Churchill Residential Care And Nursing Homes Limited

St Judes Nursing Home

Inspection report

29-31 Mayfield Road
Sutton
Surrey
SM2 5DU

Tel: 02086431335
Website: www.stjudesnursinghome.co.uk

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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?	Good

Summary of findings

Overall summary

St Jude's Nursing Home is registered to provide nursing care for up to forty older people who may be living with dementia. There were 39 people living in the service at the time of our inspection.

We carried out this inspection on 10 October 2017. At our last inspection in May 2015 the service was rated as 'Good'. At this inspection we found the service remained Good.

The service had a registered manager in post at the time of the inspection. 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.

People living in St Jude's Nursing Home were safe because staff assessed and took action to reduce their risks of avoidable harm and abuse. The provider undertook thorough checks of staff during the recruitment process to ensure they were safe and suitable to provide care and support. Medicines were stored safely and administered in line with the prescribers' instructions. Staff followed appropriate hygiene practices to reduce people's risks of infection.

Staff were trained to deliver care to people effectively and were supervised when doing so. People gave their consent to the care and support they received in line with the Mental Capacity Act 2005. People received the support they required to choose and eat nutritious meals throughout the day. Healthcare professionals attended the service regularly ensure people's health needs were met in a timely manner.

Staff were kind and caring towards people and treated them with respect. People's privacy and dignity were promoted and staff shared positive relationships with people. People received compassionate care and support to manage their pain as they approached end of life.

People's needs were assessed and care plans guided staff towards meeting them as people preferred. People were supported to engage in a variety of activities and measures were in place to prevent social isolation. The provider gathered and acted upon feedback from people and their relatives and complaints were dealt with appropriately.

The registered manager developed an inclusive culture within the service. Staff felt supported and able to share their views about improving the service. The quality of care people received was the subject of audits and the service worked closely with other organisations to promote best outcomes for people.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

St Judes 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 10 October 2017 and was unannounced. This meant the provider did not know we were coming. The inspection was undertaken by one inspector and one 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.

Prior to the inspection we reviewed the information we held about St Jude's Nursing Home including notifications we had received. Notifications are information about important events the provider is required to tell us about by law. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to share with us some key information about the service, what the service does well and improvements they plan to make.
We used this information to plan the inspection.

During the inspection we spoke with seven people, eight relatives and two health and social care professionals. We also spoke with five staff, two activity coordinators, the clinical lead, the administrator and the registered manager. We reviewed 10 people's care records and risk assessments. We checked medicines stocks and storage and reviewed 22 medicines administration records. We reviewed 10 staff files which included pre-employment checks, training records and supervision notes. We read the provider's quality assurance information and audits. We looked at complaints and compliments from people and their relatives.

Good

Is the service safe?

Our findings

People and relatives told us that they felt St Jude's Nursing Home was safe. One person told us, they felt, "very safe". A relative told us, "It's a very safe place."

People continued to be supported by staff who knew how to protect them. Staff received regular training in safeguarding adults and this was reinforced by the registered manager in team meetings and one to one supervision meetings. Staff we spoke with were able to tell us about signs that might indicate a person had been abused and the actions they would take to keep people safe. Staff understood the provider's safeguarding reporting procedures and knew how to whistle-blow if they felt their concerns about people's safety had not been adequately addressed.

People's risks of experiencing avoidable harm continued to be monitored and reduced. Staff assessed people's risks across a number of areas including their mobility, health, skin integrity. Where people presented with risks staff took action to mitigate them. For example, people who remained in bed for lengthy periods because of their health needs were identified to be at risk of pressure ulcers. The actions taken by staff to protect people's skin included the application of barrier creams to vulnerable areas such as people's heels and lower back, supporting people to reposition regularly and using air mattresses. Staff recorded the actions they took to reduce risks to people in care records and made referrals to the relevant healthcare professionals when new or increased risks were identified.

People, relatives and healthcare professionals told us there were enough staff available to deliver care and support safely. One person told us, "There's always plenty of staff about." The registered manager regularly reviewed staffing levels to ensure there were staff in sufficient numbers to meet people's changing needs.

People were protected from the risk of unsuitable staff. The registered manager and the nursing homes' administrator followed appropriate and robust recruitment procedures. This included interviewing candidates, taking up two references to confirm their experience, competence and reliability. Checks against criminal records and lists of individuals barred from working with vulnerable adults were carried out. The registered manager also confirmed the identities of candidates and their eligibility to work in the UK.

