Bupa Care Homes (CFHCare) Limited

St Nicholas Nursing Home

Inspection report

21 St Nicholas Drive, Netherton, Liverpool, L30 2RG
Tel: 0151 931 2700
Website: www.bupa.com

Date of inspection visit: 15 & 16 July 2015
Date of publication: 15/09/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement

Overall summary

This was an unannounced inspection which took place over two days on 15 & 16 July 2015. The inspection was 'focused' in that we were following up on previous breaches of regulations identified on an inspection in January 2015; these were in the areas of – medication management, infection control, care planning and privacy and dignity. We also included a review of staffing as we had received some concerns prior to the inspection indicating staffing inconsistencies effecting care.

This report only covers our findings in relation to these specific areas / breaches of regulations. They cover three of the domains we normally inspect; 'Safe', 'Caring', and 'Responsive'. The domains 'Effective' and 'Well-led' were not assessed at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'St Nicholas Nursing Home' on our website at www.cqc.org.uk.

St Nicholas Nursing Home is owned and operated by BUPA, a large national organisation. The home provides nursing and personal care for up to 176 people in six separate units. Three units provide general nursing care; one provides nursing care for people living with dementia. One unit provides personal care to people with dementia and one provides nursing care to people who have a learning disability. The home is set within a residential area and is close to all amenities and public transport.

The service had 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.

Medicines

Summary of findings

At our last inspection in January 2015 we found the home in breach of regulations relating to safe administration of medicines. This was because people were not always protected by the medication administration systems in place. We told the provider to take action. The provider's action plan told us that systems had been reviewed and improved. At this inspection we found that the management of medicines were still not safe. From our findings during the visit and the continued high incidence of medicine errors, we found that people were still not protected against the risks associated with medicines. We found medicines were not being given at the right times, inappropriate storage, people missing medicines as they had not been ordered, medicines given 'when required' lacked supporting protocols, gaps and were seen in medication administration records.

Staffing

In the four weeks prior to our inspection we received three separate concerns regarding the staffing levels in the home. Two of the concerns related to the provision of consistent nursing staff on the units and was causing concern with some aspects of care. For example, completion of medication rounds was difficult and meant that people were not being given medication at the right time.

We visited five of the six units in the home and checked on staffing levels. We were told by staff that not units were consistent in maintaining staffing levels and there were shortages on occasions. On the nursing units we found delays in completing the medicine rounds when one nurse was allocated. We were told medication rounds were particularly difficult to time right when the unit was reduced to three care staff which had happened occasionally. On these occasions the nurse also needed to support care staff delivering personal care and this meant difficulties with monitoring people who needed nursing care needs. We found that people had not been given some of the medicines at appropriate times.

We spoke with the registered manager regarding these concerns. We were told that there was an ongoing issue with the provision of nursing staff to the home and there was a high usage of agency staff to cover. The manager felt this was improving and there was a sustained plan to recruit nursing staff.

Although improving, the overall evidence at the time of our inspection was that there was insufficient numbers of suitably qualified and experienced staff to meet the needs of the people using the service and other regulatory requirements at all times especially medication safety.

Care planning

At our last inspection in January 2015 we found the care planning for some people had not been updated to reflect their changing care needs. The risk of not updating major changes to people's care plans is that staff may be unaware of their changed care needs and there is an increased risk that specific areas of care might not be effectively monitored and reviewed. We told the provider to take action.

Following the last inspection we received an action plan from the provider that told us how improvements would be made. Part of this included a full review of the care plan documentation and a move towards a new system of assessment and care planning to focus the care with a more personalised way.

We reviewed people's care records on three of the units we visited. Most of the care records we reviewed had changed over to the new care planning system and so had had a recent review and the care plan had been updated and therefore reflected their current care needs. We found these care plans to be more focused in terms of identifying and personalising peoples care needs.

We found, however, some examples were staff had not still updated care plans and records effectively as care needs had changed.

For example the care plans for two people contained a range of care planning information. However, the care plans had been written when both people were far more able and independent. The care plans included a monthly evaluation and these contained more up to date brief information to reflect the change in the person's needs. This showed that the original information in people's care plans was out of date. Staff were therefore not reviewing/evaluating the correct information. For example the care plans read that one person could 'weight bear' [in terms of their mobility] and use a stand aid hoist and use the toilet when this was no longer the case and they now needed to be hoisted for all transfers and were incontinent.

