St John's House Care Limited

St John's House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 30 October 2017 and was unannounced. We also returned on the 2 November 2017. The manager and regional manager was given notice of the second date, as we needed to spend specific time with them to discuss aspects of the inspection and to gather further information.

St Johns House was registered by the Care Quality Commission (CQC) on 21 November 2016. New services are assessed to check they are likely to be safe, effective, caring, responsive and well-led. This was the first comprehensive inspection since the provider registered with CQC, as such; they had not yet received a CQC rating.

St Johns House 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.

St Johns House accommodates 60 people over two floors with a passenger lift available to access both floors. Each floor has separate adapted facilities. The first floor specialises in providing care to people living with dementia. At the time of our inspection there were 20 people living at the home.

A recently appointed manager was in post and had submitted their application to register with CQC. 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. Both the manager and provider were available on the day of our inspection.

At this inspection we found systems for monitoring quality and auditing the service had not always been effective. This is an area requiring improvement.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People who were able to said they felt safe at the home.

Systems were in place to identify risks and protect people from harm. Care records contained guidance and information to staff on how to support people safely and mitigate risks. Risk assessments were in place and reviewed monthly. Where someone was identified as being at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required. Accidents and incidents were accurately recorded and were assessed to identify patterns and trends. Records were detailed and referred to actions taken following accidents and incidents.

There were sufficient numbers of staff to meet people's needs. Staff recruitment procedures ensured only those staff suitable to work in a care setting were employed. Newly appointed staff received an induction to

prepare them for their work. Staff had access to a range of training courses and said they were supported to attend training courses.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely. However, medication audits indicated a high level of errors each month, in relation to administration. We found people's safety had not been impacted.

People's capacity to consent to care was properly considered and the home worked in accordance with current legislation relating to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. This included training for all staff on both subjects. Throughout our inspection, we saw that people who used the service were able to express their views and make decisions about their care and support. We observed staff seeking consent to help people with their needs.

There was a varied and nutritious menu where people could make choices. People had sufficient to eat and drink and were offered a choice throughout the day.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular health checks. People's rooms were decorated in line with their personal preferences.

We found people looked happy and were relaxed and comfortable with staff. People were supported by staff who understood their needs and abilities and knew them well. Staff were kind and caring towards people and upheld their privacy and dignity at all times.

People's privacy was respected. Staff ensured people kept in touch with family and friends. People were able to see their visitors in communal areas or in private. The service placed a strong emphasis on meeting people's emotional well-being through the provision of meaningful social activities and opportunities. People were offered a wide range of individual activities, which met their needs and preferences.

People were involved in planning and reviewing their care as much as they could, for example in deciding smaller choices such as what drink they would like or what clothes to choose. Where people had short term memory loss staff were patient in repeating choices each time and explaining what was going on and listening to people's stories. Staff had good knowledge of people, including their needs and preferences. Care plans were individualised and comprehensive ensuring staff had up to date information in order to meet people's individual needs effectively.

The manager told us complaints would be listened to and managed in line with the provider's policy. People had access to information on how to make a complaint, which was provided in an accessible format to meet their needs. Complaints had been investigated. Records were kept of the complaints and actions taken.

People and their relatives were involved in developing the service through meetings. People and their relatives were asked for their feedback in annual surveys. Staff felt the management team were very supportive and said there was an open door policy.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People had detailed care plans, which included an assessment of risk. These were subject to a regular review and contained sufficient detail to inform staff of risk factors and appropriate responses.

Staff had received safeguarding training and knew how to recognise and report abuse.

There were sufficient numbers of staff to make sure that people were safe and their needs were met.

Medicines were managed in accordance with best-practice guidelines.

Is the service effective?

Good

The service was effective.

Staff had received Mental Capacity Act (MCA) training and our observations confirmed staff promoted choice and acted in accordance with people's wishes.

Staff were trained in a range of topics, which were relevant to the specific needs of the people living at the home.

People were supported to maintain good health and had regular contact with health care professionals.

People were provided with a balanced diet and had ready access to food and drinks.

Is the service caring?

Good

The service was caring.

