Randomlight Limited

St Nicholas Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Nicholas Care Home is a residential care home providing personal and nursing care to 93 people at the time of the inspection. The service can support up to 176 people within 6 buildings. At the time of the inspection however, 2 of the buildings were not in use. Of the 4 buildings operating, 1 provides specialist nursing care to people who have a learning disability and autistic people. This unit is known as Brocklebank House. Brocklebank House can accommodate 28 people. At the time of the inspection, 19 people were residing on this unit. The other units provided nursing and residential care to older people. Several people lived with dementia.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
The physical layout of the building was not homely or domestic in style. It was clear from the roadside people were living within a care setting.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People experienced locked and inaccessible areas within their own home. The reasons for any restrictions were not based on people's individual risk. Systems to oversee the application of authorisations to deprive people of their liberty were not sufficiently robust.

People were not supported to develop their independence skills, and everything was done for them. People were not involved in or encouraged to participate in the day-to-day home related tasks such as cleaning or cooking.

Right Care:
Care was not person centred and people were not always being consulted before being provided with care. People's communications needs were not always recorded and there was a lack of awareness of how to apply national best practice supporting people with a learning disability and autistic people. Some inappropriate language was used when referring to people who used the service.

People were not always supported to make informed decisions about their care. Some care plans were brief and did not include information how to best support people. Effective systems were not in place to ensure there was learning from events which occurred at the service.

Staffing levels were insufficient in Brocklebank House to enable all people to access the community to pursue their leisure interests and form meaningful relationships within their local community. The activities available were of poor quality and care staff did not recognise planning social and leisure activities as part of their role.

Right Culture:
The culture in Brocklebank House needed to be improved to meet the needs of people with a learning disability and autistic people. People were not given the opportunity to lead a fulfilled and valued life and experience high quality care.

Not all staff who worked on the unit had the appropriate skills and knowledge to support people effectively. When staff members did hold these skills, they weren't always deployed in the most effective way.

Most, but not all, of the improvements we identified were in relation to meeting the needs of people living in Brocklehurst House. Frequent changes in management had impacted on the quality of the care delivered across the service in general. The provider had failed to put in sufficient measures to mitigate this risk. There was a lack of evidence of a commitment to continuous improvement. Actions from previous inspections had not been sufficiently addressed.

Although we identified significant improvements were needed, people across all units told us they were happy living at St Nicholas care Home. People received their medicines as prescribed and were supported to attend medical appointments when needed. Regular checks were made on the building and equipment to ensure they were safe to use.

We observed people receiving visits from family and friends and people's bedrooms were welcoming and could be personalised to their taste. Staff members told us they felt supported in their role and all people we spoke with had confidence in the new manager who had recently been appointed.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 23 March 2023). The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about management of the safety of people following an incident. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We have identified breaches in relation to staff skills and knowledge, person centred care, treating people with dignity and respect, ensuring the service operates in line with the Mental Capacity Act 2005, a lack of effective governance systems and provider oversight of the quality of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

St Nicholas Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 3 inspectors, a specialist professional advisor, who was a nurse and an 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.

Service and service type
St Nicholas Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. St Nicholas Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. The manager was new and had only been in post for a couple of weeks.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 13 people who used the service and 13 relatives about their experience of the care provided. 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 spoke with 21 members of staff including the manager, deputy manager, nurses, care staff, domestic staff, kitchen staff, activity staff, administrative staff and a member of the maintenance team.

We reviewed a range of records. This included 19 people's care records and multiple medication records. We looked at 6 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

Following our visits, we spoke with 2 professionals who visit the service on a regular basis.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure accidents and incidents were appropriately monitored and analysed. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Incident analysis following accidents and incidents was not robust. We could not be certain trends where being identified and appropriate actions taken to prevent further accidents and incidents re-occurring.
● Actions taken following specific events, such as referrals to other agencies following an incident of choking or following a fall, were not always recorded. We were not always assured referrals had been made in a timely manner.

