R & E Kitchen

St Johns Nursing Home

Inspection report

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Date of inspection visit:
18 August 2016

Date of publication:
06 October 2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We undertook an unannounced focused inspection of St John's Nursing Home on 18 August 2016 as a result of concerns raised during our previous inspection in April 2016. We inspected the service against one of the five questions we ask about services: is the service Safe?. This inspection was completed as we wanted to follow up on some of the concerns we had regarding the care provided to people living at the home. These included identified shortfalls relating to good governance. In April 2016 we had found the service had not identified significant issues relating to the safety, care and welfare of people who lived at the service. We also found they did not have effective processes in place to monitor and mitigate the risks to service user's health and wellbeing.

We carried out an unannounced comprehensive inspection of this service in April 2016 where seven regulatory breaches were identified. Following the inspection the provider wrote to us to say what they would do to meet these legal requirements. They were also working with health and social care professionals who were providing advice and support in improving the service. We met with the provider to discuss our concerns and wrote to them to provide further details about how they were failing to comply with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. We told them they were required to become compliant with Regulation 17 by 31 July 2016.

The purpose of this focused inspection was to determine whether the provider had become compliant with Regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014. These were the areas we had found which most compromised people's health and safety. We will follow up all other areas of non-compliance which were detailed in our report of April 2016 at our next unannounced comprehensive inspection of the service.

St Johns Nursing Home is registered to provide care treatment and accommodation for up to 38 people. At the time of our visit 29 people were living there. There were nine double rooms. The home had a registered manager in post although they had tendered their resignation. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Although overall we found the environment to be calmer with people's requests for support answered in a more timely way, the provider continued to be in breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014 as they had had not made consistent improvements to ensure people's safety and welfare. We were not satisfied people always had enough to drink, and we were not satisfied people were protected against the risk of scalding. We did not see sufficient evidence that staff had suitable skills to care for people with diabetes or for people at risk of choking.

Staff did not manage wounds in line with NICE (National Institute for Health and Care Excellence) guidance and there were no validated pain assessments in place to ensure people received pain relief when they

needed it.

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.

Risks to individuals were not managed appropriately to keep people as safe as possible.

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. The service was rated as being inadequate at our inspection in April 2016. This rating remains as we did not inspect all domains and the service had not suitably addressed the areas of concern we had highlighted during our inspection in April 2016.

This inspection took place on 18 August 2016 and was unannounced. The purpose of the visit was to follow up on significant concerns we had during our previous inspection which took place in April 2016. The inspection team consisted of one inspector and a specialist advisor. The specialist advisor was a qualified nurse who had experience in best practice relating to frail older people especially those with dementia and end of life care needs.

During our visit we spoke with three people who lived at the service and observed care provided to ten people in communal areas. We spoke with one relative and with six staff. We looked at fifteen people's care records and at other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection we found the provider was in breach of Regulation 17 1,2(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
This regulation related to good governance. We found there were not systems and processes in place to assess monitor and mitigate risks relating to health welfare and safety. We told the provider they needed to become compliant with Regulation 17 1,2(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 31 July 2016. We gave them this time to enable them to make the required improvements and so they could benefit from the support and advice provided by staff from Hampshire County Council and staff from the CCG.(Clinical Commissioning Group)

We returned on 18 August 2016 to establish if the provider was compliant with Regulation 17. We looked at the areas of previous non-compliance which had the greatest impact upon people. We looked at how staff managed risks to people regarding eating and drinking, this included how they managed to care for people who received nutrition directly into their stomach. We looked at how the service managed to support people assessed as having a risk of choking. We looked at how well staff cared for people with wounds and how they assessed people's pain when they were unable to discuss this with staff themselves. We also looked at how staff were made aware of any allergies people had regarding medicines and at the storage of prescribed food thickeners.

The provider was still not able to demonstrate people were consistently receiving sufficient to drink. Although people in communal areas all had drinks in front of them staff did not always prompt them to drink and so some remained untouched. Some people had their fluid intake monitored. Records for one person had been duplicated and different fluid intakes were recorded for the same day on different charts. This made it difficult to understand the amount of fluid this person had actually taken. Other people's fluid charts showed a varying amount of drink offered and taken and there was no guidance for staff about the desired amount of fluid people should have daily. There were some large gaps in recording, for example, one person was recorded as having drunk 500mls of fluid one day but nothing had been recorded since lunchtime one day until breakfast the following day. Very little was recorded to show people were being offered drinks during the night. This raised the possibility that people had large amounts of time where they had not been offered anything to drink.

