The Shaw Foundation Limited

St Johns Nursing Home

Inspection report

St Peters Walk,
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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

St Johns Nursing Home is registered to provide care and accommodation to up to 43 people who need nursing care. At the time of our inspection 34 people lived at the home. The accommodation is split over two units. The Limes unit on the first floor provides care for people with an enduring mental health condition can accommodate up to 14 people and was full. The Pines unit on the ground and lower ground provides care for 26 older people who are living with dementia and had seven vacancies. In addition are three individual flats for people with a mental health condition to promote their independence.

The inspection took place on the 23 and 27 November 2015 and was unannounced.

At the time of our inspection a manager was in post however they had not yet registered with the Care Quality Commission although they were in the process of applying. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

The manager was aware of the need to recruit staff to reduce the dependence on agency staff who did not always know people. People did not always receive the correct medicine at the correct time due to the length of time the medicine round took.

People who lived at the home and their relatives told us they felt safe at the home. They were however aware of the use of agency staff and how this could affect the care of their family member. Risks to people's safety and welfare were assessed however staff were not always aware of recent changes to people's care.

People were cared for by staff who were kind and considerate. Staff had an awareness and understanding about the need to obtain people's consent before care and support was provided and of people's right to refuse care. The manager was aware of their responsibility to ensure people were not restricted unlawful and had submitted application for authorisation to the local authority where this was required.

Staff felt supported by the manager and they had received training and support to help them provide care and support to people. Staff were aware of how to recognise abuse and of the systems in place to support them report any concerns they had. Staff had an awareness of how to maintain people's privacy and dignity.

People who lived at the home and their relatives were involved in the planning and reviewing of the care and support provided for people. People were able to participate in hobbies and other interests.

Relatives had confidence in the new manager and knew how to raise any complaints which they felt would be listened to and action taken.

People who lived at the home as well as their family members and staff were encouraged to be involved in the running of the home. Quality monitoring systems were in place however these were not always evaluated to check the action needed had taken place.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People were cared for by agency as well as permanent staff, risks to people's care needs were not always know to them. People did not always receive their medicines as prescribed or at the correct time. People told us they felt safe and they were supported by staff who had an awareness of how to protect people from the risk of abuse.

Requires improvement

Is the service effective?
The service was effective.

People were supported by staff who were aware they needed to gain consent from people prior to them providing care and support. People's needs were met by staff who were trained and supported. People liked the food they received and were able to access healthcare professionals.

Good

Is the service caring?
The service was caring.

People received care and support from staff who were kind and considerate. People's right to privacy and dignity was respected.

Good

Is the service responsive?
The service was responsive.

People who lived at the home and their relations felt listened to. They were able to raise concerns with the management and these were resolved. People were able to make choices as to how they spent the day. People were regularly assessed and their opinions were taken in account.

Good

Is the service well-led?
The service was not consistently well led.

People were aware of the manager and spoke highly of them. People were not always assured of a quality service as audits carried out were not always evaluated and reviewed.

Requires improvement

St Johns Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 23 and 27 November 2015 and was unannounced. The inspection team consisted of one inspector 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 service. The expert by experience involved in this inspection had experience in dementia care.

As part of the inspection we looked at the information we held about the service provided at the home. This included statutory notifications. Statutory notifications include important events and occurrences such as accidents and serious injury which the provider is required to send us by law.

We spoke with seven people who lived on the first floor of the home and briefly with two people who lived on the ground floor. In addition we spoke with five relatives. We looked at how staff supported people throughout the time we were at the home. As part of our observations we used the Short Observational Framework for Inspections (SOFI). SOFI is a way of observing people who may not always be able to voice their opinions of the quality of the service provided.

We spoke with the manager (not registered with the Care Quality Commission at the time of the inspection), a project manager, the area manager and the deputy manager.

We looked at the records relating to four people who lived at the home as well as medicine records. We also looked at complaints and quality audits completed by staff at the home.

Requires improvement

Is the service safe?

Our findings

Relatives we spoke with told us they believed sufficient staff were on duty to meet people's needs. They were however aware of a dependency upon agency staff. The manager and the area manager confirmed the service had operated on agency staff due to difficulty in recruiting suitable staff. The manager and other staff told us agency staff were regularly on duty accounting for half the care staff at any one time. In addition the manager was dependant on agency nurses due to similar difficulties in recruitment. Management and staff we spoke with confirmed that where possible regular agency staff were employed to provide as much consistency in care as possible. For example one agency nurse told us they regularly worked four shifts per week. Agency staff were provided with information about people's care needs to assist them provide care.