Systems had not been established since our last inspection to ensure accidents and incidents which occurred at the service were sufficiently analysed. This placed people at risk of harm as there was limited evidence of learning lessons from such events. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded immediately during the inspection. They confirmed they were working through all recorded accidents and incidents which had occurred since our last inspection to review the information and identify any lessons learnt.

● People were protected from the risk of abuse and staff completed training in this area. A staff member told us they, "Wouldn't hesitate" to report any concerns.
● People told us they felt safe living at the service. A person commented, "This is my home. I am happy here. I am looked after by the staff well."

Staffing and recruitment
● Staffing levels were appropriate to meet people's personal care and nursing needs. We observed staff to be always present in communal areas and we observed prompt responses to people when asked. However, we received mixed feedback from people about the responsiveness of staff if they called for assistance from their bedrooms. A person told us, "I can wait for what seems like hours to get to the toilet. It's not their fault.

There's just not enough staff."
● Staffing levels were appropriate to meet people's task based and nursing needs, however, were not always sufficient to meet the emotional and leisure needs of people. For example, people who lived in Brocklebank House were not all able to leave the service on a regular basis and access their local community because there were not enough staff to facilitate this.
● There was a lack of appropriately qualified staff deployed in Brocklebank House. Nurses who held a specialist qualification in working with people with a learning disability and autistic people worked night shifts. They were not involved in the development and review of care plans so were unable to impart their knowledge.
● Agency care staff were utilised at the home. We found little evidence of inductions completed with agency staff to ensure they had awareness of health and safety information relating to the home and understanding of the care to be provided to people.
● Agency staff did not know the person they were supporting, nor understood the support they were about to provide. 1 agency staff member told us, "I don't actually know" when asked the name of the person they were supporting.
● People told us agency staff do not know their care needs. A person told us, "[Agency] staff come in and don't know how to handle me. This creates more work for the regular staff, and they end up doing it all."

Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed to meet the needs of people who used the service. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded during the inspection and confirmed the nursing staff members who held an appropriate qualification and had experience of supporting people with a learning disability and autistic people would be redeployed to work on day shifts in Brocklebank House.

● Staff we spoke with told us agency reliance had reduced due to ongoing recruitment and regular staff working additional hours. Staff who worked on some of the units also told us the staffing levels had recently been increased by the manager.
● Staff were safely recruited. Appropriate checks had been made before being offered employment.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure risks were effectively assessed or mitigated. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12. However, ongoing work was needed to improve governance systems to sustain these improvements.

● Risk assessments and care plans were in place to mitigate risk. However, further work was needed in some areas to improve detail and ensure clear and accurate records of the care provided to people were kept.
● Some care plans needed updating to reflect when a person's needs had changed; or a new risk to a person became evident. This was immediately rectified once raised with the management team.
● Routine checks on the environment and equipment were up to date and certificates were in place to demonstrate this.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12. However, ongoing work was needed to improve governance systems to sustain these improvements.

● Medicines were safely managed.
● Protocols were available for people who required medicines on an 'as required' basis. Further work was needed to ensure they were consistently stored on the medicines systems and care plans fully reflected this guidance.
● Records of medicines administration were maintained and in line with best practice.
● Medicines were stored securely and only administered by staff who were suitably trained.
● We observed medicines administration. Staff were knowledgeable and confident in their approach.

Preventing and controlling infection
● Systems were in place to prevent and control the risks of infection, however, some aspects of the living environment required further improvement.
● In some parts of the service, pieces of furniture and soft furnishings needed deep cleaning or replacing. We raised any significant issues with staff during our visits and prompt action was taken.
● Staff were knowledgeable about safe systems of work to follow in the event of an infectious outbreak at the service.
● The manager had received some support and guidance from the local health protection team. Their feedback demonstrated standards were steadily improving.
● The provider was enabling visiting in line with government guidelines. We observed lots of visitors throughout the inspection.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The provider was not always working within the principles of the MCA.
- The DoLS authorisation for 1 person had expired and had not been reapplied for within the required timeframe.
- For other people, records were missing, or information did not reflect peoples current care needs. For example, a number of people had restrictions in their care plans such as having personal items locked away, bed sensors and bed rails. DoLS information did not always include this information.

Systems were insufficient to ensure care was delivered in line with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager responded during the inspection. They confirmed they were working through the DoLS information for each person and updating practices accordingly.

Adapting service, design, decoration to meet people's needs
- The service was not always adapted, designed or decorated to meet people's needs.
- People were restricted from accessing all areas of their home. For example, some communal areas were often kept locked and being used to store fresh laundry and equipment. The kitchen area in Brocklebank House was locked and stored staff personal belongings.

● In another unit, bedrooms were locked when people were not in their room to prevent other people entering these rooms. However, risk assessments had not been completed to address this on an individual basis. People did not hold their own bedroom keys which meant they were not always accessible as people had to ask staff to open their bedrooms.

Restrictions were imposed on the environment which were not always necessary and restricted people's freedom of movement and access to areas within the home. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager took action during the inspection to ensure the kitchen area of Brocklebank House was unlocked, decluttered and made accessible to people. The manager spoke of their plans to better utilise the small lounge areas in other units. This included plans to develop a library.

● People had the equipment they needed to be supported effectively and, where they had chosen to, personalised their own bedrooms. A person told us, "I like my room."
● Appropriate signage was evident within the units to assist people to orientate around the service.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough however, the approach taken by staff was not always person centred.
● The experience of people varied across the service. We made observations when staff offered choice and sat with people to assist them to eat without them feeling rushed. However, we also observed staff did not always communicate with people, talked between themselves and swapped between people when assisting them with meals with no explanation. There was a lack of condiments or napkins offered to people on some units.
● People were not always assisted to eat where they chose. A person told us, "I prefer to go into the lounge for meals but sometimes they haven't got the staff to assist me to get there, so I'll eat in my room."

The mealtime experience of people was not person centred and staff took a task-based approach to delivering care during mealtimes. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded immediately during the inspection. They were implementing new audits to monitor and improve the mealtime experience.

Staff support: induction, training, skills and experience
● Training was not always applied in practice to ensure people's needs were being met.
● Staff completed online and face to face training to develop their skills and knowledge when supporting people with a learning disability and autistic people. However, there was little evidence this training had been put into practice. For example, staff received training in positive behaviour support approaches when supporting people in distress. This is a best practice approach, but the learning had not been utilised to develop effective care plans.
● Conversations with a number of staff and the nursing team demonstrated a lack of knowledge about best practice approaches when working with people with a learning disability and autistic people.

Training delivered to staff in how to interact appropriately with people with a learning disability and autistic people was not applied sufficiently as it did not inform staff practice in this area of support. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team responded immediately during the inspection. They sought additional support from the community learning disability team to improve practice.

● Permanent staff confirmed they received an induction when they started employment. A staff member told us, "I have been given an induction pack and printout about the clients to get to know them."
● There were some gaps in training records and a number of staff needed to complete refresher mandatory training. The manager had oversight of this and was addressing any shortfalls.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with other agencies to ensure people received consistent, effective and timely care. However, we received feedback from 2 professionals who told us their expertise had not always been taken on board when they provided advice on how to effectively support people who resided in Brocklebank House.
● People's physical care needs had been assessed before they moved to the service.
● Records confirmed people were supported to access their GP and other physical health services when required.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- People were not always supported in a way which promoted dignity and encouraged people's independence. People were not always treated in a positive way to ensure their equality and diverse needs were being respected.
- We observed a lack of positive interactions between staff and some people who used the service. People spend long periods with no acknowledgement or interaction from staff. We observed a person being supported from an area of their home in their specialist armchair. Staff gave no explanation to the person about where they were going or for what purpose.
- Some of the language used by staff to describe people was not dignified. For example, people who needed assistance to eat and drink were referred to as 'semies' and 'those we need to feed'.
- Language used in care plans also needed to be reviewed as people were not always respected as individuals. For example, a person's day was referred to as 'a shift'. People were described as 'suffering' from their learning disability or medical condition. A person's care plan referred to behaviours they displayed including 'stealing' food and 'being caught' entering the kitchen area. