OPERATIONAL COMPLIANCE REPORT

ST JOHNS NURSING HOME
Rownhams Lane
Rownhams Southampton
SO16 8AR

30TH SEPTEMBER 2016

CAREPORT

Contents

APPENDICES

SECTION A - Notes Regards Sections 1 - 6

This Report forms part of an audit report which is to be read in conjunction with this document and the comments made herein. The audit report is contained within the Appendices regards this care service.

Our audit is designed to gauge whether the home is meeting regulations introduced by CQC with effect from 1 April 2015 using Key Lines of Enquiry (KLOES). To get to the heart of people's experiences of care and support our focus is on the quality and safety of services, based on things that matter to people. The key questions are therefore:-

Is the service safe?	Requires Improvement	●
Is the service effective?	Requires Improvement	●
Is the service caring?	Good	●
Is the service responsive?	Requires Improvement	●
Is the service well led?	Requires Improvement	●
OVERALL RATING	Requirement Improvement	●

Our views may differ from the last CQC report published and indeed, with CQC's current views if they were to inspect the service now. The findings we have reported are based on our own findings on the day of our inspection (whether announced or unannounced) and our interpretation of the CQC Regulatory Framework.

As part of our inspections, we carry out an operational audit of the care home using our own Careport Audit Tool (appended). Where possible we also spoke to the owners of the home, the manager of the home and staff. Where appropriate, we also spoke to service users and to visitors within the care home on the day of our visit.

Where authorised (please refer to our engagement letter) we also spoke to the local safeguarding team, commissioning teams and CQC Inspection Office.

Careport have also reviewed safeguarding records regards alerts made over the last 12 months, the last 12 months complaints records and the last 12 months incident and accident records along with actions in all of these areas that the service carried out to make improvements.

Please also refer to the careport action plan at the end of the appended audit.

SECTION B – SUMMARY OF FINDINGS

The overall standard is derived on the basis we understand CQC arrive at ratings as follows:-

At least two of the five key questions would normally need to be rated 'Outstanding' and three key questions rated as 'Good' before an aggregated rating of Outstanding can be awarded.

There are a number of KLOES ratings combinations that will lead to a rating of 'Good'.

If two or more of the key questions are rated Requires Improvement, then the overall CQC Rating will normally be Requires Improvement.

If two or more of the key questions are rated Inadequate, then the overall aggregated CQC Rating will normally be Inadequate.

St Johns Nursing Home is registered to provide nursing care for up to 38 adults. The home is owned by Mr. R Kitchen. The home is without a Registered Manager, however, a new Manager was appointed three weeks ago Mrs. Christine Harris. The Quality Compliance Manager is Mrs. Kani Trehorn who has been acting as the Interim Manager following the departure of the previous manager and her deputy. The accommodation includes 30 single bedrooms and 6 double rooms.

St Johns was inspected under the new CQC inspection on the 25th and 27tt of April 2016. with the following outcomes:-

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	
OVERALL RATING	Inadequate	

Careport's audit highlighted that there are areas of concern in relation to the following:-

- *Safe care and treatment;*
- *Obtaining consent;*

- *Quality monitoring of the whole service;*
- *Improvements required to the safeguarding of service users and associated documentation;*

We found gaps in the requirements relating to parts of:-

- *Care planning and risk assessments;*
- *Documentation to evidence best interest meetings;*
- *Infection control;*
- *Health and safety requirements around mandatory checks and risk assessments;*

People were protected from the risks of inadequate nutrition and hydration, although some care plans had not been re-written for some time and monthly assessments where not undertaken which are required at the very least monthly (or upon a change in care requirements).

Residents were provided with a choice of suitable foods to meet their needs. People were given the necessary support, such as ensuring soft diets were available in an appetising way and that a choice of drinks were available at all times through the day.

Deprivation of Liberty Safeguards (DoLS) had been considered for some residents but not all who required a DOLs had been assessed and referred. There was limited to no evidence that Best Interest meetings had been arranged for those residents who were without capacity.

Arrangements to act in accordance with people's consent were not in place. Very few care plans we reviewed had signatures to evidence consent and staff were not documenting when verbal consent had been obtained. Where people were thought not to have capacity to make certain decisions, Mental Capacity Assessments were carried out and some decisions were made in people's best interests, there was, however, limited no documentation to evidence this. There were also consent form signed by relatives who did not hold Leading Power of Attorney for health.

There was no evidence to demonstrate that in the event of an evacuation there was a red grab folder although there was some equipment to use. We were informed a PEEP's plan was completed the day before and was stored in the resident care files. This would result in chaos in the event of an emergency copies being required in a grab file for the emergency services to use.