Medicines were administered to people safely. Most medicines were kept in blister packs. We checked 22 blister packs and their corresponding Medicine Administration Record [MAR] sheets. We found that people received the right medicines at the right time and staff signed MAR sheets appropriately. People's 'when required' medicines were recorded appropriately and included protocols which stated the name of medicines, when they should be administered and the maximum dosage permitted within a 24 period. Medicines trollies were locked and secured with the keys for them held by nurses. Senior nurses audited medicines three times each month. We found that where discrepancies were identified during these audits action had been taken. For example, where staff identified inaccurate information on medicines packaging they were returned to the dispensing pharmacist for correction. This meant people received their medicines as prescribed.

People were protected against infection. Staff wore personal protective equipment (PPE) when delivering personal care. For example, staff wore gloves when supporting people to shower and disposed of them afterwards prevent bacterial cross contamination. Staff followed daily, weekly and monthly cleaning schedules which were audited by the home's administrator. The nursing home was clean and free of malodours.

Good

Is the service effective?

Our findings

People continued to receive care and support from a trained and knowledgeable team of staff. One relative told us, "The nursing staff and care staff are excellent." Another relative told us, "They seem to be trained well enough".

People received support from staff who undertook regular and relevant training. The registered manager ensured that all staff were trained in mandatory areas including infection control, mental capacity and safeguarding. Training specific to people's needs was also delivered to staff. This included continence care, managing behaviours, dementia and pressure care. Nurses were supported to maintain their registration with their professional bodies. This included support to access professional publications and undertake clinical training such as catheter care and syringe pump competency. Staff files contained certificates from the training courses they attended and the registered manager maintained a training matrix which showed the training planned for and completed by staff.

New staff received an induction before delivering care. The induction process included watching important training videos, reading policies and shadowing colleagues. The registered manager determined the duration of induction periods based upon new staff members previous experience in adult social care. The registered manager told us, "The most important parts of induction are getting to know people, other staff and the environment. It is important for staff to feel happy and supported." To enable this new staff were allocated a mentor to support them through their induction phase.

People were supported by supervised care staff and nurses. One member of staff told us, "I feel very well supported. I discuss all my concerns and have always been supported to work through problems." Staff received regular supervision from their line managers. Records were made of these one to one meetings to review at the following meeting. We read staff supervision records and saw that issues included people's needs and staff training. Additionally, staff were invited to discuss their strengths and weaknesses and the support they required to improve their effectiveness. Staff participated in annual appraisal meetings which focused on their knowledge, quality of work, reliability, motivation, communication and care delivery. Appraisals included staff pre-appraisal questionnaires in which they evaluated their own performances. This meant staff were supported to reflect on their practice.

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 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).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people were subject to DoLS we

found that the relevant documentation was in place. This included the assessments to determine their lack of capacity to make specific decisions and the minimum restrictions required to keep people safe. For example, some people had bedrails in place to prevent falls and injuries. Care records in relation to people's DoLS authorisations also stated the dates upon which the restrictions were due to expire.

People and relatives told us that meals were enjoyable. One person said, "I like them." A relative told us, "There is a very good menu. The food is lovely." Another relative told us, "An alternative is always available". People were supported to make choices at mealtimes. Staff offered people options to choose from. For example, at breakfast people were offered a selection of cereals, toast or a cooked breakfast. People received the support they were assessed as requiring to eat. For example, some people were assisted by staff to eat and some people had the consistency of their food and drink changed to ensure they ate and drank safely. We saw that kitchen staff had a large noticeboard on display which provided information about people's special diets. This information included details about people's special diets, including where people were vegetarian or abstained from particular foods for religious reasons.

People were supported to have timely access to healthcare services. One health and social care professional told us, "They always get in the right professionals at the right time." The service was actively supported by a local GP practice. The GP and pharmacist undertook weekly visits to the nursing home to review changes to people's clinical needs, meet new arrivals and review medicines. Staff made referrals to healthcare professionals when required. Records showed that a range of professionals including tissue viability nurses, palliative nursing specialists, a speech and language therapist and physiotherapist had all attended the service to support people in the days and weeks leading up to our inspection.

The service was adapted to meet the mobility needs of people. The nursing home had two elevators and a stair lift. Hoists were available to support people to transfer. In addition to its large lounges and dining areas the service had a number of small communal areas. These were used as quiet, reflective and relaxing spaces as well as locations in which people could meet with relatives and visitors.

Good

Is the service caring?

Our findings

People continued to describe the staff as caring. One person told us, "All the staff are lovely." Another person said, "They treat me well." A third person told us, "They care and that's all you want really".

People and staff shared positive relationships. One relative told us, "Staff are really friendly, and they give lots of stimulation, and share some of themselves with the residents." Staff we spoke with knew people well and the information they shared with us about people was confirmed in care records and by relatives.

People were supported to develop life story books. These contained information such as where people grew up, went to school and started work. They highlighted family information including people's siblings, children and grandchildren. Within them people were supported to answer questions such as, "What was your favourite childhood memory", "who were your childhood friends", "what places are special to you", and "what events in your life have been significant or special to you." Life history books gave staff insightful information about people and provided meaningful topics for conversation with people.

People were supported to make choices about the care and support they received. One member of staff told us, "Offering choices is continuous. We offer people choices all day from personal care and breakfast to activities and where they're want to sit and what they wear or watch on TV." Another member of staff said, "I ask people if their ready to get up or have a wash now, if they say no that is alright. I respect the decision and come back a bit later and ask them then. It's important for people to have and feel a sense of control." People were referred to by their preferred names. This included formal titles such as Mr or Mrs as well as favoured abbreviations of first names.

Staff respected people's privacy. Staff told us and we observed that they knocked on people's bedroom doors and waited to be asked to enter. Where people were hard of hearing we saw staff knock people's doors before slowly opening them and clearly stating who they were and requesting permission to enter. People and relatives told us that staff enabled them to meet privately both in people's bedrooms and the quieter areas of the home.

People's dignity was maintained. One member of staff told us, "We protect people's modesty as a matter of routine. So for example I would cover someone's body with a towel whilst washing their face so they're not completely and unnecessarily naked." Another member of staff told us, "We close people's bedroom doors and their curtains when giving person care." People's care records were written in a manner that conveyed respect and highlighted people's strengths

People receiving end of life care were treated with compassion and supported to be pain free. One person told us, "They are good at keeping my pain under control. Staff are very attentive and are always checking that I'm ok." Another person told us, "It really is perfect for what I require at this stage." Relatives of a person who had received end of life care told us, "I couldn't recommend [the service] more highly. They couldn't have done more." Staff developed end of life care plans for people. These covered areas such as pain relief, symptom control, spiritual intervention, nutrition, hydration, personal care, oral care and comfort. One

healthcare professional told us, "It is reassuring to have a team so experienced and skilled supporting people who are so frail."

Good

Is the service responsive?

Our findings

People continued to receive care that met their individually assessed needs. Nurses assessed people's needs prior to their arrival at the service to ensure the service was able to meet people's needs. Areas assessed included people's health, mobility, mental capacity, communication and risks. Where needs were identified care plans stated how they should be met. For example, one person had a moving and handling assessments and care plan which described how two staff should support them to use a hoist to transfer when having a bath. Similar guidance was given regarding the use of sliding sheets to support another person to reposition in bed. This meant staff had clear guidance about meeting people's needs.

People received personalised care. People made choices about their care and support which were noted in care records. People had personalised bedrooms with mementos, personal effects and photographs on display. Care records noted where people preferred to have their bedroom doors left open at night time. People were allocated keyworkers. Key workers are members of staff with specific responsibilities including helping people to organise their rooms as they wish, obtaining toiletries, liaising with relatives and spending quality time with people talking or engaged in activities. Keyworkers also arranged quarterly reviews of people's care to which relatives and professionals were invited.

The service made available a range of activities for people to engage in. The service had two activities coordinators who planned, led and delivered activities to people in large and small groups as well as to people individually. People were supported with activities that were relevant to their earlier working lives. For example, former seamstresses were supported with sewing activities within arts and craft sessions. Those who could no longer sew were supported to wind wool. People who had enjoyed baking for their families were supported to prepare bread mixes during sessions which involved kneading, rolling and cutting dough. People enjoyed cheese and wine tasting sessions. Staff used the sessions to encourage conversation. A member of staff told us, "We ask questions like where does this cheese come from? Have you been there? Where have you been on holiday? What were your favourite holidays? Then we ask others have been there. It's about stimulating interaction between people and reminiscing together." A music therapist visited the service fortnightly and people were regularly entertained by visiting performers. One person told us, "I really enjoy the singers when they come." A member of staff told us, "Sometimes you wouldn't recognise people for their excitement when an entertainer performs."

