R & E Kitchen

St Johns Nursing Home

Inspection report

Rownhams Lane
Rownhams
Southampton
Hampshire
SO16 8AR

Tel: 02380732330
Website: www.saintjohns.uk.net

Date of inspection visit:
25 April 2016
27 April 2016

Date of publication:
24 June 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 25 and 27 April 2016 and was unannounced.
Our previous inspection had taken place in January 2015. At this time we judged overall that the service required improvement before it could demonstrate it provided consistently safe, effective, caring and responsive care. As a result of shortfalls in all these areas we concluded that they also needed to make improvements in the leadership of the home. We said there were two breaches in legislation, these related to the management of medicines and systems and processes relating to good governance. At this inspection we found the required improvements had not been made and there were other shortfalls which also constituted breaches in regulation. These related to the way the service safeguarded people from possible abuse or neglect, the way in which they identified and managed risks, particularly to people's health, and the way they gained people's consent to their care and treatment. We found staffing levels were not always adequate to meet people's needs. Some elements of the delivery of service were task centred which had an impact upon how well the service could demonstrate it was providing care which always met the needs and preferences of the people living at St John's.
St Johns Nursing Home is registered to provide care treatment and accommodation for up to 38 people. At the time of our visit 36 people were living there. There were 9 double rooms. Since our last inspection a new registered manager had been employed.
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. The registered manager was not a nurse. She was supported by a registered nurse who was head of clinical Care. The registered manager demonstrated that had understood some of the shortfalls within the home but action taken had yet to have an impact upon the overall quality of the service.
Some people were happy with the quality of care and support they were being provided with and health care professionals and relatives all provided positive feedback when they were surveyed about the quality of care and treatment people received. The complaints procedure had improved.
We witnessed some kind and caring interaction between staff and people who lived at the service. However the service continued to have significant shortfalls which at times put people at avoidable risk. You can see what action we told the provider to take at the back of the full version of the report.
Special measures.
The rating for this service is 'inadequate'. This means that the service has been placed into 'special measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.
Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from

operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The management of medicines needed to improve to ensure people received their medicines consistently and safely.

Assessments of risk to people's health and safety needed to provide more guidance and people needed to be monitored more closely to ensure staff provided consistent and appropriate care and support.

Not everyone felt safely cared for and so safeguarding at the service needed to improve.

There were not always sufficient staff deployed to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.
The service needed to ensure they were applying the principles of the Mental Capacity Act 2005 regarding consent to people's care and treatment.
People's hydration and nutritional needs were not being effectively monitored which put them at times at unnecessary risk.
The service did not always work actively with others to make sure health care needs of people using the service were addressed in a timely way.
Care staff were supervised but nurses were not receiving clinical supervision.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.
There were times when people's privacy was compromised.
Most staff were kind and caring but some staff had a task centred approach which made it difficult for people at times to feel their views and wishes were being listened to and acted upon.

Is the service responsive?

Requires Improvement

The service was not always responsive
Although people were consulted at times about their care and treatment needs, staff needed more consistent guidance to ensure people's medical needs were being consistently met.
Some people told us there was not always enough to do.
The complaints system had improved.

Is the service well-led?

Inadequate

The service was not well led.
Although there were systems to assess the quality of the service provided these continued to be ineffective in driving improvements.
The culture and values the provider tried to promote were not always in evidence in the home.

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.
The inspection took place on 25 and 27 April 2016 and was unannounced.
The inspection team consisted of one inspector and a specialist clinical advisor who had experience in the nursing and care of frail older people especially those living with dementia and people with end of life care needs.
We spoke with ten people living at the service and observed care and support being provided to people in communal areas. We spoke with six staff and the registered manager. We spoke with four visitors.
We reviewed records of care for eleven people who were living at the service. We also looked at other records relating to the running of the home. These included records relating to staffing, accident and incident recording, complaints and quality assurance documents.
After the inspection we spoke with four health and social care professionals to gather their opinion about the quality of care and treatment provided at the service.
.

Inadequate

Is the service safe?