People were treated with kindness and dignity by staff who took time to speak and listen to people.

Staff acknowledged, maintained and promoted people's privacy.

People were consulted about their care and had opportunities to maintain and develop their independence.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support, which was responsive to their changing needs and met people's social, and leisure needs in an individualised way.

People made choices about aspects of their day-to-day lives. People and/or their representatives were involved in planning and reviewing their care.

People knew how to raise any concerns and told us that they would feel confident to do so.

Is the service well-led?

Requires Improvement

The service was not always well led.

The monitoring of quality and safety of the service, were yet to be embedded and sustained.

There was an honest and open culture within the staff team. Staff told us they felt well supported.

People benefitted from a well organised home with clear lines of accountability and responsibility within the management team.

Staff told us that the manager was approachable and that they were encouraged to discuss any issues or concerns.

St John's House

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 checked 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.

The inspection was prompted in part by information shared with CQC detailing potential concerns about the management of risk. These risks included care staff not trained to respond to a first aid emergency, a delay in responding to call bells and inadequate levels of staffing to meet people's needs. This inspection examined those risks.

This inspection took place on 30 October 2017 and was unannounced. We also returned on the 2 November 2017. The manager and regional manager was given notice of the second date.

On the first day of our inspection visit, the inspection team consisted of one inspector, one specialist nurse advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was for dementia. On the second day of our inspection visit, there was one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including safeguarding concerns shared with us from the local authority and notifications of significant events the provider sent to us. Notifications are events that the provider is required by law to inform us of.

Due to the nature of people's complex needs, we were not able to ask everyone direct questions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spent time observing people in areas throughout the home to see interactions between people and staff. We observed people as they engaged with their day-to-day tasks, the care they experienced, including the lunchtime and teatime meal, medicines administration and activities.

We spoke with seven people who lived at the service and four relatives. We spoke with the recently appointed manager, provider, operations manager, regional manager, training manager and entertainment manager. We spoke with the head of residential, three care staff, one senior carer and the chef. We also spoke with a visiting district nurse and occupational therapist.

We looked at the care plans and associated records for five people. We reviewed the provider's internal checks and audits, staff training records, staff rotas, accidents and incidents, menu's, relative questionnaires, and health and safety checks. Records for four staff were reviewed, which included checks on newly appointed staff and staff supervision records.

Good

Is the service safe?

Our findings

People were protected from avoidable harm by staff that had been trained to recognise the signs of potential abuse. We spoke with five people who also told us they felt well cared for and safe. One person told us, "I feel very safe I am quite happy with the people here. They [staff] like to be about when I have a shower; they sit outside to offer me support when needed." Another person said, "I am safe. There's always someone around if I need them".

One relative told us, "I think [my relative] is safe here I don't have any reservations, things take time to get into place, [my relative] should have a monthly blood test and it took a while to get it sorted it seemed sluggish a week or two went by but it is sorted now." Another relative told us, "My [my relative] is very safe living here I am more than happy, [they] fell at home that is why [they are] here they have done a prevention of falls assessment."

We asked staff about their understanding of safeguarding and what action they would take if they suspected abuse was taking place. Without exception, all the staff we spoke with told us they would report any concerns they had to the manager. The provider's policy relating to safeguarding procedures was kept in the carers' office and the staff told us they would also check with this policy to ensure that appropriate action was taken.

People's risks were identified, assessed and managed safely. Risk assessments relating to people's mental health, physical health, personal health, moving and handling, behaviour, skin integrity, nutrition and falls had been completed and were stored within people's care plans. Risks were assessed as high, medium or low. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. We looked at risk assessments for five people and these contained advice and guidance for staff on how to manage and mitigate potential risks to people. For example, where people were at risk of developing pressure ulcers they had been assessed using Waterlow, a tool specifically designed for this purpose. People assessed at risk had pressure relieving equipment being used to maintain their skin integrity; staff ensured cushions were moved with the person when they moved.