The Manager and staff we spoke to had a good understanding of the signs of abuse and how to respond appropriately to any allegations of abuse. We saw displayed evidence of numbers to contact on entering the building in the event that a referral should be made to the local authority safeguarding team

There was little or no evidence to suggest that the Manager and staff responded to verbal complaints as there was no documented evidence to support this.

Monthly reviews had not consistently taken place including involvement of significant others.

Staff had received recent training and a new training matrix was in place. There was also a new supervision matrix, whilst supervisions took place these were not as regular as we would like and appraisals did not include personal development plans.

We found that, in general, staff understand how to meet the needs of people in the practice of care on the floor of the care home. We did see evidence staff had been provided with training in this area.

There was little evidence to demonstrate that the home regularly assesses and monitors the quality of service delivered. There was new documentation in place but not a full suite of meaningful quality audits to undertake such checks.

The service does not regularly seek the views of people using the service, their relatives, staff members or external professionals.

The home did not have suitable arrangements in place regarding involving people in planning their end of life care.

People told us, and we witnessed, that staff treated people with kindness and respect throughout our audit. We undertook observations of staff interacting with people who used the service. We saw staff respond and approach people in a kind and calm manner. We saw that staff showed, through their conversations with residents, empathy and understanding towards the people they cared for. We saw that people's privacy and dignity was respected by the way staff assisted people.

The staff recruitment processes in general were safe

People were cared for by staff that were supported to deliver care and treatment safely and to an appropriate standard. We found there was enough qualified, skilled and experienced staff to meet people's needs.

We saw people looked well kept, dressed appropriately and their hair and nails were clean and cared for.

This report highlights continuous improvements required at the nursing home.

A major risk while these requirements are outstanding is obviously if CQC re-inspect the home, which they will do at some point. This could also be affected by the ongoing large scale investigations plus any new safeguarding alerts, complaints, whistleblowing incidents or simply a Local Authority or CCG monitoring visit.

In our view this will require a good deal of additional work for the Manager who at present is very new to the role, and the quality compliance manager. It may, for a temporary period, also require some supernumerary time for the new Deputy Manager to support the improvement process. It should also be acknowledged that the improvement process will be additional work for the whole staff group.

The remainder of this report highlights the five Key Lines of Enquiry, Is the service Safe?; Is the service effective?; Is the service Caring?; Is the service Responsive?; Is the Service Well-Led?

SECTION 1 - IS THE SERVICE SAFE?

Over all we saw that there had been some improvement in the provision of care and processes but we were unable to evidence consistency of these improvements. We did not see specific skin integrity care plans in place. Generally this was incorporated into the personal care plan which was not identifying specific equipment to be used to prevent pressure sores occurring.

Waterlow risk assessment records showed that people had been assessed as being at 'high risk' of developing pressure ulcers. However, the specific equipment to be used to reduce the risk was not identified in care planning documentation. Although we saw some pressure mattresses and cushions being used across the home we could not be sure that this equipment was appropriate to meet people's needs as people had not been individually assessed. This meant that the home did not have effective systems to plan care and treatment so as to ensure the welfare and safety of these people.

For one person, the care planning documentation did not state the specific equipment that was required to help this person to transfer and how staff would support them. it did not specify how the transfer would be carried out safely with the staff member. It also did not specify the type of hoist or specify the type and size of sling which was required.

We spoke with several staff about safeguarding all showed a good understanding of their responsibilities in relation to this. When asked how they would respond if they saw bruising and suspected physical abuse one staff member was very clear to tell us any action they would take to ensure the person was protected.

We found a number of minor issues with the cleanliness and hygiene of the home. The home and equipment was generally clean. We identified that hoisting equipment was not cleaned between residents to minimize the risk of cross infection. There were also a number of bed rooms that had carpets in situ which were giving an offensive aroma. However, there was clear evidence to show that this was being addressed as a number of rooms now had a lino wood effect flooring in place. We also saw cleaning of the lounge carpet taking place. This evidenced that the home was taking action to improve the cleanliness of the home. We saw that effective cleaning schedules where in place and that the housekeeping staff took pride in their work. We did not however see evidence of an infection control or infection surveillance audit.

Staff confirmed there were medicine audits carried out including individual service user audits which were helping to identified and resolved any issues identified in a timely manner. Stock checks suggested that all medicines which had been administered had been signed for appropriately. We were able to confirm medicines had been given as prescribed. One person had received a controlled drug as prescribed, and they had received adequate pain relief.