Summary of findings

The risk of people's care being missed was increased without a clear plan of care which is regularly updated.

The concerns we identified are being followed up and we will report on any action when it is complete.

At our last inspection in January 2015 we had found the home in breach of regulations relating to cleanliness and infection control. This was because people were not protected from the risk of infection because appropriate guidance was not being followed. People were not being cared for in a clean, hygienic environment. We told the provider to take action. At this inspection we found that overall management of infection control had progressed and, overall, regulations were now being met.

At our last inspection we found an example where privacy when using the toilet [for people living with dementia] had been infringed. On one unit we found a lack of effective locks on toilet/bathroom doors for people to use. This was seen to compromise people's privacy and dignity. We told the provider to take action.

The provider sent us their action plan which told us locks had been provided on toilets and this would continue to be monitored with regular maintenance checks. On our inspection we checked a sample of locks on bathroom and toilet doors and these were in place and working.

We spoke with people who lived at the home about privacy and dignity and no concerns were raised. Warm, friendly interactions between people who lived at the home and staff were seen throughout the inspection. We made observations of staff carrying out care that showed a relaxed and homely atmosphere.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

We found that people were not protected against the risks associated with medicines because the provider's arrangements to manage medicines were not consistently followed.

There were not enough staff on duty at all times to help ensure people were cared for in a consistently safe manner.

The home was clean and we found management of infection control had improved. This meant that the provider was now meeting legal requirements.

We have revised the rating for this key question from 'requires improvement' to 'inadequate'. We will review our rating for 'safe' at the next comprehensive inspection.

Is the service caring?

Requires improvement

The service was not always caring.

People living at the home were relaxed and settled. Relatives told us they were generally happy with the care and the support in the home.

We observed mostly positive interactions between people living at the home and staff. Generally, staff were observed to treat people with privacy and dignity.

We found previous breaches of people's privacy and dignity had been addressed.

This meant that the provider was now meeting legal requirements.

While improvements had been made we have not revised the rating for this key question. To improve the rating would require a longer term track record of consistent good practice. We will review our rating for 'caring' at the next comprehensive inspection.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care planning was not always updated in good time when people's care changed.

St Nicholas 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 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 two days on 15 & 16 July 2015. The inspection team consisted of three adult social care inspectors, a pharmacy inspector and a specialist advisor for infection control.

We were not able to review a Provider Information Return (PIR) before the inspection because we had not requested this prior to 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 reviewed other information we held about the home. This included the home's 'action plan' sent after the last inspection, telling us how the home were making improvements and meeting regulations.

During the inspection we visited five of the six of the units [houses] that make up St Nicholas Nursing Home. These included two units supporting people living with dementia. Some of the people living in these units had difficultly expressing themselves verbally so 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 17 of the people who lived at the home. We spoke with seven visiting family members. As part of the inspection we also spoke with two health care professionals who were able to give some feedback about the service.

We spoke with 25 staff members including care/support staff and the registered manager. We also spoke with other senior managers in the organisation.

We looked at the care records for 11 of the people living at the home, medication records for 17 people and other records relevant to the quality monitoring of the service. We undertook general observations and looked round the home, including some people's bedrooms, bathrooms and living areas.

Inadequate

Is the service safe?

Our findings

Staffing

In the four weeks prior to our inspection we received three separate concerns regarding the staffing levels in the home. Two of the concerns related to the provision of consistent nursing staff on the units and was causing concern with some aspects of care. For example, completion of medication rounds was difficult and meant that people were not being given medication at the right time.

We visited five of the six units in the home and checked on staffing levels. We went to Alexandra unit**.** There was one nurse on duty. We were told there would more often than not be another nurse on duty but there was not on this occasion. The nurse told us they were 'okay' because most days they were on with another nurse for at least part of the day. This was confirmed by the rota.

We were told by staff that not all other units were as consistent and there were shortages of staff on occasions. However, staff felt supported by the unit manager on Alexandra unit.

We saw the nurse on duty still had half of the medication round to complete at 10.00am. Medication rounds were particularly difficult to time right when the unit was reduced to three care staff which had happened occasionally. On these occasions the nurse also needed to support care staff delivering personal care and this meant difficulties with monitoring people who had nursing care needs.