Our observations on the day confirmed staff were mindful of people's rights to take risks. Staff encouraged and supported people to maintain their independence. Care staff ensured they prompted people to dress themselves and assisted with ensuring people dressed in the correct order. One person told us, "I can get to the toilet myself but I find transferring myself difficult, I am trying to walk a little further each day ready for when I return home with care, the staff do encourage me and tell me how much I am improving, they are very kind." Staff were visible around the home and quickly noticed if anyone was trying to mobilise on their own without waiting for help if they needed assistance. The people we spoke with did not feel there were any restrictions placed on their actions or movements. Accidents and incidents were logged and risk assessments reviewed and updated if needed. Senior staff reviewed people's risk assessments on a monthly basis to ensure they were in line with their current needs.

Risks arising from the premises or equipment were monitored and checks were carried out to promote safety. These checks included the gas heating, electrical wiring, fire safety equipment and alarms, Legionella and electrical appliances to ensure they were operating effectively and safely. The service had a fire risk assessment, which included guidance for staff, in how to support people to evacuate the premises in an emergency.

Staffing numbers were determined by using a dependency tool, which looked at people's level of need in areas such as mobility, nutrition and maintaining continence, although these remained flexible. Staffing could be changed if required, for example if people became particularly unwell. Care plans detailed whether people could use their call bells effectively and monitored people accordingly. Staff were attentive to people's needs, knowing them well and interpreting body language. For example, one person became agitated in the lounge and staff discreetly assisted them, ensuring they were comfortable in a quieter environment.

Records, and our observations, confirmed there were sufficient skilled and experienced staff deployed to ensure the safety of people who lived at the home. We received mixed feedback regarding how quickly staff responded to call bells. One person told us "There can't be enough staff, the length of time it takes people to answer the bell, especially when the shift change, it is a poor." A second person told us, "I press my bell and they don't answer."

On both days of our visit we rang the call bells on five occasions from different areas of the service to see how quickly staff responded. Overall staff responded in less than three minutes. On the first day of our visit we found that the emergency sound and the routine sound for assistance were the same. The manager agreed that this meant staff would not be able to tell which call was urgent. On the second day of our visit the provider had arranged for all the call bells to have a different sound installed in the event of an emergency. Between the first and second day of our visit the manager had also implemented a call bell audit. The manager showed us they were able to print off an audit trail from when the call bell had been pressed to when it was responded to. The manager had already completed an audit and had identified there had been some delays in people's request for support. The manager told us this audit would continue on a weekly basis and would be discussed at team meetings to share the findings. The manager had already approached the people who had been impacted by the delay for assistance. The provider and manager had offered an apology to those people and an opportunity to make a complaint. We reviewed accident and incident records and found the delay to people's request for assistance had not impacted people's safety. We were assured the provider and manager had an effective system to monitor this area in future to promote better practice and improve staff response time.

Shifts had been arranged to ensure that known absences were covered. Over the past three months the provider explained there had been a lot of staff changes, which had meant the use of agency staff. However, rota's confirmed this was minimum and people were now being supported by a stable team. One relative told us, "[My relative] is safe here but staff have left, about 12 maybe more which was unsettling for [them], it has settled now." The service also had a 24 hour on call system in case of unforeseen events and if additional staff were needed.

Staff files showed that safe recruitment processes were in place. Checks had been made with the Disclosure and Barring Service to ensure that new staff were safe to work in the care profession. In addition, two references were obtained from previous employers before staff commenced employment.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. We observed medicines being administered and staff did so safely and in line with the

prescription instructions. Although earlier medication audits indicated a high level of errors each month, on this occasion we saw that Medication Administration Records (MAR) were in place and had been correctly completed to demonstrate medicines had been given as prescribed.

All senior staff was trained to administer medicines. The manager completed an observation of staff to ensure they were competent in the administration of medicines. Medicines were locked away as appropriate and were stored in a locked drugs cabinet within a locked storage room. The senior carer for each shift held the keys to the medicines storage room. A refrigerator dedicated to medicines storage was also in the room. The fridge temperature and room temperature were within recommended ranges to ensure the efficacy of the medicines; daily checks were made and temperatures recorded. We checked a sample of the medicines and stock levels and found these matched the records kept.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (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 Act 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 made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Appropriate DoLS applications had been made, and staff acted in accordance with DoLS authorisations. Where Deprivation of Liberty Safeguards decisions had been approved, we found that the necessary consultation had taken place. This had included the involvement of relatives and multi-disciplinary teams. We checked people's files in relation to decision making for those who were unable to give consent. Documentation in people's care records showed that when decisions had been made about a person's care, where they lacked capacity, these had been made in the person's best interests.