The manager informed us the number of staff on duty had remained the same although the number of people living at the home had reduced. Some people were receiving care on a one to one basis. The manager was aware however that the use of agency staff presented difficulties due to the inability to manage staff effectively.

On the first day of our inspection an agency nurse was on duty on the ground floor. We were informed there would usually be two nurses on duty. A second nurse came on duty later on but by the time they arrived, this had already impacted on the care people received. For example we saw both nurses completing the administration of medicines prescribed for breakfast time at 12:45pm. By this time some people were seated ready for their lunch. The agency nurse told us they were later than usually due to only initial having one nurse on duty for the first part of the shift.

We looked at the medicines for seven people to ensure they had received their medicines as prescribed. The records completed by the nurse gave no indication on the lateness of the administration. We found errors or a lack of recording regarding the medicines of all seven people and could not be certain people had received the medicines they were prescribed.

Nursing staff had recorded the number of tablets remaining in stock following each administration. However, we found these were not always correct and it was agreed by the manager and nurses on duty that it was evident nurses were not always checking these balances. The medicines of three people had either too many or too few tablets remaining available for nursing staff to administer, for one person this accounted for more than one medicine. The manager acknowledged the evidence showed people had not always some of their prescribed medicines or had a dose in excess of the amount prescribed. The manager undertook to carry out a full audit of the medicines to identify any additional concerns and to address the errors with either the nurses involved or agencies nurses were working from. On the second day of our inspection we were informed that some agency nurses would not be returning to the home due to the errors found.

Staff were aware of the need to protect people from risks. Risks associated with the care provided to people were assessed and recorded. These were updated as required.

We found that the provider had strategies to make sure risks were identified and managed. We saw risk assessments included the actions needed to reduce risks to people's safety. Plans were in place to guide staff on what they needed to do to support people. For example people at the risk of falling. We saw people were assisted with specialist equipment as needed, such as hoists and provided with pressure relieving equipment such as special cushions to protect their fragile skin. However, not all staff had been made aware of the changes in one person's needs which meant they had not used the correct size of sling while they supported this person to move with the aid of a hoist or were not aware of the change. Although there had been no injuries or harm to this person at the time of our inspection this practice did not ensure risks to this person were consistently reduced. This was mentioned at the time of our inspection and staff were made aware of this person's revised risk assessment to inform their practices.

People were seen to be at ease with staff members and did not indicate any signs of worry or hesitation. People who lived on the first floor were able to talk with us. Nobody told us of any concerns about their safety. On the ground floor we saw people who lived there were at ease with staff. People's body language and facial expressions showed they were relaxed with staff.

Relatives we spoke with told us they believed their family member to be safe living at the home and raised no concerns with us. One relative told us they felt their family

Requires improvement

Is the service safe?

member was safe and cared for. Another relative told us, “Staff are lovely. They never loose their patience”. A further relative told us they were satisfied when they left the home their family member was safe and well cared for.

Staff we spoke with were able to describe the action they would take if they became aware of any abuse taking place. One member of staff told us, “If I saw anything I would bring it to the attention of the manager”. One member of staff told us they had reported a matter where people were placed at risk of harm. They told us the matter was dealt with correctly and ensured people who lived at the home were safeguarded.

Staff confirmed appropriate pre-employment checks had taken place before new staff were able to commence work at the home. These checks helped the manager make sure suitable people were employed.

Good

Is the service effective?

Our findings

We looked at how staff sought consent before they provided care and support for people. 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 interest and as least restrictive as possible.

We found from speaking with staff they understood the principles of MCA. Staff were aware of the need to speak with people to gain their consent before they provided care and support. Staff we spoke with were aware people may have the capacity to make some decisions while they may not have capacity in relation to other areas. Assessments were carried out regarding people's capacity in making decisions regarding aspects of their care. In situations where it was assessed people lacked capacity we saw best interest decisions had been made. For example in relation to people's personal care needs and the use of items of equipment to keep people safe. These had involved relevant people such as family members and professionals as appropriate.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The manager had completed and submitted to the local authority DoL applications. The manager was aware four of these applications had been authorised by the local authority at the time of our application. Due to the time others had been with the local authority they had recently made a further application for authorisation.

