HC-One Oval Limited

St Nicholas Care Home

Inspection report

21 St Nicholas Drive
Bootle
Merseyside
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

St Nicholas Care Home is owned and operated by HC-One Limited, a large national organisation. The home provides nursing and personal care for up to 176 people in six separate units; currently one nursing unit is closed. Two units currently provide general nursing care and one unit provides nursing care for people living with dementia. One unit provides personal care for people living with dementia and one provides nursing care to people who have a learning disability. There were 107 people accommodated at the time of the inspection visit.

This was an unannounced inspection which took place over three days on 29 and 30 May and 4 June 2018. The inspection team consisted of three adult social care inspectors, a pharmacy inspector and two '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.

There was a registered manager in post. 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.

At the last inspection in November 2017 the home was owed by BUPA Care Homes Limited who have since sold the home to HC-One Limited. The home is again in transition as HC-One Limited are now selling the home on. At the last inspection there were outstanding breaches of regulations. This inspection was comprehensive and was the homes first inspection under the new providers.

Overall, we found the service had been stabilised over the past six months. There have been concerns reported in areas such as personal care and nursing assessment and observation, including management of falls. These have been reduced in number and seriousness with respect to the homes previous history. We looked at these areas of concern as part of the inspection.

Of the four outstanding breaches of regulations – two have been met and two remain. We have given the home a quality rating of 'Requires Improvement'. This is the ninth consecutive time the service has been rated Requires Improvement since January 2014.

At the last inspection we observed there was not always enough staff to carry out care in a timely manner. There was a high use of agency staff cover which had inherent risks around the effectiveness of communication and knowledge around people's care needs. On this inspection we found improvements and did not find people at serious risk. We did find, however, continued inconsistencies in staff cover which had the potential to put people at risk of unsafe care at times.

HC-One Limited are a large national organisation with established systems in place to continually assess and monitor the delivery of care in the home. We found the introduction of a new care planning system and

documentation had not been delivered effectively and gaps in the documentation and care records. One of the key management objectives, to ensure appropriate staffing at all times, had also not been fully met.

You can see what action we told the provider to take at the back of this report.

At the last inspection in November 2017 we found people were not protected against the risks associated with medicines because the provider's arrangements to manage medicines were not consistently followed. There was a risk associated with the use of agency staff. On this inspection we found improvements and systems in place helped ensure safe delivery of medicines. The breach had been met.

We made a recommendation for improved practice.

Previously we had found inconsistencies in assessing some people's health care needs and delivering effective outcomes. We found this had improved and there was more consistent delivery of care and people's health care needs had been reviewed appropriately. The breach had been met.

Similarly, we had found on the previous inspection some examples evident where people's dignity was clearly compromised. We found this had improved and all the people we spoke with and their relatives told us they felt privacy and dignity was upheld by staff and their approach to care. The breach had been met.

Staff were aware of the first aid procedures and equipment used in case of an accident or emergency.

People's clinical risks such as falls, pain and diet were routinely assessed and monitored. This helped to maintain people's safety and welfare.

Staff files showed appropriate recruitment checks had been made so that staff employed were 'fit' to work with vulnerable people.

People we spoke with and their relatives told us they felt safe in the home. People knew who to speak with if they felt concerned about anything. Nobody we spoke with or observed expressed any issues regarding their safety.

There had been several safeguarding investigations at St Nicholas Care Home since our last inspection. Staff had assisted the local authority safeguarding team and agreed protocols which had been followed in terms of investigating. This helped ensure any lessons could be learnt to ensure safe and effective care.

We found that the home was overall clean and hygienic.

We found the home was operating in accordance with the principles of the Mental Capacity Act 2005 (MCA). People were being appropriately supported to make key decisions regarding their care and treatment.

We observed meal times and saw that meals were served appropriately and people who needed support to eat had sufficient staff time allocated and that staff took time to talk with and socialise with people.

Staff told us the training they received was good. The 'training matrix' we saw showed that some staff needed training updates and this had been identified and was organised. There was an established induction programme for staff.

We saw references in care files to individual ways that people communicated and made their needs known.

We also saw good examples where people had been included in the care planning, so they could play an active role in their care although this was not always apparent.

A complaints' procedure was in place and people, including relatives, we spoke with were aware of this procedure. We spoke with the registered manager who showed us how complaints were recorded and responded to.

We saw that people were provided with some social activities. These were not however always evident on the units we inspected. There was a need to further review how activities were planned and implemented.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There was not enough staff deployed at all times to help ensure people were cared for in a consistently safe manner. This potentially put people at risk of unsafe care.

People were protected against the risks associated with medicines because the provider's arrangements to manage medicines were followed.

People's clinical risks were routinely assessed and monitored to help maintain their safety.

Recruitment processes were thorough and helped ensure staff were fit to work with vulnerable people.

The home was clean and we found systems in place to minimise the spread of infection.

Is the service effective?

Good

The service was effective.

There was support for people's health care needs and when needed people were referred for appropriate support to health care professionals.

Staff understood and were following the principles of the Mental Capacity Act (2005).

Staff were supported through induction, appraisal and the provider's training programme.

We saw people's dietary needs were managed with reference to individual preferences and choice.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was respected.

People and their relatives told us they were happy with the care and the support in the home. We observed positive interactions between people living at the home and staff.

People we spoke with and relatives told us the registered manager and staff communicated with them about changes to care and involved them in any plans and decisions.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were provided with social activities but these were not always consistent or individualised and could be further developed.

There were examples of good practice regarding the individualisation of care plans and people's care records evidenced an individualised approach to care. In some examples we found a lack of assessment and planning around end of life care.

A process for managing complaints was in place. People we spoke with and relatives were confident they could approach staff and make a complaint if they needed.

Is the service well-led?

Requires Improvement

The service was not fully well led.

The provider had not met regulatory requirements and key areas of their improvement plans for the service including consistent staffing and maintenance of care records.

There were systems to get feedback from people so that the service could be developed with respect to their needs and wishes.

At the time of the inspection there was a registered manager in post to provide a lead in the home and they were supported by a clear management structure. We found the registered manager to be open and constructive.

St Nicholas Care 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection which took place over three days from 29 May to the 4 June 2018. The inspection team consisted of three adult social care inspectors, a pharmacy inspector and two people who were '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.

We could access and review the Provider Information Return (PIR) as the registered manager sent this to us as part of the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service.

We contacted the commissioning bodies such as the local authority contracts unit and the local commissioners of health to get any feedback. The feedback was mixed and we were told about several safeguarding investigations that had arisen since the last inspection of the home which raised issues around delivery of care.

During the visit we visited all the five units that currently make up St Nicholas Care Home [one unit was closed]. Units visited were Huskisson and Gladstone, accommodating people living with dementia; Canada and Langton units which were both general nursing units and Brocklebank which accommodates people with a learning disability.

People living on Huskisson and Gladstone had difficultly expressing themselves verbally. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We were able to speak with 14 people who lived at the home. We spoke with 11 visiting family members. As

part of the inspection we also received feedback from three health care professionals who visited the home.

We spoke with 19 staff members including nursing, care/support staff and the home's registered manager and clinical service manager. We also spoke with other senior managers within the organisation.

We looked at the care records for 11 of the people living at the home, four staff recruitment files, medication records and other records relevant to the quality monitoring of the service. These included safety audits and quality audits, including feedback from people living at the home and relatives/visitors. We undertook general observations and looked round the home, including some people's bedrooms, bathrooms and living areas.

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Requires Improvement

Is the service safe?

Our findings

The people we spoke with and their relatives generally felt safe in the home. Comments included, "I've been in quite a few homes and this is the best one so of course I'm safe," "Yes I'm very safe here," "Yes they're a good lot here" (meaning the staff), "Me and my brother know [person] is safe here and we have no concerns about care" and another visitor said, " [Person] is very safe here."

At the last inspection of the home in November 2017 the had been in breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 with regard to the provision and deployment of adequate staffing at all times to help ensure safe care for people. The high use of agency nursing staff had led to poor communication and incidents where people's safety had been compromised.

A new provider had taken over the running of the home soon after the last inspection and the registered manager sent us an improvement plan which stated that staffing levels would continue to be reviewed with the aim of ensuring 'staffing is at agreed levels on each unit'.

On this inspection we found staffing had improved but still lacked consistency at times which placed people at potential risk of receiving unsafe care.

There had been improved nurse recruitment since last inspection with 11 additional nurses recruited. The nurse agency usage showed reduction from last inspection. There was also evidence that the registered manager was monitoring the competency of agency staff and their usage. At the last inspection there was 205 hours agency use for one week; on this inspection we found average usage had been reduced over an eight-week period to 160 hrs weekly.

An Inspection of the 'staff on duty' rota over a four-week period showed the home short staffed on 35 out of 420 shifts covered. This was 8.3% shifts short [based on the homes own agreed staffing numbers]. This is a 100% improvement on the last inspection when 16.4% of shifts were not covered. It was also the case that overall the home in some instances [across all units] were 'over staffed'. When discussed with the registered manager this was interpreted as a staff deployment issue, in some instances, rather than insufficient numbers across the home.