Staff had received MCA training and our observations confirmed staff promoted choice and acted in accordance with people's wishes. Throughout our inspection, we saw that people who used the service were able to express their views and make decisions about their care and support. We observed staff seeking consent to help people with their needs.

Staff received training in a range of areas, which the manager had assigned as mandatory and essential to the job role. This included emergency first aid, moving and handling, fire safety, health and safety, infection control, food hygiene and safeguarding. In addition to the mandatory training, the manager had ensured specialised training was given to care staff to be able to meet the individual needs of people being supported. This included staff completing training in continence, pressure area care, care planning, dementia care and diabetes. We looked at the staff training certificates contained in staff files, which confirmed that staff had received essential training to enable them to support people effectively. One relative told us, "They [staff] all accept they have got to say the same things over and over again. It was important to me to have somewhere offering dementia care, [my relative] has a diagnosis of Alzheimer's, and they [the provider] claim dementia care as their expertise, well they really do work well with dementia."

Due to a number of staff being appointed in the last three months, not all staff had completed emergency first aid training, however all staff without this training had been booked on a course in November 2017. The provider told us that any staff member that was not able to complete this course in November would be offered an alternative date in December 2017. On the second day of our visit, the manager had updated the rotas to reflect who the nominated emergency first aider was, so that all staff on duty knew who would take the lead in the event of an emergency. The nominated first aider was also displayed in reception and at each care station. This provided assurances that in an emergency staff and people would know that the employee responding to the emergency was trained to do so.

All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Staff were encouraged to complete various levels of National Vocational Qualifications (NVQ) or more recently Health and Social Care Diplomas (HSCD). These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability (competence) to carry out their job to the required standard. This ensured people received effective care from staff that had the knowledge and skills they needed to carry out their roles and responsibilities.

All of the staff we spoke with had received recent, formal supervision or a yearly appraisal. Records showed that at the meetings staff discussed their work, training, residents' needs, any problems, staffing and any suggestions for improvements. Records showed the discussions that had taken place, together with a review of actions agreed from previous supervision meetings.

People were supported to have sufficient to eat and drink and to maintain a balanced diet. The kitchen had an information board which, displayed people's dietary needs. For example, for those who required a soft diet or who lived with diabetes. We observed good communication between kitchen staff and care staff, who advised the chef of changes made to people's diets following input from visiting professionals, such as dieticians and Speech and Language Therapists. People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The manager had completed these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for this purpose. Plate guards were used, where needed, to help people to eat their meal independently. We observed people's likes and dislikes were documented and kept in the kitchen, accessible to staff.

We observed the lunchtime and teatime meal in the dining room. The atmosphere was calm and relaxed and there was music playing at teatime which people told us they enjoyed. Tables were nicely laid with tablecloths and condiments. Staff assisted people who required support with eating their meal in a discreet and unhurried way. Fruit and biscuits were always available if people wanted a snack. People's food and fluid intake was routinely monitored, whether or not they were at risk of malnourishment. We observed that drinks were freely available at mealtimes and throughout the day in people's rooms and communal areas. People we spoke with told us, they were happy with the food and drink provided. One person told us, "The food is generally nice." A relative told us, "The food is very nice I have eaten here once, we had a Sunday lunch as a family." Another relative told us, "The food is excellent, I have eaten here." Another relative told us, "The food is very nice, I think they [staff] try very hard, they are very accommodating, they changed [my relative's] menu so [they have their] own, to fish because [they don't] like meat in sauces." We noted issues related to food and drink were regularly discussed at residents' meetings.