Relatives we spoke with believed staff on duty to have the skills and ability to meet the needs of their family members and had the ability to care for their family member. Staff we spoke with told us newly appointed staff received induction training to ensure they had the skills and knowledge to care for people safely. Staff told us they received the training and support they needed to enable them carry out their role. One member of staff told us they had enjoyed the dementia care training they had done because they had learnt a lot and had a better understanding of people as a result. The member of staff concerned spoke about how they saw people as individuals rather than a person who lived with dementia. A member of staff told us they were trusted to look after, "People's loved ones". All the staff we spoke with told us they were supported by the manager and were able to seek advice and support at any time they needed it.

People we spoke with told us, "The food is very good here. I never miss a meal". We saw people eating their mid-day meal on the ground floor and noted people appeared to enjoy what they were having. Some people had their meals served to them in adapted bowls in order for them to remain independent while eating. Staff were seen while they assisted people were necessary in line with what was recorded within people's care plan. One member of staff frequently return to one person to provide further encouragement while they were eating. Throughout the meal time the atmosphere was calm with staff enabling people to eat and drink.

Relatives we spoke with confirmed they were kept informed in any changes to their family member's health care needs. We were told healthcare support and guidance was sought from specialists such as tissue viability and speech and language specialists where relevant.

People were supported with their health needs so that they remained well. This was confirmed by relatives we spoke with. One relative told us their family member had been unwell a couple of times. They told us staff had, "Done wonders". Another relative confirmed a chiropodist was due to visit that day and that other healthcare professionals had been involved in the family member's care. Relatives we spoke with confirmed they were kept informed in any changes to their family member's health care needs.

We saw people's plans reflected people's health needs and provided staff with guidance on how to support people and recognise any deterioration in their health. Staff we spoke with had an understanding about the health issues of people we asked them about. They were aware of recent recommendations from health professionals which included doctors and psychiatrists regarding the people's

Good

Is the service effective?

physical and mental health issues. We saw people's health needs had been assessed and people had input from the doctor, tissue viability nurse, speech and language therapists.

Good

Is the service caring?

Our findings

During our inspection we saw examples of staff working in a kind and caring way with people who lived at the home. People we spoke with were complimentary about the staff. One person told us, “The staff are lovely they will help you if they can”. Another person told us they were happy with the level of care they received and added, “I can’t think of anywhere I would rather be.” One person on the ground floor told us, “It’s lovely here. I am quite alright.” We heard another person tell their relative, “I’m alright here”.

Relatives we spoke with were complementary about the staff at the home and the care their family member received. On their arrival at the home we heard one relative say about their family member, “You are nice and warm and look well”. One relative told us staff were, “Wonderful” with their family member.” Another relative told us, “Nowhere could be more suitable” for their family member and “I have lots of praise for the care provided and the staff. Everyone is pleasant.” The same relative added, “Staff are very nice. I am full of admiration for them.” A further relative told us their family member was, “Looked after very well”

When staff were engaged with people who lived at the home we saw they were considerate and friendly. For example while we were carrying out our Short Observational Framework for Inspections (SOFI we saw a member of staff hold a person’s hand while they provided care and support. We also saw occasions where people showed signs of anxiety or were upset. On all of these occasions we saw staff provided support in a kind and calm way providing the reassurance people required. On other occasions we saw staff ensured they were at the same height as people they were speaking with in order to maintain eye contact.

People were involved in aspects of their care. For example people were able to choose where they sat in the communal areas and where able to spend time in their own bedrooms if they wished. Staff were seen to promote people’s independence where possible. For example when staff needed to assist people with eating and drink we saw staff encourage people to hold the cup along with the staff member. Other people were able to tell us they went for walks in the surrounding area or into the town. We saw people had personalised their own bedrooms.

Relatives we spoke with told us they believed their family member was treated with privacy and dignity. Staff we spoke with were aware of ways to ensure people had these values upheld and were able to give examples of the practice they carried out. We brought to the attention of the manager that we saw some staff members wipe people’s hands and mouths without any consultation beforehand. We did however see other examples when staff were more aware of the need to up hold people’s dignity. For example staff closed bedroom doors while they provided personal care. We saw staff knocked on bedroom doors before they entered people’s bedrooms. When people needed assistance with aspects of their care and support this was carried out discreetly.

Relatives we spoke with told us they were made to feel welcome at the home at any time. We saw relatives join their family member with a drink or a meal. One relative told us, “I feel the love when surrounded by you all (members of staff).

Good

Is the service responsive?