Staff told us that generally the staffing was okay on Alexandra unit. Three staff on the unit said they had concerns about night staffing as they felt that one nurse and two carers was not always sufficient. Their concerns were compounded by the fact that there was a high use of agency nurses on night duty who might not know the care needs of the people living there. One member of staff reported a night shift recently when there was only an agency nurse and one carer on shift. A day carer stayed until midnight and then a carer was sent over periodically from another unit throughout the night to support turning people. A member of staff was then brought in to start their shift at 6.00am. Most staff said the staff on the unit were dedicated and worked well as a team. One staff said, "The team work is great. Three staff and a nurse in the afternoon feels okay. We can cope but with two at night we can't always cope."

We viewed the staff rota from 3 to 9 July 2015 [one week]. There were 24 people with nursing care needs living on Alexandra unit. There were two occasions when one nurse was on rota. On these days the overall numbers were reduced from six to five staff. In addition to the nursing and care staff numbers, each of the nursing units had a 'hostess' employed who supplemented staffing numbers and was responsible for ensuring people's dietary needs were catered for. Agency staff were being used to cover nursing shortages and we saw this was recorded on the duty rotas. The night staffing rota was seen and listed all agency nurses on duty and staff told us this had been the case for approximately the last two months.

We found a similar picture on the other two nursing units we visited. Canada unit was the only nursing unit currently admitting people following a previous agreement with the Care Quality Commission following previous issues of concern. On the day we visited the unit there were two nurses [one of these was a senior manager who was covering the unit as a nurse on the duty rota was sick] and four care staff. There was also a hostess. We saw that people's personal care needs were not being rushed and the pace of care was relaxed and care was being delivered.

We saw, however, that only one nurse was completing the medication round. This had started late as the unit had not been initially covered by a second nurse. In effect this meant that the medication was not completed until close to 12.00 midday. We found that people had not been given some of the medicines at appropriate times.

When we spoke with people living at the home and their relatives we got positive feedback. We were told that there was enough staff to deliver care. One person said, ''We are looked after well. Staff are very good and are there when needed.'' Another person commented There is enough staff. They give good care.'' Relatives and visitors we spoke with said there seemed to be enough staff about and nobody we spoke with had any complaints about staffing. Other indicators of sufficient staff included positive observations of care being delivered on all of the units. Observation charts such as fluid charts and personal care charts were up to date.

Inadequate

Is the service safe?

Despite improvements we were told there were still inconsistencies in staffing however, and there were times when staff struggled to deliver a safe standard of individualised care. For example, on Canada unit we were told about two recent days [5 & 7 July] when the unit had only one nurse and three care staff all day; this to meet the nursing and personal care needs [such as supporting people to wash, dress and assist with toileting], for 23 people at the time. This was confirmed by the 'staff on duty rota' seen and was below the provider's stated numbers to deliver care. The 'staff on duty rota' for the week preceding our inspection [w/c 3 July 2015] showed that each of the nursing units had at some stage in the week, experienced staffing numbers below those stated by the provider as required for delivery of a consistent standard of care.

We were concerned that only one nurse was on duty on the unit. This was emphasised by a nurse who told us of one evening shift [on Canada unit] when there had been some people receiving end of life care, and medicines that needed a second nurse to check. This meant a nurse coming over from another unit to check but this was delayed due to the nurse having duties to attend to on their own unit. This meant a delay in giving some medicines. There had also been an admission to the unit and the nurse had not been available to admit the person and check admission details and medication at the time of their arrival. The nurse then stopped the medication round to review the new admission and it was found there had been a failure of the hospital to send the person's medicines and this then had to be followed up. In addition, the person admitted had a fall and had to be further assessed by the nurse. This was an additional unforeseen event which increased the risk of the single nurse not being able to manage all of the nursing needs of people on the unit at the time. The description of events indicated a lack of nursing support to manage the unit at a time of both planned and some unforeseen events.

On Huskinson unit [unit for people living with dementia] we were told that on the day before our inspection [on 14 July] that there had only been three care staff and one nurse on duty. Although a 'bank staff' had been on the duty rota, this staff member had not been present as they were on training confirmed by the duty rota. Again, on the 3 July Huskinson unit had been staffed with only three care staff and one nurse. Staff reported that this made the delivery of care 'rushed' and it meant that there was limited quality time for people who had highly dependent care needs and were living with dementia. These people were particularly vulnerable.