People were supported to maintain good health and had access to a range of healthcare services and professionals. Care records documented the involvement of healthcare professionals such as the GP, chiropodist, district nurse, optician, dietician and speech and language therapists. If needed, staff would support people to attend their hospital appointments. Advice and guidance given by these professionals was followed by staff. One relative told us, "My [relative] has medical problems, a heart condition, there was an occasion when the staff were concerned about [their] breathing so they called the paramedic out, they arrived and admitted [my relative] to hospital. Last week the staff called the GP out, [my relative] wasn't quite right he came and gave antibiotics for a chest infection but the staff dealt with all of that and phoned to let me know".

Accommodation was over two floors and there was a passenger lift to provide access to the upper floor. We

saw that people could move freely around the home. There was one lounge with a dining area included on both floors. There was also the use of a formal dining room if people preferred. There were multiple areas for people to rest, sit and relax. Communal areas were warm and cosy which gave a nice homely feel. People were involved in the choice of furnishing for their bedrooms and were able to choose their favourite colours and personalise their bedrooms with photos and items of their choice. There were communal bathrooms and WCs situated on the ground and first floor. The innovative design of the first floor resembled that of a village scene that included a village square with a central cherry blossom tree as a focal point, a village store and a cinema and book emporium. There was a sitting area which had an artificial lawn to resemble an allotment with gardening tools. There were soft toys placed around the service for people living with dementia to engage with.

Good

Is the service caring?

Our findings

At this inspection, people described staff as kind and caring. People told us, they felt they were treated with respect and dignity. One person told us, "The staff are very caring, the people running it are very obliging." Another person told us, "A lot of the staff are extremely nice, they do their best, I find the night staff very helpful and very nice, you are shown kindness, consideration and respect, 99% of the time they do what they possibly can to help."

One relative told us, "The staff are caring I have never seen any other interaction than kindly. I absolutely feel [my relative] is taken care of, [they are] kept warm and [they are] never chivvied to do something [they don't] want to." Another relative told us, "The staff are very respectful and caring they know the residents are dependent on them, staff sit talking to [my relative]."

We observed examples where staff demonstrated a kind and considerate approach. For example, we saw one staff member softly touch the cheek of a sleeping person in order to rouse them gently for their lunch. On another occasion, we saw that a staff member reassured and comforted a person as they assisted them to mobilise, showing concern for their wellbeing. The people we spoke with told us that staff treated them with kindness and consideration.

Throughout our visit staff were attentive to people they were caring for and demonstrated they knew people very well, including people's relatives. Staff knew people by name, and some of the conversations indicated they had also looked into what they liked, and what their life history had been. People were comfortable around staff. We noticed when one person was distressed, staff were attentive and kind towards them. We also saw a staff member walking along a corridor with one person linking their arm and they were walking at a slow pace.

The premises were spacious and allowed people to spend time on their own if they wished. We saw people spending time in the lounge areas, in their bedrooms and in the smaller seating areas. People looked well cared for. They were tidy and clean in their appearance, which was achieved through good standards of care.

We observed a high level of engagement between people and staff. Consequently where possible, people felt empowered to express their needs and receive appropriate care. We looked at people's care plans and daily records in order to ascertain if staff involved people and their families with their care as much as possible. Care plans and risk assessments were reviewed regularly by staff and signed by people, relatives or representatives. We found evidence that people or their representatives had regular and formal involvement in on-going care planning or risk assessment. Therefore, there were opportunities to alter the care plans if people and their representatives did not feel they reflected their care needs accurately.

Staff were able to describe to us how they upheld people's privacy and dignity when providing personal care and support for example, by ensuring bedroom doors were closed. One staff member told us, "I make sure that the bedroom door is closed and that the curtains are drawn and I chat to them [people] to help them

relax and feel comfortable." During our inspection, we observed staff knocking on people's doors before entering and closing doors when providing personal care. We saw that people were dressed appropriately for the time of year and people were supported to maintain their personal appearance so as to ensure their self-esteem and self-worth.

Personal histories had been completed for people, This provided staff with information about people's earlier lives, their food likes and dislikes, travel, music and activities they liked to do. Any special dates were also recorded, so staff could support people to remember happy times or sad times. This enabled staff to see what was important to the person and how best to support them.