The feedback from nursing staff was generally [but not wholly] positive. They did highlight shortages [nurses] but felt they were 'getting on with things' and the general standard of care was being maintained. An exception was Canada and Langton units [general nursing] where the feedback from people and relatives evidenced a need for more staff on occasions. The staffing on Huskisson was improved for the last inspection.
We found, however, that occasional failure to ensure staffing levels at all times had the potential to place people at risk. Examples of this, prior to the inspection, included two 'whistle-blower' reports of poor staffing. Both concerns had been reviewed by the registered manager and evidenced mostly appropriate staffing but some gaps in cover where staff had not been appropriately deployed.

On this inspection, Canada House staff reported changeable staffing and high use of agency. The use of agency cover on this unit was the highest when reviewed with an average of 64 hours a week. This was reported by staff to affect communication on the unit as well as there being some examples of people being placed at risk. For example, an incident occurred on the night of the 3 May 2018 prompting a safeguarding investigation. This had involved a person who was reported to be 'restless and wandering' all night and clearly needed close monitoring; they had sustained unexplained bruising. On the night in question there had only been two staff on duty from 12 – 6am; one of these an agency nurse. This was a lack of adequate cover for 28 people with high nursing needs. Only two staff had been on duty for both nights on the 2 and 3 May.

On Langton Unit a person was observed to have a high risk of choking and needed supervision and assistance when eating. This was prescribed in the care plan as sitting with person to give support. This was not observed to be the case, staff were deployed in the dining area but the level of support to the person could not be provided with the staff present which potentially placed the person at risk.

Staff on Langton unit reported difficulties with staffing. One staff commented, "The biggest grievance is staff shortages which can put patients at risk. There is a lot of paperwork and not enough time to do it. Even if we have a full quota of staff on duty they can be deployed to other units leaving us short."

Another staff reported that sometimes care such as hoisting people, which required two staff, was carried out by one staff as there was not enough time for 'The work to be completed'.

When we spoke with people and their relatives on Langton and Canada units they cited good approach to care by staff but lack of staff numbers at times leading to staff being 'rushed' and 'under pressure'. Comments included: "Staff are very good but there's not enough of them. Staffing levels would be my concern about this place," "My daughter in law has complained in the past. There was an issue of breakfast being late at 11.30 and lunch being 1.00pm which is bad because [person] is a diabetic; I believe the problem has been resolved," "Yes, there are occasions when there are not enough staff," and "The staff are lovely, but they need more people, especially in the morning."

On Gladstone Unit we found staffing levels to support 27 people living with dementia on the 'staff on duty rota' as five carers for the morning shift and four care staff on the afternoon shift. These figures were generally maintained although senior staff on the unit reported agreed figures were in fact six in the morning and five care staff in the afternoon. This was supported by a copy of the unit rota which highlighted staff needed to make up to 6 in the mornings shift and 5 in the afternoon / evening. The registered manager did not dispute this.

On day of inspection Gladstone unit was operating with five carers in the morning. Gladstone unit was the only unit with no additional 'hostess' to assist with meals. We observed a lack of staff present in communal areas. This was because staff were busy assisting people out of bed and with their personal care routines and then into the dining room for breakfast. The senior staff giving out medicines was observing the day area and had to stop giving out medication on one occasion to support people. This disturbance to the medication procedure had the potential to increase the risk of errors. The senior carer advised this was a common occurrence.

We observed that Gladstone was not as clean as other units. We spoke with the domestic staff who has similar hours to other units [10 daily] but had to take three hours out to assist with washing up in kitchen as there was no hostess, which left reduced hours for cleaning.

After the feedback to the managers, CQC received confirmation that Gladstone would be employing a hostess [Although this had been previously identified by managers as an issue].

This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 in respect of failure to provide consistently sufficient numbers of suitably competent and experienced nursing staff.

At the last inspection in November 2017, we found the provider had failed to protect people against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because we found administration errors, issues with administration records, and some routine checks had not been completed. An action plan which was produced by the provider to address the issues showed improvement with compliance.

On this inspection we found improvements had been made and the breach had been met. However, we found other improvements could be made.

A medicines inspector visited three units and looked at the medicines administration records (MAR) for 13 people living in the home. Treatment rooms were visibly clean and tidy and medicines were stored securely. Staff completed a daily checklist to ensure that medicines were stored correctly. Records were clear and there was evidence that stock checks were being completed. We checked a sample of medicines stocks and these were correct. There were no gaps in records indicating that people had received their medicines as prescribed.