We spoke with the registered manager regarding these concerns. We were told that there was an on-going issue with the provision of nursing staff to the home and there was a high usage of agency staff to cover. For example, the week ending 9 July 2015 [previous 7 days] the home had used 237 agency hours to cover shifts. The manager told us that currently a total of 176 per week were needed to cover nursing vacancies; 156 of these were to cover nights.

The manager felt this was improving and there was a sustained plan to recruit nursing staff. For example, nurses had recently been recruited and were currently being inducted. This meant that in four weeks' time it was projected that 96 of the 156 hours would be covered by new nursing staff. The manager pointed out that they had inherited a situation in May 2015 when 308 hours had been needed and this had been reduced to the current 176 hours. In addition, the rate of staff sickness had improved from over 8% in September 2014 to a current level of 4%. The manager felt this evidence demonstrated sustained improvement. In addition, all of the units now had unit managers in place; an improvement from the last inspection in January 2015 when only three units had recognised managers.

Although improving, the overall evidence at the time of our inspection was that there was insufficient numbers of suitably qualified and experienced staff to meet the needs of the people using the service and other regulatory requirements at all times; especially medication safety.

This is a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014.

Medicines

We visited the home in May 2014 and we found concerns about safe handling of medicines. We visited the home again in September 2014 and found that people were still not protected against the risks associated with the unsafe use and management of medicines. We issued a warning notice to ensure that improvements were made quickly to ensure people were safe. The provider's action plan told us that systems had been reviewed and improved.

Inadequate

Is the service safe?

We visited the home in January 2015 to check if improvements had been made in medicines handling to ensure people were protected. We found that some improvements had been made. However, from our findings and the number of reported medicines errors, we found insufficient progress had been made to protect people and we found that medicines were still not handled safely because the provider's arrangements to manage medicines were not consistently followed.

On 15 July 2015 we visited the home to check if improvements we had seen during our last inspection had been made maintained and further improvements in safe medicines handling had been made to ensure people were protected against the risks associated with the unsafe use and management of medicines.

We were accompanied by a pharmacist inspector on this visit who looked at a sample of medication records and medicines on two different units in the home as well as other records and documents relating to the management of medicines. We looked at how safely medicines were handled for 17 people on Canada unit and found concerns about the safe handling of medicines for all those people. On Huskinson unit we found fewer concerns about the safe handling of medicines for people.

The medicines storage areas were clean and tidy and medicines were kept securely in locked trolleys and cabinets. However, on one unit we found unwanted medicines were not stored securely which meant that they could be misused. We also saw that on one unit the medicines trolley was left unattended with the doors open when the nurse was supporting a person who was a little confused. This meant that people had access to the trolley and medicines could be misused. We also found that some medicines were incorrectly stored in the fridge which could have affected how they work. The records of fridge temperature were not always completed so it was not possible to tell if medicines had been stored at the correct temperatures.

Medication was not obtained safely. We found that three people missed doses of some of their prescribed medicines for between one and five days because there was no stock available in the home. Missing doses of medicines places people's health at risk of harm.

People were not given their medicines safely. As at previous inspections we saw that the morning medicines round took a long time to compete. On the day of our inspection the morning medication round was not completed until nearly midday. Some medicines must be given with specific time intervals between doses to ensure people's health is protected. As at previous inspections, nurses did not record the time medicines were given so it was possible that doses could be given too close together. If people are not given their pain relief at regular intervals they may suffer unnecessary pain.

We saw that arrangements had not been made to give medicines safely with regard to food. We saw that some people were prescribed medicines, such as antibiotics that must be given before food were given with food. If medicines are not given at the correct times they may not work effectively which may place people's health at risk.

As at the previous inspections we looked at records for people who were prescribed medicines to be taken 'PRN' [when required] including medicines prescribed for when people became very poorly. The improvement plan which the home produced to ensure improvements in medicines handling were made stated, 'all medication that is prescribed as PRN will have an up to date PRN protocol in place'. We found that some information was still unavailable to guide staff about how to administer medicines prescribed in this way. The improvement plan also stated that when medication 'is prescribed as a variable dose it will have a specific care plan in place'. However, when people were prescribed medicines which had a choice of dose we found there was still no information recorded to guide staff when selecting the appropriate dose of medication for each person. It is important that this information is recorded to ensure people were given their medicines safely and consistently.