Staff had been made aware of a risk to people drinking hot drinks which could scald them. A risk assessment had been devised for all residents advising staff to add cold milk or cold water to reduce the temperature of hot drinks. Staff were told no drinks should be served over 44 degrees Celsius to people and staff had been advised they should test the temperature of hot drinks with a thermostat available.

We observed people remained at unnecessary risk due to drinks that were served too hot. One person had a cup of very hot black coffee in front of them. Staff were not in attendance. The person was living with dementia and needed supervision to eat and drink safely. We could see the steam coming from the top of the cup of coffee they had been given. We intervened and discussed the situation with the head of care who took action to ensure the person concerned was not placed at unnecessary risk. We also observed one staff

saying to a different person whilst placing a cup of hot tea in front of them "Here is your cup of tea but don't touch it yet it's too hot" This person had needed support to eat and drink at a mealtime. Another member of staff came across and removed this hot drink.

We did not find staff had a good understanding of diabetes management. One person who had diabetes and who required insulin did not have their blood glucose levels checked even when they appeared drowsy which could have been a sign their blood glucose levels were raised. Staff had not followed a request from a GP who had asked for twice daily records of the person's blood sugar levels for five days. This had commenced the previous day to our inspection but already by the afternoon of our visit there had been two blood glucose tests missed.

People's weights had been recorded every month, with the exception of June 2016 when the weighing scales had been broken. There was however no guidance for staff about what to do if people's weight changed. For example, one person who had diabetes had gained a significant amount of weight over the past three months but this had not been discussed with healthcare professionals.

At our inspection in April 2016 we had concerns about the way the service managed the care of people who received nutrition directly into their stomach via a PEG (Percutaneous endoscopic gastrostomy) tube. During our visit in August 2016 no one living at the service was receiving nutrition in this way. The head of care said nursing staff did not have the skills to care competently for people who needed this support The provider had purchased a PEG feeding policy. There was a page for staff signature at the front of the policy folder but the only signature belonged to the head of care. We spoke with two nurses about the policy. They were both aware there were new policies being downloaded but on the day of our inspection they told us they had not yet seen them. We were not satisfied that staff had the skills and knowledge to care competently for people who needed to receive nutrition via a PEG.

At our inspection in April 2016 we found one person who was at risk of choking had not had this risk effectively assessed and sufficient actions had not been taken to ensure their wellbeing. Staff had not shared information with other relevant organisations such as CQC and Hampshire County Council under safeguarding arrangements as they were required to do. At this inspection we found although some measures had been put in place to reduce the risk of the person choking there were still some areas which had not been addressed adequately, such as when the person was doing leisure activities, as they had a tendency to place things such as crayons in their mouth. This had happened on one occasion. This put the person at continued unnecessary risk.

At our inspection in April 2016 we found the service did not care for wounds effectively and had not followed National Institute for Health and Care Excellence (NICE)guidelines regarding ulcer management. At this inspection we found the records relating to the monitoring and care of a person's wounds remained unclear. There were still no photographs or measurements which meant it was not possible to track the progress of people's wounds effectively.

At our inspection in April 2016 we found there were no validated pain assessments in place and so it was not always possible to assess if people received pain medication when they needed it. This was relevant particularly when people were unable to verbalise to staff they had pain. On the day of our visit no pain assessments were in use and there were many people living at the home who had lost verbal and cognitive ability. This meant people continued to be placed at risk of being in untreated pain.

At our inspection in April 2016 we found that people's medicine records did not have photographs of the person for identification or records of any specific allergies they had . This put people at risk of receiving

medicines which could harm them. We looked at 15 records and found there remained gaps in the provision of photographs and allergies on the fronts of five of these. The Clinical Lead told us they had been in post for four weeks and they had not updated all of these. However they were able to show us the completed versions on the computer which required to be inserted in people's records. This meant while the provider had not implemented the revised information it was available to be added and we were assured this would be completed straight away.

We observed that prescribed food thickeners were stored appropriately. This was an improvement on our inspection of April 2016.

Allergies people had were in the process of being updated on their records.