Good

Is the service responsive?

Our findings

People's needs were assessed before they moved into the service. Where a person's care was funded by the local authority, an assessment was obtained from the funding authority so that a joint decision could be made about how their individual needs could be met. The assessments completed prior to an individual moving into the service formed the basis of each person's care plan.

We observed people received personalised care that was responsive to their needs. Care plans provided advice and guidance to staff about people's care and how they wished to be supported. Care plans included information on people's personal care, health care, mobility, social care, communication, religious and cultural preferences, dietary needs and medication. Information about people's daily routines, likes, dislikes and preferences were contained in their care plans. One person were identified as being at risk of developing pressure sores. We noted risk assessments had been made concerning the person's skin integrity, in addition to possible contributory factors, such as mobility, continence, nutrition and hydration and their diabetic state. Pressure sores are graded between one and four, one being the mildest form. The district nurse told us, that there was no one living at St Johns House with a pressure sore above Grade 2 and that staff were following instructions from the district nursing team.

Care plans were reviewed monthly to ensure they met people's needs and were in line with their preferences. Where people wished, their loved ones were involved in their three monthly reviews and relatives told us that they had been involved where appropriate. One relative told us, "We have been invited to a review meeting every three months."

Staff completed daily records for people, which showed what care they had received, whether they had attended any appointments or received visitors, their mood and any activities they had participated in. The daily records gave clear information about how people were so that staff on each shift would know what was happening. Staff were responsive to changes in need and referred people to appropriate health professionals in a timely way. For example, one person complained that their bottom was painful. The manager reported that there was no evidence that the person was suffering from a pressure sore but she was going to refer the person to the district nursing team for an assessment for an airflow cushion to relieve any pressure. Staff used clear body maps to monitor people's skin and to show why and where topical creams were required.

There were several visitors during the inspection and the front door was always answered promptly by staff that welcomed people and ensured that they signed in the visitor's book before entering the service.

The service placed a strong emphasis on meeting people's emotional well-being needs through the provision of meaningful social activities and opportunities. People were offered a wide range of individual activities, which met their needs and preferences. We looked at documentation and spoke with the provider's entertainment manager. We noted there were a wide variety of social, educational and occupational opportunities for people living at the home. These included: special live performances with an orchestra, movement to music, quizzes, a Christmas fayre, cinema time, baking, shopping, coffee morning,

games in the games room, music reminiscing, library club, dominos and gardening. During our visit, we observed people baking and making quiches. During the afternoon a quiz and discussion took place in the lounge. A hairdresser visited and people had their nails painted.

There was also one to one input for people who did not like to engage in communal activities. These included board games, reading or discussions. The entertainment manager and manager also chaired residents' meetings. We looked at the minutes of the latest of these, held on 11 October 2017. We noted the meeting was well attended; there was an agenda, suggested by the people who live in the home and action planning devised as a result of the meeting. There were timelines attached to these with named a responsible person or people.

The service sought annual feedback using a survey, which was sent to people and relatives. Survey responses were positive overall and where responses showed that improvement could be made, these were actioned.

People's concerns and complaints were encouraged, explored and responded to in good time. Formal complaints were dealt with by the manager, who would contact the complainant and take any necessary action. Complaints were listened to, investigated and managed in line with the provider's policy. People said that they would be confident to make a complaint or raise any concerns if they needed to.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems were in place to regularly review the quality of the service that was provided. There was an audit schedule for aspects of care such as care plans and infection control. This allowed the manager to identify any concerns or possible risk to the service provided to people. We saw that the care plan audit had identified that care plans needed to be updated and recorded how many had been reviewed and updated by the date of our inspection. The manager told us that ensuring care plans reflected people's current level of need was their priority. However, there was no date or timescale given for this to be completed. This meant that the manager could not be sure when everyone would have an effective care plan which met their needs.