Our findings

At our last inspection in January 2015 we found that improvements were needed in the way in which medicines were administered and stored. We said the service had breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection the provider wrote to us describing how they were going to achieve compliance with this regulation. At our inspection in April 2016 we found that the required improvements had not been made. The registered manager said they were changing their pharmacy provider. As such the current systems to manage medicines were going to change in the near future and the registered manager thought this would improve how medicines were managed.
Some Medicines Administration Records did not have photographs of the person for identification or records of any allergies they had. We had already discussed with the provider at the inspection in January 2015 that allergies were not always recorded on the Medicine Administration Charts and improvements in this had not been made. This put people at continued unnecessary risk of receiving medicines which could harm them.
Improvements were needed in the way oxygen was stored and managed. The regulations concerning the safe use of oxygen state that cylinders should always be secured to avoid the risk of the cylinders falling and damaging the flow metre causing a discharge of oxygen, especially in a confined place. The oxygen cylinder stored at St John's was not secured.
Medicines were not being disposed of safely. Medicines disposed of at St Johns, had been placed in a domestic type storage box without a lid in a lockable storage room. The box was almost full of disposed medicines. The box contained various tablets and capsules that had no means of identification. This was not in line with The National Institute for Health and Care Excellence (NICE) Guidance which state "Medicines for disposal should be securely held in a tamper proof receptacle".
Training in the management of medicines had not been provided consistently. One nurse told us they had not had a competency assessment and their training in this area had been "some years ago". According to NICE "Care home providers should ensure that all care home staff have an annual review of their knowledge, skills and competencies relating to managing and administering medicines". This was of concern as we had found a number of areas regarding the management of medicines which needed to be improved upon and these had not been identified by staff administering medicines at the service.
The proper and safe management of medicines continued to be a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Although most people told us they felt safely cared for, two people told us they did not always feel safe at St John's. Both said some staff were rough when they were assisting them to move and both described some staff as "Spiteful". One person, who bruised easily, had a large bruise on their arm. We asked them how this had happened and they said "They did that when they threw me across the bed, they are so rough" They said "Some people don't like me here" The head of care said this person had a history of being paranoid and making allegations. Whilst their records said they could become confused and agitated at times there was no reference to them making allegations. The registered manager reported both allegations to Hampshire County Council under safeguarding protocols at the time of our inspection.

There had been a previous incident which could have constituted neglect which had not been reported to

Hampshire County Council under safeguarding protocols in a timely way.

One person who was being cared for in bed was shouting out during the first afternoon of our visit. We observed they did not have access to their call bell which was placed in a holder behind their bed. We gave it to them and they said "Thank you I didn't know I had one of these" We asked staff why their call bell was not available. They said the person was not able to use it. This was not the case. Staff had no clear guidelines about how to monitor this person who was clearly distressed at times.
On the second day of our inspection we checked and found the same person still did not have access to their call bell. Another person who could also use their call bell did not have access to their call bell either. This made it difficult for both people to alert staff when they needed assistance. After our inspection we contacted Hampshire County Council to share our concerns that people were not always being safely cared for.
This was a breach of 13(1) 13 (2) of the Health and Social Care Act2008 (Regulated as systems and processes must be established and operated effectively to prevent abuse of service users.

Staff had not done all that was reasonably practicable to assess and manage risks to people's health and wellbeing. For example, systems to protect people from pressure ulcers or sore skin were poor. Where people had developed wounds there were no photographs or measurements taken to help to evaluate the wound progression or improvement. This meant people's wounds were not effectively monitored. Where people were being nursed in bed records showed they were not always supported to change position regularly to promote healing of sore or broken skin.
Where people needed to use continence pads there was no guidance for staff about how often people needed these to be checked or changed, to ensure people's comfort. We observed at times during our inspection occasions when this had not been done frequently enough as people appeared uncomfortable and they had an odour which indicated they needed staff support. There was also no guidance about how often to apply barrier cream to people's skin. We would expect this cream to be applied to people every time they had their continence pad changed as barrier creams are used to protect the skin from damage or infection. We saw comfort charts were ticked once a day for creams applied which did not give us an assurance that barrier creams were applied each time the person had been washed and changed.

We observed at times during the day a staff member was going around the home with a trolley offering people drinks. A number of people required thickener in their drinks because they had difficulties swallowing liquids. There was no list on the drinks trolley to indicate which people needed to have their drinks thickened. We spoke to a staff member about this. They said "We hear this at handover and we tell whoever is doing the drinks". This information was not included in the morning handover we attended and the written handover sheet we saw did not include everyone that was at risk because of swallowing difficulties. The service did not have effective systems in place to identify risks to people with complex needs in their eating and drinking.

A record was kept of any accidents which had occurred. These mainly related to slips, trips and falls resulting in no or minor injury. One incident recorded however related to an incident which put a person at severe risk of choking. The registered manager and the clinical lead nurse had not been aware of this incident before we discussed it with them despite it happening over three months previously. There was no evidence that staff had monitored the person's health following the incident. The person's risk assessment had not been updated to guide staff about how to keep the person as safe as possible in the future.

We observed a person had been left unsupervised with a piece of toast hanging out of their mouth. They were partially reclined in bed. They were clearly not able to eat this without support. We were concerned that this could put them at increased risk of choking. We reviewed the person's care records and found that

it did not contain any clear guidance about how to support this person to eat and drink safely although it said the person had refused most meals for the previous two days. Nursing staff had recently visited the person to provide them with their medicines, which they had also not been able to take. These were left on the person's over bed table. They said they had left the medicines for the person to take later as they were having their breakfast.
Some people required powdered thickener to be added to their drinks as they had difficulty swallowing. We observed two tins of powdered thickener had been left in one of the lounges. These needed to be stored securely. This presented as a potential risk which had been highlighted in a NHS patient safety alert. The safety alert had been issued as some people in other services had come to significant harm when they had ingested this powder.

This was a breach of 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risk assessments relating to the health, safety and welfare of people using services must include arrangements to respond appropriately and in good time to people's changing needs.

There were insufficient numbers of staff available to meet people's needs. At the time of our visits 36 people were living at St John's. Nineteen people needed two staff to help them to move safely. Some people were cared for in bed and at times we observed people in their rooms who were distressed and needing comfort which was not quickly provided. The registered manager said there were two nurses on duty in the morning until 2.30 pm and five care staff. There was one nurse on duty for the rest of the day with a minimum of four care staff. In the afternoon two care staff were based on each floor and the nurse worked where needed. This meant there were times when only two staff were present on each floor. When they were both assisting a person who needed the support of two, there was no one to supervise and support anyone else who needed assistance. Staff confirmed they sometimes found this difficult to manage. We observed staff at times could not assist people as another staff member was not available. One person had to wait to go to the toilet which caused them some distress. One person said "They don't come when I press my bell". People we spoke with all had similar opinions about the available numbers of staff at the home. One relative told us "The girls work really hard but sometimes there are not quite enough of them and they cannot get to people, so some have to wait. The worst time is in the evening and some mealtimes too". The registered manager said she was currently advertising for a twilight nurse and staffing had recently increased to four during the night to reflect increased needs (This meant one nurse and three care staff were on duty during the night), The head of care was at times supernumerary and at other times was included in the staffing hours.

At the time of this inspection there were not sufficient numbers of staff deployed to meet people's needs. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed staff recruitment records and found safe and effective recruitment practices were followed to ensure that staff did not start work until satisfactory employment checks had been completed.

Inadequate

Is the service effective?

Our findings

At our last inspection in January 2015 we found that improvements were needed to ensure that staff were acting in accordance with the requirements of the Mental Capacity Act 2005. At this inspection in April 2016 we found the required improvements had not been made.

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. We observed staff asked people for their consent before they assisted them with their care. If people refused, this was noted in their records. When there was a doubt about people's ability to make decisions about their care and treatment at St Johns, their mental capacity was assessed, however, these assessments were not always decision specific. This was not in line with The Mental Capacity Act which states assessments of capacity need to be time and decision specific.
Relatives had been consulted to help to make decisions about people's care and treatment which is good practice when people are deemed to lack capacity to make their own decisions about their care and treatment options.
However the service had at times taken into account relative's wishes about the treatment of their relative when the person themselves may be able to make this decision. For example, one person living at St John's was deemed as having capacity to consent to their care and treatment. Their relative's opinion, which may or may not have reflected the opinion of the person concerned, had been documented at the front of their care records.
This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment of service users must only be provided with the consent of the relevant person.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The registered manager had submitted relevant applications and some were waiting to be assessed by the local authority.