We saw that there was guidance for staff to follow when applying creams. However, in some cases we found this guidance did not always match the prescribers' directions.

We saw that one person was prescribed a thickening agent used to thicken their fluids to minimise the risk of choking. We saw that the thickness had increased but the staff member who made this person's drinks was unaware of the change and told us that she made the drinks to the old thickness. This placed their health at risk of choking. We found that there was no evidence that people who were prescribed thickener for their drinks had been given it because there were no records made.

Inadequate

Is the service safe?

During the inspection we saw that another person had not been given their nightly antibiotic on three nights. This placed their health at risk of harm.

We found that records about medicines were not always accurate. On one unit we saw that nurses signed for creams which they had not applied. On the other unit care staff signed the records from memory sometime after they had applied the creams. We saw that records about controlled drugs [medicines of potential abuse controlled by statute] were not always made at the time those medicines were given to people. It is important that records of administration are made at the time medicines are given in order to ensure they are accurate and reflect exactly what medicines have been given to people as it is not safe to rely on nurses' memory.

We found that staff did not always record the exact quantity of medication that arrived in the home for people. This made it impossible to keep track of their medicines and the records could not show that the medication had been given safely. We saw there were gaps, missing signatures, and some unexplained symbols such as crosses and lines on the records. This meant it was not possible to tell if medicines had been given to people as prescribed.

We saw that a number of medication errors had been reported which included a failure to administer three doses of very strong pain relief over a 24 hour period due to poor record keeping it was reported that the person had been agitated and in pain which meant the incident had resulted in serious injury

This remains a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014.

Infection control

At our last two inspections of the home we have found the home in breach of regulations relating to cleanliness and infection control. Following our inspection in September 2014 we issued a warning notice and told the provider to take action. When we inspected again in January 2015 we found there had been improvements but there were still areas that needed further action. This was because people were not protected from the risk of infection because appropriate guidance was not being followed. People were still not being cared for in a clean, hygienic environment. We told the provider to take action.

At this inspection we found that overall management of infection control had progressed and there were systems now in place to ensure consistent standards of infection control.

Prior to our inspection we received information from Liverpool Community Health [LCH] who had visited the home in June and July 2015 to complete infection control audits on two of the units. We saw copies of these audits and the units were compliant. Previous areas for improvement, such as attention to hand washing, management of infectious outbreaks and cleaning had been actioned. We spoke with LCH prior to the inspection. They told us there had been one infectious outbreak in the home in February 2015 and this had been well managed.

The home's manager had sent us an action plan which was regularly updated. This told us that a supernumerary housekeeping supervisor had been employed to oversee and support domestic cleaning arrangements. The home had also identified key staff as infection control 'champions' and a lead nurse for the home.

When we inspected we found areas had been improved. For example, on general inspection of units we found levels of cleanliness to be improved. Toilets and bathrooms had hand wash facilities including liquid soap and paper towels for use. People who lived at the home and visitors we spoke with told us the home was generally maintained in a clean state with no pervading odours.

Infection control was now high on the agenda and each unit had their own infection control champions which met regularly and undertook audits. Hand hygiene audits were completed by the champions. All the staff we spoke with were aware of who the champion was for their unit.

All the rooms were at a high standard of cleanliness and the mattresses beds and bumpers were clean and regularly audited as part of the cleanliness audit. The night staff completed a cleaning and check list rota to ensure the standard was maintained. Slings for the hoists were clean and in plentiful supply with the appropriate size for people. They were laundered weekly and more frequently when soiled.

Improvement was noticed in the dining areas where food debris had previously been under the tables and chair arms. They are now part of the night staff check list and the furniture was clean.

Inadequate

Is the service safe?

The units visited had sufficient wipes for people who had not washed their hands prior to eating and after meals. Protective aprons for people were clean and laundered after use. Staff used the colour coded aprons for the purpose intended. Personal protective equipment was used and disposed of appropriately and hand decontamination fluid was appropriately used. The sluice areas were clean and tidy and free from dust, although there was one commode pan that had been put through the washer but not checked before being stored. All the commodes were clean and odour free.

People and their relatives we spoke with said the home was clean and tidy and said they had seen a big improvement to standards of hygiene.

All of these improvements helped ensure people were protected for the risk of infection.