There were however, some issues with medicines on each unit we visited. One person's MAR did not have a photograph to help identify them. Another person had three medicines that were prescribed to be taken 'when required' and there was no additional information in the file, to guide staff how to give these medicines safely.

Some people were prescribed paracetamol to be taken when required. Staff had recorded the amount given but did not always record the time of administration. This is important to ensure a safe gap is left between doses. We also found two people with handwritten medicine records that had not been checked and signed by a second member of staff to ensure no errors had been made.

We recommend that the service continues to review medicine records in line with current good practice.

Medicines in use were stored in medicine trolleys. Dates had been recorded on medicines with a shortened expiry once opened, however we found a tube of eye gel, still in use, that had expired. We looked at the record for a person who was prescribed medicine via a patch. Staff were recording the application position; however this was not rotated in line with manufacturers guidance to reduce the risk of skin irritation. Staff assured us that these issues would be addressed.

We looked at the comprehensive monthly audit checks being done on each unit. The audits looked at storage, documentation and administration of medicines. Any issues and actions for improvements needed were listed. The documents were signed and dated when actions had been completed. In addition, staff looked at five different people's medicines each day on each unit to ensure everything was correct. Managers had examined the results and the number of errors that had been reported. The report demonstrated an improving picture over the last 12 months with a significant reduction in the number of errors reported.

At the last inspection we found assessment of clinical risk concerning people's healthcare needs was not always being met. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. On this inspection we found improvements and this aspect of care was more consistent. The breach had been met.

Risk assessments had been carried out to assess people's clinical risk; for example, the risk of developing a pressure ulcer. Pressure ulcers are caused by 'sustained pressure being placed on a particular part of the body'. We found this area of care continued to be managed appropriately. The home had low incidents of pressure ulcers overall. The risk of people getting pressure ulcers was routinely and regularly reviewed. One example was a person who had developed pressure ulcer and had been referred to the community matron. There was a wound care plan in place with good monitoring, including photographs. There was an on-going assessment of risk in place reviewed monthly.

There were risk assessments for the use of bedrails to help ensure people were safe. Dietary needs and nutritional requirements had also been recorded and assessed routinely using an appropriate assessment tool (Malnutrition Universal Screening Tool – MUST). Weight charts seen had been completed monthly.

We saw that in some people's care files it was noted specific pieces of equipment were needed to ensure their safety and wellbeing, for example, pressure relieving cushions and mattresses. On observation these pieces of equipment were found to be in place and they were being used appropriately. Equipment such as, shower chairs, commodes were also in place as recommended in the care files.

We found staff had knowledge of the whereabouts of first aid equipment for use in an emergency. On Huskisson Unit we saw a first aid box in the unit office with a list of contents for checking. Personal Emergency Evacuation Plans [PEEP's] were in place for each person in case of an emergency at the home such as a fire, so that staff would know what level of assistance each person would need.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at four staff files and asked the manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people.

Staff we spoke with had a good understanding of the importance of maintaining people's safety and reporting any concerns, including alleged abuse, to the registered manager of the home. All staff we spoke with were confident they could report any concerns, they would be listened to and appropriate action taken.

We had been notified about safeguarding incidents that had occurred since the last inspection. These were incidents or examples of care were people could be at risk of abuse and neglect and required investigation. Some of these involved medication errors which had been picked up through internal audits [checks] and notified appropriately. The themes for other incidents were lack of appropriate personal care, lack of clinical care and management of falls. Staff had assisted the local authority safeguarding team and agreed protocols had been followed in terms of investigating which helped to ensure any lessons could been learnt and effective action taken. This approach helped ensure people were kept safe and their rights upheld. We saw that the local contact numbers for the local authority's safeguarding team were available along with the providers safeguarding policy.

We looked at examples of people at risk of falls and found assessment and monitoring to be generally effective in helping to maintain people's safety. For example, one person had sustained and fall and we

found a falls risk assessment was in place as well as specific risk assessments to maintain a safe environment including use of suitable safety equipment to prevent injury. There were routine audits conducted looking at accidents and whether lessons could be learnt.

We checked some specific maintenance and safety records. We carried out a spot check of a number of safety certificates for gas safety, electrical safety, legionella risk and safety checks for the temperature of the hot water. Equipment such as, bed rails, wheelchairs, hoists and other equipment were also routinely maintained. These checks evidenced good monitoring of environmental safety in the home.

All units were secure and access could only be gained by inputting the correct code into the key pad at the entrance, the code to exit the unit being different. The codes were changed regularly.