People's nutrition and hydration needs were not effectively monitored and managed. Some people had lost weight over recent months. It was not always clear why they had done so.
When people had lost weight or when they had been assessed as being at a high nutritional risk for other reasons, staff recorded the amount they ate and drank each day; however, this was not being done effectively or on a consistent basis. The amount people had eaten and drunk was not always recorded and there was insufficient guidance in people's plans of care to guide staff about what was sufficient food and fluid intake for people. There was also no guidance about what to do when people refused any food or drink for a period of time.

The service was caring for people who required their food to be delivered directly to their stomach via a

tube. When this was the case, instructions were not in place within the person's care plan to ensure they were provided with appropriate and effective support. This included oral care. Mouth care is an essential part of nursing people who do not have oral intake. There was no guidance for staff about the frequency of oral care and the care plan was not up to date or sufficiently detailed. We observed one person who needed support with their oral care had dry cracked lips and their lower teeth looked unclean. We spoke with staff about this at the time of our inspection so they could take action to improve the person's comfort
We observed one person was provided with a straw on more than one occasion in their beaker which actually impeded their ability to drink by themselves. They had to remove the straw which they did with difficulty to enable them to drink independently. This indicated staff did not have a strategy to address the nutritional needs of people using the service.
This was a breach of Regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not demonstrated they had met the nutritional and hydration needs of people who lived at the service.

People said they generally liked the food and said they had a choice of hot meal each day. The registered manager said the service could cater for people who had special dietary needs such as those with wheat intolerance or those who were vegetarian. They said everyone was on a diet suitable for diabetic people as this promoted their health.

The evidence about how well people were supported to maintain good health was mixed. Most people we spoke with and their relatives were happy with the health care they received although one person told us they wished they could be consulted more, for example, about their medicines. We found that people's care records summarised people's medical history, but lacked indivualised and detailed information about how their medical conditions, such as Diabetes, or Parkinson's disease impacted on their health and wellbeing and what staff needed to do to support them. Health care professionals who had completed a quality assurance survey in 2015 gave positive feedback saying they were consulted appropriately about people's healthcare concerns and said they were satisfied with the quality of the nursing practice. Other healthcare professionals who had visited the service recently found some improvements were needed regarding the planning and management of people's health care needs. We found there were occasions when people should have been referred to external health care practitioners to support them with particular medical needs but there had at times been a delay in doing this. This had on occasion increased the risk of the person's medical condition deteriorating. This included people who had diabetes.

This was a breach of Regulation 12 (2) i of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not always worked actively with others, both internally and externally to make sure that care and treatment remains safe for people using the service.
Registered nurses did not receive any clinical supervision. Clinical supervision provides an opportunity for registered nurses to reflect on and review their practice, discuss individual cases in depth and change or modify their practice and identify training and continuing development needs. The lack of clinical supervision was concerning as we had identified during our inspection some aspects of clinical care which needed to be improved upon.

This was a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as providers must ensure as staff should receive appropriate on-going or periodic supervision in their role to make sure competence is maintained.
The registered manager said that all care workers were receiving supervision and would have an appraisal in 2016.

Staff received training in key health and safety areas such as fire safety training, infection control, and moving and handling and new staff had completed an induction in line with skills for care. Skills for Care provide practical tools and support to help adult social care organisations in England recruit, develop and lead their workforce.

A number of people at the service were living with dementia but very few staff had received any training about how to support people with this condition. We discussed this with the registered manager at the time of our inspection. They said the service had a new contract with a different provider of training and that one day every month would be dedicated to training For example in the next month the training was going to cover safeguarding of adults and nutrition and hydration . This was going to be repeated the following month to ensure all staff had the opportunity to attend. This contract was going to include training in the care for people living with dementia.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in January 2015 we had found that the service was not always caring. This was because information about people's needs was exchanged during staff handover in a way which was not confidential and so there was a risk people's privacy could be compromised. At this inspection in April 2016 we found this had improved and staff handovers now took place in private. There however remained times when people's privacy and dignity continued to be compromised. There were nine double rooms at the service. We observed privacy screens were not being used in all shared rooms. We observed one person who was being cared for in bed did not have any covers on. Their bedroom door was open and although staff had recently been in to attend to them they had not made any attempt to cover them or make them more comfortable.
We asked people what it was like to live at St John's. One person said "Variable, I don't think there is peace and harmony." People said most staff were caring. Visitors we spoke with were mainly happy with the care people received and visiting professionals surveyed said staff were friendly and helpful.

We observed a variable quality of interaction between staff and people who lived at the service. Some staff were kind and patient, for example, we observed one staff who had noticed a person had not eaten much of their food spent time gently encouraging them to eat some more. Another staff got a cushion for a person who appeared uncomfortable. They were kind and patient checking carefully with the person concerned they had positioned it correctly. Other staff were observed laughing and joking with people in a friendly way. At other times however we observed staff walking through communal areas not interacting with any person there.

Visitors were made welcome and we observed one relative was provided with lunch which they ate alongside their husband Staff said "We get close to relatives. They need your support just as much"
Although staff could describe what people's needs were they did not always demonstrate a good understanding of how to support people in a caring way. For example one person was described as being as "very agitated and distressed for no reason" This person could not hear well and needed information written down for them. We observed some, but not all staff communicated with them in this way.

There were some aspects of the service which were task centred. One example of this was people's daily records which included a section about nail care. Staff ticked to confirm they had done this. However we found four people's nails were not clean despite there being ticks in their records. The registered manager recognised that the service at times had been task centred and had introduced a resident of the day scheme. Resident of the Day is an initiative that helps care home staff to understand what is important to each resident and to review in depth what would make a difference to them.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in January 2015 we said the service was not always responsive. This was because people's positive experience at mealtimes was compromised because there was a lack of dining tables which meant people had to have meals in their armchairs. Since our visit in January 2015 a conservatory had been added which contained tables and chairs for dining. These were not being used and people currently living at the service still ate their meals in armchairs in the communal lounges, or in their bedrooms. Staff said this was people's choice. People we spoke with did not express an opinion to us about where they preferred to eat.

At our last inspection in January 2015 we said the service needed to make other improvements to provide consistently responsive care as peoples changing needs were not always reflected in care plans. At this inspection in April 2016 we reviewed again how people received personalised care which was responsive to their needs. There was some evidence that people were consulted about the care provided and the registered manager for example said they spent time with each person when they were writing or updating people's plans of care. There were brief written assessments for people admitted to the home and these included their medical and care needs and social history. Care plans had been devised from this initial assessment Some care plans were better organised than they had been at our previous inspection. However some still lacked detail and proper evaluation to ensure staff could provide consistent care which was responsive to people's medical needs. For example one person had an infection which had been diagnosed by their GP in December 2015. They did not have a care plan regarding this infection, and therefore staff lacked written guidance about how to support this person consistently.
Care plans did not provide guidance on how staff might help people to maintain their continence. Some people were described as continent but wore pads for protection. We visited people in their rooms and some rooms had an odour which indicated to us that the person's comfort needed to be attended to. Daily records stated that incontinence care was given but there was no guidance for staff about how to maintain people's continence. There were times when people clearly needed more support either to be assisted to the toilet or for staff to assist them to change their continence pad. Staff meeting minutes of March 2016 recorded staff had asked about double padding people. This is poor practice and staff were clearly told during the meeting that it was not acceptable. We were not satisfied that the service was promoting people's continence consistently.

There was insufficient guidance in place to ensure staff administered pain relief consistently to people when this was needed. We saw a person was clearly in pain and they had not been administered any pain relief.We observed two medicines rounds and found that while the staff seemed to know people well, when they asked people if they had pain they asked multiple questions in ways that were difficult for people to answer. Staff did not use validated pain assessment tools. These diagnostic tools assist in assessing the severity and quality of pain experienced by people when they cannot always do this for themselves. We asked a nurse when they would administer analgesia. They said "when people have bad pain". There was no definition of what 'bad' meant. People experience pain in different ways and it is important that staff have individualised guidance about how each person may present when in pain.
We observed one person who asked staff to be taken to the toilet. Staff told them they could not do this as

they needed another staff to help them. The person became more distressed and was calling help, and rocking backwards and forwards in their chair. A nurse came into the room but did not offer to assist the staff member present. It was 25 minutes before two care staff assisted the person.
This was a breach of Regulation (9) (1) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 as providers must to everything reasonably practical to make sure that people who use the service receive person centred care and treatment that is appropriate and meets their needs.