Our findings

People on the first floor we able to tell us they felt involved in their own care plan and in the way staff provided care and support to them. We saw people on the first floor had had involvement in their care plans, in reviewing these and agreeing plans for the future.

We spoke with relatives of people who lived on the ground floor and they felt engaged and involved in planning the care provided for their family member. One relative told us any changes were discussed in full before they approved it and they put into place. Another relative told us they were very involved in their family member's care and that they had agreed with everything suggested to her about the care provided.

Staff we spoke with told us they involved relatives in the care of their family member's as much as possible. Staff had an awareness of people's likes and dislikes and had involved family members in preparing a family history for their family member to assist staff get to know what was important to each individual who lived at the home.

Staff responded well to incidents within the home or when people were unwell. For example one person fell to the floor. The staff on duty attended to the person and checked they were alright and not injured before supporting them back to a chair. On another occasion a person reported feeling cold and tired. A member of staff responded to this and ensured a nurse attended to them to check them over. On another occasion we heard a member of staff say to a person who lived at the home say, "Your knee is hurting you today isn't it. I will get the nurse to come and check it".

People were able to participate in some interests and activities. One person on the first floor told us, "I get my paper every morning". Other people on the first floor told us they were able to go out for a walk when they wanted and to go out and have a cigarette. People on the ground floor were seen to participate in some craft work while others received individual time with staff chatting.

People were seen to be engaged in one to one activities with members of staff during the course of the inspection. We saw people who lived at the home react positively when two separate people brought dogs into the communal areas. These were taken around to meet a number of people who were seen to smile while able to stroke them and say hello. We saw items were available around the home for people to pick up, feel or hold. Relatives told us they found the home to be friendly and homely and were pleased with the care provided.

The manager along with the activities coordinator had held meetings with relatives to gain their views and work in partnership with them. A meeting was scheduled on the day of our inspection which was attended by two relatives. The meeting involved those present in planning the care provided for people.

We saw some questionnaires had been sent to relatives. The response was low and provided little feedback as to how relatives had found the care provided to their family member.

Relative we spoke with were confident they could raise any concerns and they would be dealt with. One relative told us, "I would speak with someone and they would sort it". We looked at the records maintained by the manager following complaints and concerns raised. These showed the action taken by the manager when they had looked at the complaint and how they had resolved the matter. We saw apologies were given and action to prevent a reoccurrence taking place.

Requires improvement

Is the service well-led?

Our findings

The previous registered manager of the home left in April 2015. Since that time the provider has not had a registered manager. During our inspection we spent time with the new manager. The manager was fully aware of the need to register with the Care Quality Commission (CQC). At the time of our inspection they were in the process of obtaining the required documents for them to apply to the CQC to become the registered manager. The manager had a good knowledge of the work carried out by the CQC and of the expectations placed upon the registered manger.

We saw audits were carried out by management staff working for the provider. These audits had identified areas where improvements were required. Some areas were similar to those we had also identified as part of the inspection such as improvements regarding medicines. Action plans were in place as a result of the shortfalls. Although the area manager believed many of the areas identified were met therefore was no evidence they had been re-evaluated to ascertain their effectiveness.

Relatives we spoke with were complementary about the new manager and spoke of the confidence they had in him. One relative described him as, “Excellent”. Another relative told us, “The manager seems approachable and will react.”

All the staff we spoke with were complementary of the manager and believed he would make changes within the home to improve the service offered to people. One member of staff told us, “I like the manager. It’s a friendly place to work.” Another member of staff told us, “He’s approachable and listens to staff. He’s trying to make a difference and bringing in new staff”.

Staff we spoke with confirmed regular staff meetings took place and they told us they felt well supported by the manager. Staff confirmed they were able to raise any matters they wanted to as part of the meetings. Staff were aware of the manager’s efforts to recruit staff members.

The manager was aware of the need to recruit new members of staff due to the high level of agency staff used at the home. The manager told us of his desire to recruit staff who were compassionate and able to be developed by training.

We spoke with the manager about some of the people who lived at the home. We found he knew people well and had a good awareness of people’s needs. Staff we spoke with told us he regularly attended staff handovers and took a genuine interest in the care people received.

The project manager who was reviewing care plans and carrying out audits informed us they were implementing a new system of assessment and care planning at the home. The new system was to ensure people who lived at the home were at the centre of the process from the initial assessment onwards. We saw these were in place for some people and plans were in place to ensure all these were effective across the whole home.