Housekeepers were present on the units and areas seen were clean [see above for comments re Gladstone Unit]. On inspection most visitors and people, we spoke with had no concerns about the cleanliness of the home. The management team completed infection control audits, as part of monitoring safe standards in the control of infection.

Good

Is the service effective?

Our findings

Prior to the inspection up to this inspection we had received two concerns regarding the lack of clinical care for people with more acute health care needs. One of these was in January 2018 and involved failings around a person having been assessed for care around pressure relief and the need for oxygen therapy. Another concern, more recent in April 2018, was around the care of a person exhibiting behaviour which threatened other people's safety.

On this inspection we followed through the care of 11 people living at St Nicholas Care Home and found clinical care of people with health care needs was being managed appropriately. This was in relation to clinical care needs such as, wound care and management of complex health care needs. On Huskisson unit we found a person living with dementia was exhibiting challenging behaviour. Staff were fully aware of the person's care needs and had liaised effectively with supporting professionals from the Community Mental Health Team [CMHT]. A nurse for the CMHT advised us that staff had been effective in monitoring the person's care and had called for regular reviews by both social workers and nursing professionals.

In another example we received some feedback from a stoma nurse specialist who commented on the good support provided by staff for a person who needed support with their stoma. On Canada Unit a person who received their nutrition via specific route (via a tube into their stomach), had a care plan to support this practice and care of the tube was being monitored closely by the staff to ensure it was working correctly and safely.

All the people we reviewed had evidence of effective referrals and reviews with external health and social care professionals at the appropriate time to optimise their health. This also included GPs, speech and language therapy team (SALT), dietician and a community matron. We saw people's medical conditions were clearly recorded and staff followed specific care and treatment plans to support these conditions.

There were exceptions and areas of clinical care that could be improved. For example, one professional advised us of an incorrect wound dressing being applied which had not supported appropriate wound care [this had been reviewed]. The CMHT also told us that clinical care to support people living with dementia could be improved with the addition of nursing staff with more specific and appropriate professional qualifications. We fed this back the registered manager who informed us that a new Registered Mental Health Nurse [RMN] was being employed the week of our inspection.

We reviewed many of the care monitoring charts for areas such as, repositioning people being nursed in bed and fluids and diet charts. We saw these were updated during the day and these charts helped to provide a good evaluation of the care provided.

We looked at how thickened fluids were recorded. This provided sufficient details around the number of scoops of thickener to be added to drinks in accordance with the instructions from the dietician and SALT team. Staff we spoke with were aware of the number of scoops to be added and they told us how they recorded in the information on people's thickening fluid chart. These records had been completed to

evidence this. [There was an exception on Langton Unit which we fed back to the registered manager].

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 make decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found staff understood the principals involved and the records we saw clearly documented good examples where people who lacked capacity had had 'best interest' decisions made. Examples of these were in relation to people who had bedrails in place to reduced risk of falls from their bed and people who had 'do not attempt cardio pulmonary resuscitation' (DNACPR) in place. These were completed appropriately and decisions made in people's best interests were supported by additional support plans and assessments.

There were examples of supporting documentation around relatives having lasting Power of Attorney (LPA) to show they could make decisions for the person concerned. Overall there was clear evidence that families were consulted with regarding any best interest decisions including the initial admission to the home.

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 found this was being monitored well on most units. For example, we saw documentation where people with authorisations in place were being regularly reviewed; there were dates recorded when the authorisation was up for review. A failure to complete some of the new care documentation which had been introduced by the new provider meant that records for some people were missing and not immediately available. This included copies of Deprivation of Liberty Authorisations for some people on one unit. The registered manager was fully aware of all people who had been assessed and were on authorisations however.

People we spoke with at the inspection told us they felt staff had the knowledge and skills to support them with their care. Induction Training included shadowing more experienced staff and completion of a probationary period which covered six months. We saw a copy of the induction package for staff which included a four-day classroom based induction. The induction was based around current skills for care standards. We spoke with one member of staff who told us their induction consisted of five days training where key topics were covered. There was also a period of being supernumerary which they felt gave them confidence in their role. Another staff commented, "Training is fine, we are always getting updates."

Training records evidenced staff had completed training such as food safety, fire training, health and safety, infection control, moving and handling, safeguarding, safer people, equality and diversity. The records however showed refresher courses were out of date. The registered manager confirmed that they had identified this and this was due to a change in provider systems which had not initially flagged the gaps. The manager confirmed that refresher training courses had been booked for staff. Additional training for staff in end of life care, pressure area monitoring, dementia training, and thickened fluids had also been provided.