Two people who lived at the home said there was not enough to do and they were bored. One said, "They would put more stuff on but they do not have time, they work hard for their money but they can't do all they do then put on entertainment for us all, also we do not all like the same things".
We spoke to staff about activities at the home. They told us "there are singers that come in three or four times a week and the residents love them". We observed one musical session and people did seem to be enjoying it. We asked if the people living upstairs and those in their rooms had an opportunity to attend organised activities. Staff replied "the residents upstairs do not want to go". We observed most people in the upstairs lounge remained there most of the day. Some had books and puzzles to occupy them; others did not seem to have much to do. This needed improvement.

At our inspection in January 2015 we said the complaints system needed to improve. At this inspection we found improvements had been made. There had been four written complaints made since the last inspection. These had been responded to in line with the services complaints procedure, and where necessary action had been taken to help to resolve issues raised.

Inadequate

Is the service well-led?

Our findings

At our last inspection in January 2015 we said the service was not always well led as although there were systems to assess the quality of the service provided these were not always effective and were not always driving improvements. At this inspection in April 2016 we found the situation remained unchanged.

The service's website states "Our core principle is to provide a much higher standard of accommodation and care than is required. We treat all our residents as family members. We believe that by creating this happy family atmosphere, you or your loved one can enjoy your stay with us and receive the very best standard of care". People we spoke with who lived at St John's varied in their opinion about how well the service was achieving this objective. Some said they were quite content, they were happy with the staff team and said they were receiving all the care and support they needed. Others were less certain with some commenting on the lack of care provided by some staff and discussed, for example, some equipment in the home which did not meet their needs. Relatives and health care professionals surveyed in August to October 2015 provided positive feedback about the service. Some professionals visiting the service more recently had expressed some concerns regarding aspects of people's care and treatment. – We took into account the positive opinions expressed about the service, also the evidence provided to us from health and social care professionals who had expressed some recent concerns and the evidence we had gathered during our inspection. We judged from this the service was not meeting their core principles.

Since our last inspection a new registered manager had been appointed. We observed they were visible throughout the home and people responded to them warmly. They were not a registered nurse and so they were supported by a registered nurse who was clinical lead. The registered manager acknowledged that at times the service had a task centred approach rather than being person centred. We noted that the registered nurses and care staff did not work effectively as a team. Nursing staff completed people's daily care records, despite care staff being the ones providing the support. At times we witnessed nursing staff not assisting care staff when they needed help. As a result people had to wait for assistance longer than was necessary.

Although the registered manager had taken some steps to improve aspects of the service, for example the complaints procedure had improved, there remained significant areas where procedures and practices needed to improve further to ensure people received a consistently good quality of care. Previous sections of this report discuss the shortfalls we found during this inspection and describe a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We expect systems and processes to be in place and we need to be provided with evidence they are operated effectively to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The quality assurance processes in place had not been effective in identifying the clear shortfalls in the service.
The lack of effective quality assurance systems in place continued to be a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have taken enforcement action about this by issuing a warning notice to the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not doing everything reasonably practical to make sure that people who use the service receive person centred care and treatment that is appropriate and meets their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users must only be provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments relating to the health, safety and welfare of people using services must include arrangements to respond appropriately and in good time to people's changing needs. The service had not always worked actively with others to make sure care and treatment remained safe. The service was not demonstrating the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care	Safeguarding service users from abuse and improper treatment Systems and processes must be established and operated effectively to prevent abuse of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not demonstrated they had met the nutritional and hydration needs of people who lived at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff deployed to meet people's needs Nursing staff needed to receive on-going or periodic supervision in their role to make sure competence is maintained.