One person required daily recordings of their pulse taken. We found the person had their pulse recorded on 26, 27, 28 and 29 of September however, there was no evidence that any pulse recordings had been taken for the month of October or on the day of our visit. The most recent audit had not identified this. We fed this back to the manager who implemented a new form to record the person's daily pulse. This was shared through the staff handover and the communication book. The person's pulse was also checked at the time of our visit and was found to be in a safe range.

Medication audits indicated a high level of errors each month, we found these errors to be in relation to administration however the audit tool did not give assurances of what action was being taken to prevent future errors.

The manager told us that as a result of our visit they were able to see improvements to the response to audits was needed. The manager said, "Previously the management did not follow up on actions when we received the audits. I will be with the quality assurance officer during future audits so we can go through her findings and address the issues found more promptly." The regional manager told us, "We investigated your findings (from feedback given on day one of our visit), and that has led to us making improvements to the auditing system in regards to the action plan. We have made the system colour coded, identifying what needs addressing more immediately."

The manager completed a range of other quality monitoring audits. These included accidents, incidents, safeguarding, pressure wounds, complaints and health and safety. On the audit form there were details in relation to date, name, details, action taken, explained or unexplained, if safeguarding or CQC notification had been raised and details, outcome i.e. closed, on-going, no further action. The form also included a section for recording any details of any trends developing and noted actions taken. Records demonstrated that information from the audits was used to improve the service and information recorded was used to reduce risk of untoward events occurring.

All care records for people were held in individual files and all of the people's records were stored securely.

People and staff we spoke with told us St Johns House had really good leadership. St Johns House had the benefit of strong focused leadership. A manager worked five days a week and there was a newly appointed

deputy manager and senior care staff who supported the manager. The manager team said that she had an excellent relationship with the management team, and staff at the home. Although the manager was newly appointed, they had worked at the service for 6 months as the deputy manager. Staff and the management team commented that they were all comfortable about being able to challenge each other's practice as needed.

During the inspection, the manager continuously demonstrated her in-depth knowledge of each person living there and of her staff team. Any question we asked was met with detailed information. For example, during the inspection, the manager stopped on many occasions to speak with the people and provided reassurance when it was necessary. People were encouraged by the management team to be involved in the inspection process as much as they wanted.

There was an open, positive culture within the home. This was led from the top down. Staff told us the manager was visible, one staff member added, "I do think it's well run. The manager is very approachable. The manager is always around". There was a culture of continual reflection by the staff and management team. They were passionate, creative and dedicated in their approach to improvement, and a visible presence in the service, accessible at all times by operating an 'open door' policy. We observed this during the day; the head of residential shared an office with all levels of staff, which resulted in a culture of shared learning and information sharing to support the running of the service. For example, staff came in regularly and asked questions, passing on important information about people and their well-being.

Staff told us that they met together through handovers during the day, staff monthly meetings and residents' monthly meetings. We looked at the meeting minutes of recent staff meetings, the latest of which was held in October 2017. We noted issues of importance to staff was discussed and resolutions found and agreed upon. Minutes of these discussions demonstrated staff discussed residents' needs, activities, changing policies and procedures, safeguarding and training needs. The meetings were well attended; the staff we spoke with were happy with the process. Without exception, staff told us, the manager had an open door policy where they could talk to them anytime they needed to. Staff were aware of the whistle blowing procedures should they wish to raise any concerns about others or the organisation.

People attended monthly 'resident meetings' where they could give their opinions and feedback. Relatives were also invited to these meetings. These meetings were chaired by the entertainment manager and manager which solely focused on the areas that people and their relatives wanted to discuss. This allowed people the opportunity to discuss any changes to the service they felt necessary, while promoting their independence. These meetings were also attended by the management team to help identify actions and minute discussions. The majority of people attended these monthly meetings; this helped to demonstrate that people and their opinions were valued. The meeting minutes viewed evidenced people were being kept up to date with any changes in the service, and encouraged to suggest forthcoming activities. One relative told us, "There have been changes of management within the home, there was a relatives meeting, I did not attend but both my brother and I received the minutes via email informing us of the management changes."

Information leaflets were available in the entrance to the home about local help and advice groups, including advocacy services that people could use. These gave information about the services on offer and how to make contact.