Care staff were also encouraged to gain qualifications in care such as, QCF (Qualifications and Credit Framework). At the last inspection in November 2017, 57% of care staff had completed their NVQ / Diploma in level 2, 3 or 4 in care. On this inspection the figure had improved to 60%. The registered manager recognised the need to improve this figure ongoing as it provides good evidence of staff having a sound knowledge base for care.

We observed meal times on all the units. People were mostly complimentary regarding the food served. One person commented, "The food's very good" and another person said, "I'm quite happy with the food here, it's always nice." 'Hostess's' were employed on all but one unit to help monitor people's food intake. People who were assessed as needing support for diet and fluids had monitoring charts in place which were up to date.

On Canada unit, tables had table clothes readily prepared and people were offered a choice of hot and cold drinks with their meal. Staff offered support to people with their meals; this support was unhurried and carried out in a sensitive manner. Staff asked people if they had sufficient to eat and whether they had enjoyed their meal. Feedback from people we spoke with was positive regarding the menu choices. The exception to this was on Langton were one person did not receive assessed support [see previous notes under 'safe' domain].

We inspected both units for people living with dementia. At previous inspections we saw there had been a series of audits carried out by the Admiral Nurse [nurse specialising in dementia care] employed by the previous provider. The audits were very detailed and covered both the experience of people living with dementia, the environment they were living in and the dining room experience. This provided valuable feedback for staff to develop further good care. The admiral nurse was no longer employed; however, the registered manager did inform us that other professional support was being considered to have input and support the development of dementia care.

There were some good examples of where staff had worked to develop a more 'dementia friendly' environment including use of signage on doors and coloured toilet seats to help identify and orientate people. There were memory boxes that were located on the outside of people's bedrooms, to assist them in identifying them as well as providing prompts for personalised conversation. Unit managers and the registered manager acknowledged that the environment could be further developed making it more dementia friendly.

Good

Is the service caring?

Our findings

At The last inspection we found a breach of Regulation 10 (1) of the Health and Social Care Act 2008 in respect of lack of consistent standards of care respecting people's dignity. The evidence for this had been on the two units for people living with dementia.

On this inspection we found improvements had been made and the breach had been met.

Prior to our inspection we had received some concerns regarding lack of attention to people's personal care. These concerns had been substantiated following investigations by the local authority safeguarding team and by the registered manager's own investigations. The registered manager had replied to the concerns raised by more person-centred care planning for the people concerned.

During our inspection we observed people's personal care to be appropriate on all of the units with examples of good attention by staff. There were no examples of poor personal care observed on any of the units and overall there was a more consistent approach.

On Huskisson Unit, where the previous findings had been based, we found staffing more settled and saw people were appropriately dressed with evidence of good standards of personal hygiene maintained. People received personal care when they needed it. One person's relative told us, "[Person] is always clean with their own clothes on. Staff take good care to ensure this."

On all units the atmosphere was observed to be calm and relaxed [Canada was a possible exception with staff appearing 'rushed' at times]. All staff were observed to be compassionate in their interactions with people. Visitors were made welcome and could have a drink if they wished. Two visitors on Langton unit told us they had enjoyed Christmas lunch with their relative at the home.

People we spoke with all praised the staff and their approach to care. Comments included, "They're very good to me," "Everyone's lovely here," and "They really care." Relatives and visitors were also complementary of the staff and told us, "The staff are smashing" and "The staff here are fantastic."

We observed many examples where staff listened and spoke with people appropriately. Staff were seen to be very caring when talking to and assisting people. We found the regular, or permanent staff knew people well and could relate their care needs and spoke about people as individuals. Staff had a good knowledge of people's preferences and individual routines. Staff told us they tried to maintain personalised care but this could be compromised sometimes if they had staff shortages.

Staff interaction with people was positive and people appeared at ease and comfortable in the presence of the staff. When staff supported people with daily tasks and activities this was carried out in a patient and caring manner so that people were assisted at their own pace. Staff offered people choices such as was they would like to sit in the lounge, what they would like to eat and drink at lunch and encouragement to take part in social activities on some of the units.

We saw where appropriate advocates such as, family members, were involved with the care reviews and the development of care plans. On one unit it was noted that there was an information pack attached to the notice board that explained what advocacy was, who was entitled to advocacy support and who to contact if staff/relatives felt it was required.

Requires Improvement

Is the service responsive?

Our findings

Not all people were involved regularly with activities although the provider did evidence a commitment in this area by employing specific staff to help with this. On Langton unit, for example, the activity staff had worked at the service for many years and worked 18 hours a week. They were very enthusiastic and clearly loved their role. They explained they always asked people what they wanted to do instead of telling them what they're going to do. Our observations confirmed they clearly had positive relationship with people and knew them all very well.

Planned activities included, mini bus outings for six people at a time to places such as Southport, a church in Crosby, and local schools. A local school sent their own minibus to collect residents and give them afternoon tea. Outings were once a fortnight on this unit. Other activities included one to one activity such as hand massage, nail painting, handicrafts, singalongs and watching old films.

We saw some activities on a one to one basis on Huskisson unit which were appropriate for people living with dementia.

People and their relatives commented favourably on the activities promoted. One relative said "Monday, Tuesday and Wednesday there is bingo, and there are other games such as dominos and people get taken for walks in the grounds or taken out in their wheelchair. The gardener does a good job with the grounds." One person said, " I get to sit outside when it's nice and another person commented " I just do a bit of crocheting." A person on Canada Unit told us, " I'm having a bird table fitted just outside my window and I'm looking forward to that."

On Brocklebank unit, for people with a learning disability, we found evidence of a personalised approach to activities including the provision of a kitchen for baking and cooking activities and socialising.

We saw that the provision of activities could be further developed in some units. For example, on Gladstone there were no activities for the people living with dementia for the week of the inspection due to staff being on holiday. The provision of a washing machine aimed at getting people living with dementia involved, with support, in domestic activities had not been plumbed in. On Langton and Canada units there were a lot of people cared for in bed with little access to any regular contact.

People were involved with their plan of care and relatives were included in this process and we saw evidence of this. For example, assessment documentation and review records made reference to people's involvement and where appropriate their relatives. Relatives we spoke with said staff communicated with them and updated them with any changing care needs. Overall, people felt they had input into their care planning. One person told us their care gets reviewed regularly and any changes are always discussed. However, some relatives and people being supported said they had not seen their plan of care. They were not concerned about this and said staff communication was good so they were aware of what was going on with people's care. One relative commented, "They [staff] are on top of things and always let me know what's happening."

'My Day, My Life, My Portrait' document recorded information about what a normal day looked like for the person. This helped staff take into account the persons care and support needs. We saw good information on the units around how people communicated their needs, expressed pain or anxiety, or liked physical touch to provide reassurance. Talking with regular staff confirmed their knowledge regarding people's needs and how they responded to the different ways people liked to communicate.

New documentation had been recently implemented and not all of these were fully completed and lacked detail. This was mostly evidenced around people's expressed wishes about their end of life care as these had not been assessed or recorded for some people.

Daily clinical notes were made for every person and these were written in a positive way and included essential information about people's daily care and activity.

Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily handovers between staff and through viewing people's care files. Evaluation of people's care was assisted by the completion of support observation charts such as fluid intake and diet charts.

The provider had a complaints' procedure which was in place at the home. The registered manager told us complaints were thoroughly investigated and the complainant was provided with a written outcome which would include apologies where there were failures or learning's needed by the home.

We saw examples of complaints made. Each complaint was recorded, and if required a safeguarding referral was made. Most written complaints were managed quickly and effectively with a written response sent to the complainant within 21 days of making their complaint.

Requires Improvement

Is the service well-led?

Our findings

St Nicholas Nursing Home has had a fluctuating history of compliance with meeting fundamental standards of quality and safety since 2014. At the last inspection in November 2017 we found the provider at the time had not met regulatory requirements with respect to sufficiency of staffing, consistency of personal care, ensuring people's dignity, and ensuring all people living at St Nicholas's were having effective outcomes for their care needs. This raised questions around the on-going effectiveness of the governance arrangements for the home. This was a breach of Regulation 17 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2104.

Since the last inspection the home has changed ownership and with the new providers, HC-One Limited, registered in March 2018.

At this inspection we found improvements in some areas with two outstanding breaches of regulations now met. HC-One Limited, being a large national provider, had ensured there were systems in place to monitor the running of the home. The home had an on-going 'Home Improvement Plan' (HIP) which has continued to be updated. The HIP concentrated on the previous key areas for development such as medicines management, care planning and provision of activities and had planned management interventions for all of these. On this inspection we found there were still breaches of regulations although we assessed the risk level as decreased from previous inspections.

Staffing had continued to be addressed by the HIP but there was further improvement necessary to ensure people's safety and consistency of care. Lack of staff at times raised potential risk in terms of people's observation and safety evidenced by the findings on the inspection. The HIP included reference to nurse recruitment and developing the role of senior care staff as well as staffing rotas to be managed effectively; these had been implemented but had not, yet proved overall effective in meeting requirements.

In addition, HC-One, since taking over the ownership of the home, had introduced a new care planning and documentation system. People's care planning documentation and records were to be transferred to the new formats. We found all the units in various stages of this process but the standard of documentation varied considerably depending on the staff's understanding as to what was required. This meant we found gaps in the [new] care documentation. This was mostly evident on Huskisson Unit with people's key assessments under the Mental Capacity Act 2005 as well as records pertaining to Deprivation of Liberty could not be located. We were told these were kept in a file by the previous unit manager but could not be found during the inspection. On Canada and Langton units there were gaps in care planning such as a lack of detail on some assessments including 'End of Life' wishes recorded for people and no 'one-page profiles' detailing people's life history completed.

There had been no training for staff regarding the implementation of the new care documentation. They had been given some templets but no other guidance. There was a lack of understanding with different staff as to what was expected. Management audits by the registered manager had eased some of the issues, for example the records on Gladstone unit were better, but had failed to stabilise the changeover protocol and

understanding by staff.

The Statement of Purpose (SOP) for the home could not be found during the inspection visit despite senior managers trying to look for this. Post inspection we were sent a one-page SOP which lacked detail and needed further development to fully describe and explain the aims and running of the home.

This is a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 in respect of maintaining accurate, complete and contemporaneous records in respect of each person.

The service had a registered manager in post who had started at St Nicholas' in December 2016. At the last inspection we spoke about the culture of the home and the main aims and objectives. The registered manager told us some key aims for the home including further embedding management systems, giving unit managers more accountability and support so they 'owned' a larger stake in the running of the home and ongoing nurse recruitment. The registered manager again reiterated these as key objectives and felt the home had made further progress over the last six months. Any future planning for the home would take account of the new provider's plans which included further marketing and possible selling of St Nicholas Care Home. The home remained, therefore in a state of flux. This was further compounded by the registered manager soon to leave the home for another post. Arrangements had been made by HC-One Limited for an interim manager to continue the running of the home.

Staff we spoke with varied in their opinions regarding the approach by the registered manager. However overall there was an appreciation of the consistent approach by the registered manager as an important factor in providing some stability at the home.

The registered manager was able to evidence a series of quality assurance processes and audits carried out internally and externally from visiting senior members within the organisation. The systems, processes and audits had been developed to capture as full picture of the home as possible. Staff had a good knowledge of the current auditing systems and how these fed into the overall analysis of how the home was operating. Findings from the audits and clinical risk reviews were discussed at clinical risk meetings with the heads of each unit.

Quality assurance processes also included regular 'residents surveys' to get people's opinions as to the running of the home. We reviewed the survey results from December 2017, which were posted around the home for people to see. 26 residents had given feedback and the overall satisfaction was noted to be high. Areas of strength were identified as 'staff know the needs of residents' and 'quality of care'. There were areas for improvement identified including 'access to information', and 'involvement overall'. The registered manager advised the findings are fed into the overall improvement plan.

One key management tool used to monitor the service had been [under the previous provider] the 'Quality Metrics' report which captured key indicators for clinical care and ensured they were continually monitored. Similar statistics were being collected by the new providers systems. There was a clinical indicator board in the registered manager's office. This provided an anonymised over view of people's clinical care and dependencies based on the audits and staff's professional judgement. The registered manager told us this was a valuable tool which provided an accurate overview of people's current health and wellbeing and was a valuable aid to ensuring people received safe, effective care as continued monitoring was made easier.

We found staff worked well in partnership with outside professional agencies and this was evidenced throughout peoples care records. The PIR told us, 'South Sefton CCG provide support, advice and audits in relation to pharmacy and infection control services. We recently liaised closely with the infection control

team to manager an outbreak of diarrhoea and vomiting. We have regular reviews by the Older Person Psychiatric Services, Mental Health Psychiatry and Learning Disability Psychiatrists and on-going support and advice from Community Mental Health team and Community Learning Disability team'.

The PIR submitted by the registered manager stated, 'The feedback from external agencies and audits (internal and external) is shared with departmental heads with lessons and learning topics identified and the HIP compiled, shared and owned by the team. Departmental heads are supported in implementation and general improvement throughout the home'.

The registered manager had notified CQC (Care Quality Commission) of events and incidents that occurred in the home in accordance with our statutory notification requirements.

From April 2015 it is a legal requirement for all services who have been awarded a rating to display this. The rating from the last inspection for St Nicholas Nursing Home was displayed for people to know how the home was performing including on the providers website.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not met regulatory requirements and key areas of their improvement plans for the service including consistent staffing and maintenance of care records.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was not enough staff, who were competent and experienced, working in the home on duty at all times to help ensure people were cared for in a consistently safe manner.