We found that the arrangements for medicines storage were appropriate. We were shown a newly designed and fitted clinical room which was clean and tidy and temperatures where well controlled.

We did not see clear procedures for giving medicines in accordance with the Mental Capacity Act 2005 in people's care plans.

We witnessed the nurse returning to the drug trolley with a number of empty medicine pots on top of a pot with a tablet inside. We were informed that this person was in their room. This demonstrated that more than one person's medication had been dispensed at the same time. This does not comply with policy. It also demonstrates a poor infection control process as the medication was contaminated from the used pots. We brought this to the attention of both the deputy and the manager. The medication was disposed of and replaced.

Staff we spoke with told us there were enough staff to meet the needs of people in the home. However, staff said that there had not been enough staff recently due to colleagues leaving. There was also a high number of newly appointed staff within the home.

There was no evidence in the care files we looked at, or in other documentation, that the service had obtained people's consent on individual aspects of their care such as their preferences for support with personal care, having their photograph taken, the rationale for restricting movement (the front door was locked) or taking their medication. This showed that the service did not have arrangements in place to obtain, and act in accordance with, people's consent in relation to their care and treatment.

The service was beginning to make arrangements to implement and work with the Mental Capacity Act (MCA) 2005. The care files we looked at contained assessments of people's mental capacity. Although there was limited to no information to demonstrate that the service had taken any steps to work in people's best interests. There were also consent forms signed by relatives of residents without capacity to make decisions. This suggested that people may not be involved in decisions when they have capacity, and appropriate steps may not be taken when people do not.

We found that several people may have been deprived of their liberty without authorisation. We found bed rails were in place for several people across the home. Residents files showed that risk assessments had been carried out. However, these assessments had not considered whether the bed rails constituted deprivations of liberty for individuals. Staff told us there had been no assessments as to whether applications for deprivation of liberty safeguards were required for these individuals, and no applications had been made.

We found that the home operated safe recruitment practices. Staff who had started work recently told us they had had an interview and before they started work, that the provider obtained references and carried out a criminal records check on them. We checked staff records and saw that these were in place. The file had a completed application form listing their work history as wells as their skills and qualifications. There were had references from previous employers, as well as a criminal records check in place.

Is the service safe? **Requires Improvement**

SECTION 2 - IS THE SERVICE EFFECTIVE?

We asked to sample some food about to be served and found that it was warm. We asked to see records of temperature checks done before food was served. Staff were able to show us evidence of all temperature checks. There was also evidence that the temperature of the fridge and freezers had been monitored as per regulations. People had not been put at risk of food borne infections as systems were thorough.

People were provided with support, where necessary, to enable them to eat and drink sufficient amounts for their needs. We saw staff supporting people to eat their meals in a respectful and dignified manner. Staff were seen to not rush people and to wait until they were ready for more food.

Staff were seen to routinely check whether other people were experiencing any problems, such as whether they were enjoying the food or whether they were eating. We observed that one person was asking for help and the care worker was kind and compassionate to her needs.

We saw that a choice of meals were offered and people were offered a choice. Staff also told us that people could have an alternative meal if they requested something different. When we asked one person how their meal was they replied, "Very nice I like fish!" They told us they liked the food, but particular this meal.

Staff had not had effective support, supervision and appraisals. We looked at the supervision matrix. It was evident that recently supervisions had been implemented by the Quality compliance manager and whilst appraisals had also not taken place there was a plan for this to commence.

We did not see any evidence of competency assessments having taken place. The newly appointed deputy had commenced employment two days prior to this inspection. He was undertaken the drug round but had not been assessed to ensure his ability.

We observed that staff responded appropriately to people living with dementia who were distressed and asking for help.

Our discussions with staff showed that they were recently provided with training and supported by the quality compliance manager to recognise and manage behaviours which challenged the service. Staff had also received training in Mental Capacity Act (2005) and DoLS.

There was a new training matrix in place but we were unable to fully ascertain what training staff had received. We were informed that all mandatory training had been completed and staff had received safeguarding and MCA. We were also informed that some staff had been identified as champions trainers. The quality compliance manager was also undergoing training in order to ensure ongoing training was maintained.

Staff told us, and records showed, that a GP visited the home regularly. Records also showed that some people had received recent visits from social workers and the tissue viability nurse.

Is the service effective? **Requires Improvement**

SECTION 3 - IS THE SERVICE CARING?

We spoke with five people who told us that staff treated them with kindness and compassion. One person said, The, [staff] are marvelous how they help day and night, they really are." Another told us, They're wonderful lovely people. No matter what you want you get. We did not see any relatives but we did speak to the local priest and church members who attended the home to conduct a service. The people we spoke to spoke very highly of the staff they had seen some changes recently especially people getting out of bed and sitting in the conservatory.

However, we found that people were not always involved in planning and making decisions about their care and support. We were informed that a bath list was still in operation which represented institutionalized care and task allocation being in operation people where only offered a bath/shower on set days. However, when we questioned a member of staff he said "Although there is a bath list if a resident wanted a bath every day he would have it". This demonstrated that people's choice and wishes were being respected.

There were suitable arrangements in place to ensure people's dignity and privacy. We saw that staff knocked on closed doors before entering. We also saw doors closed when personal care was being provided.

We did see some small rooms being occupied by two none related people. There was a screen to separate and afford some privacy when personal care was being given. Due to the close proximity of the residents dignity was compromised.

We found that where people talked about their lives and preferences readily, staff had come to know about their life histories. Life histories had been completed and were kept in individual files in their rooms for people to make reference to.

We observed lunch in the home and saw that most staff interaction with people was positive. Most staff encouraged people and offered food at a suitable pace, waiting for them to finish the previous mouthful. Staff stayed with people who they were supporting to eat, people were not disrupted through their meal.

We saw kind compassionate interactions between staff and residents. One lady asked for help and it was obvious she was feeling poorly. Staff responded quickly and responsively especially when she proceeded to vomit. We witnessed staff reassuring her whilst attending to her needs. Other staff were seen to support residents who were distressed at witnessing the poorly lady.

Information about people was treated in a confidential way. All personal information was kept in lockable offices to make sure it remained confidential. We saw that when staff wished to discuss a confidential matter they did not do so in front of other people who lived at the home. We observed bedroom and bathroom doors were kept closed when care was being provided. We read people's daily care notes, and comments were respectful although we did not see evidence that verbal consent was documented.

We saw that, in the lounge and conservatory, chairs were arranged in groups to encourage socialisation.

Staff told us that people were able to personalise their rooms and bring photographs and in some cases personal furniture. However, besides this we saw no other examples of people being involved in decisions relating to how the home was run. For example, we found no evidence that people were involved in creating the menu.

Suitable arrangements in relation to end of life care were not always in place. We did not see an advanced care planning' records in people's files and that people's preferences and choices for their end of life care were not clearly recorded. We saw no evidence of discussions with people and their relatives about how they would like their end of life care to be delivered.

We saw that Medicines Management was effective and good practices were generally maintained. Medication prescribed 'as required' or 'PRN' was administered appropriately we also saw a pain scale in operation.

Is the service caring? **Good**

SECTION 4 - IS THE SERVICE RESPONSIVE?

People did not always have their individual needs regularly assessed and consistently met. We did not see any Skin integrity care plans in any of the people's documentation we looked at or guidelines for staff to follow to reduce the risk of pressure ulcers developing. Whilst waterlow risk assessment documentation was completed it was not routinely reviewed monthly.

Staff told us, and records showed, that one person had recently been referred to safeguarding with multiple pressure ulcers. Whilst there was a folder with wound care plans there was no care plan detailing how to reduce the event of a pressure ulcer developing. We were informed that the TVN nurse had advised a pillow under a lady's calf to reduce the pressure on her heel but she then developed an ulcer on her calf.

We found that people's nutritional needs were not always monitored and managed. We saw that several people had 'Malnutrition Universal Screening Tool (MUST)' assessment. The organisation which produced this tool advise that reviews are carried out monthly for it to effectively monitor people's nutritional status. However, we saw that for some people there had been a failure to monitor their nutritional status monthly to protect them against the risks of unsafe care.

The provider did have adequate arrangements in place to meet people's social and recreational needs. We saw evidence that people had individual planned program of activities and were supported to pursue hobbies and interests. However people's hobbies and interests were not always recorded in their care plans. We saw that where hobbies and interests were recorded, there was little evidence to show how this identified how people should spend their days. We saw a timetable of activities but saw that the activities coordinator only worked Mon-Thurs. This meant that for three days a week residents did not have any specific activities, although we did see a staff member playing cards with a gentleman in the conservatory.

People's concerns and complaints were encouraged and people who lived in the home were provided with information about the home's complaints procedure. The quality compliance manager told us no complaints had been received and the complaints documentation showed none recorded. There was a complaints policy in an office file, plus this was on display in the home and provided to people in an accessible format.

Is the service responsive? **Requires Improvement**

SECTION 5 - IS THE SERVICE WELL-LED?

We saw that evidence showed that the service previously had not been well-led. However, since the appointment of the quality compliance manager there had been significant changes put in place. There was also a newly appointed home manger and a new deputy manager. We witnessed positive relationships between the three and comments and actions that would demonstrate an understanding of further improvements.

Some peoples care plans and risk assessment had been re-written. They had then not been reviewed monthly. As a consequence the service did not always identify, assess and manage risks relating to the health, welfare and safety of people or others who may be at risk from the carrying on of the regulated activity.

Staff told us there was, and we saw evidence of, risk assessments in place regarding the scalding and burning risks in the context of the vulnerability of those being cared for. We were informed that these were in place following a scald occurring in the home.

Staff told us, there were records to evidence, that the temperature of hot water outlets were tested to ensure that the temperatures were controlled and did not put people at risk of scalding. We did not however see this documentation.

We saw that a fire risk assessment had been carried out by an external company. We saw that several actions which had been identified to keep people safe had been carried out. We saw there was evidence of personal emergency evacuation plans (PEEPs) for all people to assess and plan how they would escape in the event of a fire, and to ensure that appropriate fire safety measures were in place. There was no evidence of a red emergency folder to grab containing copies of peoples PEEP's and floor plans.

We did not see mechanisms in place to regularly seek the views (including the descriptions of their experiences of care and treatment) of people using the service, persons acting on their behalf and persons who were employed at the home to enable the registered person to come to an informed view in relation to the standards of care and treatment provided. The manager informed us that there were no meetings for people using the service, and we did not find any records of these. We did see a notice that a meeting was arranged for October 2016. We did not find evidence of any people's views being obtained.

Records of minutes showed staff meetings had recently took place but these were not consistently monthly. The records did not reflect that these meetings were used to seek the views of staff and their contribution in providing a service to people.

We looked at systems in place to monitor the quality of the services provided by the home.

Records showed that some audits had been implemented and were carried out by the quality compliance manger however, these did not show evidence that people's views were sought as part of this process.

We found that there was a new document introduced which emphasised ensuring accurate handovers between shifts. We noted that staff handed over appropriate information about each person.

There was a system in place to report accidents and incidents. We saw that accidents were recorded into a log book. However, records showed that people's care plans and risk assessments were not always reviewed and updated in light of accidents and incidents involving them.

Records showed that the fire alarm, as well as automatic door releases and means of escape, were checked regularly. Records also showed that checks of the fire system and fire fighting equipment had taken place regularly. Records also showed that testing of portable electrical appliances (PAT testing) had been carried out within the past year, as well as a gas safety and boiler check.

There was however, no evidence of Health and Safety meetings haven taken place.

Is the service well led? **Requires improvement**

CAREPORT ASSESSOR GUIDANCE NOTES

Key Lines of Enquiry for each of the five areas of assessment;

Is the service safe?	
S1	How are people protected from bullying, harassment, avoidable harm and abuse that may breach their human rights?
S2	How are risks to individuals and the service managed so that people are protected and their freedom is supported and respected?
S3	How does the service make sure that there are sufficient numbers of suitable staff to keep people safe and meet their needs?
S4	How are people's medicines managed so that they receive them safely?
S5	How well are people protected by the prevention and control of infection?
Is the service effective?	
E1	How do people receive effective care, which is based on best practice, from staff who have the knowledge and skills they need to carry out their roles and responsibilities?
E2	Is consent to care and treatment always sought in line with legislation and guidance?
E3	How are people supported to eat and drink enough and maintain a balanced diet?
E4	How are people supported to maintain good health, have access to healthcare services and receive ongoing healthcare support?
E5	How are people's individual needs met by the adaptation, design and decoration of the service?
Is the service caring?	
C1	How are positive caring relationships developed with people using the service?
C2	How does the service support people to express their views and be actively involved in making decisions about their care, treatment and support?
C3	How is people's privacy and dignity respected and promoted?
C4	How people are supported at the end of their life to have a comfortable, dignified and pain free death?
Is the service responsive?	
R1	How do people receive personalised care that is responsive to their needs?
R2	How does the service routinely listen and learn from people's experiences, concerns and complaints?
R3	How are people assured they will receive consistent co-ordinated, person-centred care when they use, or move between different services?
Is the service well-led?	
W1	How does the service promote a positive culture that is person-centred, open, inclusive and empowering
W2	How does the service demonstrate good management and leadership?
W3	How does the service deliver high quality care?
W4	How does the service work in partnership with other agencies?

PLEASE USE FULL KEY LINES OF ENQUIRY DOCUMENT FOR MORE IN DEPTH GUIDANCE OF QUESTIONS AND AREAS TO ASSESS IN RELATION TO ALL OF THE ABOVE.

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