Staff took action to prevent people becoming socially isolated. People had care plans in place to mitigate the risk of social isolation. We found people who spent most of their time in their bedrooms were supported with activities of their choosing. These included completing crosswords and puzzles, as well as newspaper, book and bible reading.

People who presented with behavioural support needs received personalised support from staff . Where people presented with anxiety and problematic behaviours referrals were made to healthcare professionals for assessments. These informed the care plans which staff followed to meet people's needs. For example, one person was supported to play a recording of a relative speaking calmly to them when they became distressed. In another example, a person was supported to care for the home's pet dog to reduce their

agitation. Staff monitored and reviewed instances where people presented with behaviours which challenged, including the communication and support techniques used by staff that had been successful. This meant when people were agitated they were supported by staff using planned strategies proven to be effective in reassuring and calming them.

The provider actively sought people's views about their experiences of the care and support they received. The provider conducted surveys of people's views. Among the questions that people responded to were "do you feel respected by the staff", "how well do you feel your personal hygiene is cared for? And how do you rate the cleanliness of your room?" Survey results showed that over 95% of people rated the service as good or very good overall. People were also supported to attend residents meetings to share their views.

Relatives felt listened to. One relative told us, "Anything that we have suggested or asked for has happened." Another relative said, "You only have to mention something and it's done." Relatives completed a questionnaire at people's care review meetings. These asked questions such as, "what are your thoughts on the social interaction at St Jude's", "what are your thoughts and views of the overall care your relative receives", and "do you feel welcomed when you enter the nursing home?" The service arranged for regular relatives meetings to discuss people's care and support generally.

The provider responded in line with its policy on the management of complaints. We found that complaints were acknowledged in writing and investigated. Where complaints were upheld the complainants was informed in writing and the provider stated the "lessons learned."

The registered manager retained the complements received by the service. We read some of the dozens of thank you cards sent from relatives. These were shared with staff by, in the first instance, displaying them in the staff room and afterwards by keeping them in dedicated folder.

Good

Is the service well-led?

Our findings

Good governance continued to be in evidence at the service. There was a registered manager in post and relatives spoke favourably about her. One relative told us, "She is amazing. She runs a very tight ship and just gets things done". Another relative said, "She certainly manages well."

The registered manager was visible at the service and promoted an open culture. One relative told us, "The staff respect [the registered manager] and they work well as a team" A member of staff said, "We are encouraged to share our thoughts and feelings about things even if we have reservations or our views differ. It is a really positive experience to work in this team."

The provider conducted surveys of staff opinion. The most recent survey this year showed a 94% satisfaction rate among respondents. Staff responded positively to questions including "do you feel that you had an adequate induction" and "do you feel we are a good employer?"

The registered manager ensured effective communication within the team. Staff held handover meetings each morning and there were frequent leadership meetings. These were attended by the registered manager, clinical lead, care coordinators, activities coordinator, head of catering and head of housekeeping and promoted information sharing and collective planning. Nurses were supported to meet regularly to review clinical practices within the service such as the prevention and treatment of pressure ulcers.

People received care and support that was subject to audits. The registered manager coordinated quality checks covering a range of areas. These included checks of medicines, care records, the environment, repairs, training and activities. Where shortfalls were recognised action plans were put in place to achieve improvements. The registered manager routinely checked to confirm that actions had been successfully completed. Care records were well organised. Needs, risks and mental capacity assessments were clearly arranged within care records as were care plans, progress notes and reviews. Records related to health, safety and audits were well organised and easily to retrieved. This was evidence of effective administrative organisation by the service's leadership team.

The service worked in partnership with other organisations to ensure people received high quality care. We found partnership working with healthcare professionals including Parkinson's specialists and the Memory Clinic. The service engaged in collaborative work to support people's transitions from a local hospital and a nearby hospice into the service. The registered manager attended the local health and social care organisation's provider's forum. These meetings were used to share good practice and to provide an opportunity for the providers of adult social care to receive information about best practice. The registered manager understood the legal responsibilities of their registration with CQC and the requirement to keep us informed of important events through notifications when required.