There were still some areas we noted that could be more consistent and we relayed these to the manager. For example, staff checking of bedpans before storing away to ensure they are thoroughly clean and more frequent checking of some of the toilet facilities. We also recommended that some records such as the night cleaning audit are consistently completed and some policies and guidance should be reviewed and updated. On Canada unit we found people sharing the same hoist sling. We discussed the importance of using individual slings for people to reduce the risk of cross infection.

Overall we found there had been enough progress to meet regulations where infection control was concerned.

Requires improvement

Is the service caring?

Our findings

At our last inspection in January 2015 we found an example where privacy when using the toilet [for people living with dementia] had been infringed. On one unit we found a lack of effective locks on toilet/bathroom doors for people to use. One toilet had no lock on at all. This was seen to compromise people's privacy and dignity. We told the provider to take action.

The provider sent us their action plan which told us locks had been provided on toilets and this would continue to be monitored with regular maintenance checks. On our inspection we checked a sample of locks on bathroom and toilet doors and these were in place and working. Staff on duty and people we spoke with said they were all working.

We spoke with people who lived at the home about privacy and dignity and no concerns were raised. People's comments included, "They're a nice bunch", "The [staff] are lovely", "It's okay here." One person told us the care was 'okay' but not all staff were as attentive as others. Relatives we spoke with told us that staff always spoke with people in a respectful and dignified manner. Staff were also respectful of people's privacy when relatives were visiting.

Warm and friendly interactions between people who lived at the home and staff were seen throughout the inspection. We asked staff for examples of how they protected people's privacy and dignity. All staff spoken with gave appropriate answers and provided examples of closing doors, using towels to protect people's dignity when carrying out personal care and talking to people and asking their permission when carrying out care.

We made observations of staff carrying out care. We saw staff assisting a person to move using a hoist. Staff were careful to explain what they were doing and took time to reassure the person concerned. During the interactions when staff carried out care they appeared to listen carefully and made efforts to communicate with people effectively. An example we observed was one staff member supporting a person to have a cup of tea. The staff member spoke very reassuringly to the person, and waited patiently for the person to respond to prompts. We observed another staff member offer choices of snacks to another person, and engage positively with the person, encouraging them to eat. On one unit we observed the staff interacting with the people living there. For example, the people were looking at magazines with the staff and they were all chatting about the contents of the magazines. The atmosphere felt very relaxed and homely.

On one unit we looked at advocacy and how this might be used for people. There was no advocacy examples to see on the day, however, we did see the appropriate paperwork in place in situations where family members had lasting power of attorney for relatives.

Relatives told us that they could visit at any time. Visiting at meal-times was discouraged, on the grounds that it could be disruptive and staff where trying to keep meal times 'protected'. Relatives said they didn't mind this rule and didn't feel that they were actually being prevented from coming in at this time.

We observed some inconsistencies in staff interactions and recordings. For example the language used in some care records was negative. One person's care notes had an entry, 'Has been demanding of staff's attention' and '[person] is very demanding'. We carried out some observations on a unit for people living with dementia [Huskinson unit]. We observed staff were positive, kind and carrying out care at an appropriate pace. We did observe one poor interaction and this was fed back to the registered manager in terms of further staff development.

People told us they were listened to and staff acted on their views and opinions. One person said, ''They do listen when you talk to them but there's not always a lot of time to just talk and socialise.'' We saw different levels of staff interaction in different units. If there was a high ratio of very dependent people in terms of personal care [for example the dementia nursing unit] this time was reduced. The home employed 'hobby therapists' who were responsible for initiating some activities within the units and we saw some interactions at various times which were positive and helped people to have a greater sense of wellbeing.

The staff we spoke with had a good knowledge of people's needs. The manager and senior staff told us of the value of building consistent relationships and having continuity to the care provided.

Requires improvement

Is the service responsive?

Our findings

At our last inspection in January 2015 we found the care planning for some people had not been updated to reflect their changing care needs. The risk of not updating major changes to people's care plans is that staff may be unaware of their changed care needs and there is an increased risk that specific areas of care might not be effectively monitored and reviewed. We told the provider to take action.

We received an action plan from the provider that told us how improvements would be made. Part of this included a full review of the care plan documentation and a move towards a new system of assessment and care planning to focus the care in a more personalised way.

