registered manager had no span of control for medicines arrangements which increased the risk that people's medicines may not be available when required.
• The registered provider had not acknowledged and followed guidance and advice from partner health and social care agencies to reduce the risks to people's health safety and welfare during the month prior to this inspection. This meant that the quality of care provided for people had not improved. For example, they had failed to address the issue of an unpleasant odour by not carrying out deep cleaning as advised by local authority infection prevention and control staff. They had failed to ensure that people identified to them as being at risk of malnutrition, dehydration and developing infections received appropriate healthcare. This had resulted in at least four people being admitted to hospital.
• In addition, the registered provider had not acted upon the advice of local authority and partner agency healthcare staff regarding appropriate levels of staffing. As noted earlier in this report, this resulted in those partner agencies setting a required staffing level for the registered provider to adhere to in order to keep people safe. When asked about this the registered provider said that financially they were unable to sustain an increase in staffing levels as they did not receive enough funding by way of placement fees. This indicated

that they had not effectively balanced their responsibility to ensure people were safe and had their needs met against financial concerns. Following the inspection, we were informed by the local authority that the registered provider had instructed a reduction in staffing levels within the home to be made despite having the knowledge that people's needs were not being met.

The failure to ensure systems and processes supported high quality care, together with the failure to work effectively with partner agencies was also a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The failure to submit notifications of events which the provider is required by law to tell us about was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Part 4.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to submit notifications of events which the provider is required by law to tell us about.

The enforcement action we took:

We urgently removed the location from the provider's registration to ensure regulated activities could not be carried on from there.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to identify, assess and effectively manage risks to people health, safety and welfare; including the prevention and control of infection and management of medicines.

The enforcement action we took:

We urgently removed the location from the provider's registration to ensure regulated activities could not be carried on from there.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to identify and report situations where people were at risk and take appropriate action to protect them from potential harm and improper treatment.

The enforcement action we took:

We urgently removed the location from the provider's registration to ensure regulated activities could not be carried on from there.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 14 HSCA RA Regulations 2014 Meeting

personal care	nutritional and hydration needs
Treatment of disease, disorder or injury	The registered provider had failed to ensure people received adequate nutrition and hydration to maintain good health.

The enforcement action we took:

We urgently removed the location from the provider's registration to ensure regulated activities could not be carried on from there.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered provider had failed to ensure there was effective governance systems and a robust model of leadership in place to support the provision of high quality care. In addition, the registered provider had failed to work effectively with partner agencies to support the provision of high quality care.

The enforcement action we took:

We urgently removed the location from the provider's registration to ensure regulated activities could not be carried on from there.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The registered provider had failed to accurately determine appropriate staffing levels. In addition, the registered provider had failed to ensure all staff were sufficiently knowledgeable about people's needs so as to provide the care they required.

The enforcement action we took:

We urgently removed the location from the provider's registration to ensure regulated activities could not be carried on from there.