We reviewed people's care records on three of the units we visited. We looked at 11 records in total. Most of the care records we reviewed had changed over to the new care planning system and so had had a recent review and the care plan had been updated and therefore reflected people's current care needs. We found these care plans were more focused in terms of identifying and personalising people's care needs. We saw, on one unit, the nurse speaking with a person who had just been admitted and involving them in identifying their care needs. In another example we spoke with a person who told us the nurse had interviewed them at the time of their admission to the home and had, ''Gone through all my details and asked me about my care.'' The person had been asked to consent to various aspects of care. They told us that their care was being continually reviewed and staff were liaising with appropriate health care professionals to support their on-going care needs. When we looked at the person's care record we saw this was the case and the care was being well monitored.

On the dementia care unit [nursing] people's support plans were signed by their relatives where appropriate and where possible the people themselves had signed their own care plans. The people we spoke to confirmed they had been involved in contributing to their care plans. All of the care files we looked at had evidence of person centred ways of working, such as a 'my day, my life portrait' which contained relevant information about the person, including their likes and dislikes and any medical conditions. All care files we looked at clearly documented what the person liked to be called and any religious beliefs or hobbies they had.

We saw an example of a hydration plan for a person who needed it and this was being used by all staff. We looked at a file for a person who had no verbal communication and could see how staff communicated with them. When we asked the staff about this person they confirmed how they spoke to them and this reflected what was written in the plan. All daily notes were filled in with no gaps and we saw how people were risk assessed for falls, and what plans were in place to manage this. One person had a weight chart in place, which clearly showed a loss in weight during an identified time period. This weight loss was due to the person being in hospital at that time and the records clearly reflected this.

Relatives told us staff will always inform them of any changes or events such as a person having a fall. We saw a sheet in the care records which evidenced when staff communicated with relatives over specific issues.

We found that the new care plans and records were individualised to people's preferences and reflected their identified needs. We found, however, some examples were staff had not still updated care plans and records effectively as care needs had changed.

For example the care plans for two people contained a range of care planning information. However, the care plans had been written when both people were far more able and independent. The care plans included a monthly evaluation (although there was a gap from March to July 2015 for one person) and these contained more up to date brief information to reflect the change in the person's needs. This showed that the original information in people's care plans was out of date. Staff were therefore not reviewing/evaluating the correct information. For example, the care plans read that one person could 'weight bear' [in terms of their mobility] and use a stand aid hoist and use the toilet when this was no longer the case and they now needed to be hoisted for all transfers and were incontinent.

In another example the person's care plan said they were independent with eating and no concerns regarding their nutritional intake when they now required full assistance with their meals and drinks and supplements. In addition,

Requires improvement

Is the service responsive?

one of the evaluations of the care plan we saw was incorrect as it said 'no changes' to the original care plan when the person's needs had changed significantly. The care records were confusing as it referred to a high score for pressure ulcer risk and said the person had a pressure ulcer following admission form hospital. The wound assessments and care plan dated 17/09/2014 read, 'No pressure sores' and 'skin is currently intact'. The evaluation of the care plan, however, referred to a grade four pressure wound and detailed a pressure mattress and regular pressure area care required.

As far as we could tell the people involved were getting the required care. The risk of people's care being missed, however, was increased without a clear plan of care that is regularly updated.

Following the inspection we received the outcome report of a recent safeguarding investigation in to the care of a person who had lived at the home. The report provided evidence that the care plan had not been updated as the person's condition changed. This was in the event of the person losing weight and also, on another occasion, after sustaining an injury.

We spoke with the registered manager regarding these inconsistencies. We were told that with the change over to the new documentation some of the 'old' style care plans may have been neglected in terms of update and review. We were told that all people receiving care will have an updated care plan within the next two weeks.

This is a breach of Regulation 9(1)(b)i & ii of the HSCA 2008 (Regulated Activities) Regulations

2010.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

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 were not enough staff on duty at all times to help ensure people were cared for in a consistently safe manner.** **Regulation 18(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **We found that people were not protected against the risks associated with medicines because the provider's arrangements to manage medicines were not consistently followed.** **Regulation 12 (1)(2)(g)(I)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Care planning was not always updated in good time when people's care changed.** **Regulation 9 (1) (b) i & ii**

The enforcement action we took:
We imposed a condition on the registered provider which said: "The Registered Provider must not admit any service users to St Nicholas Nursing Home without the prior written agreement of the Commission.''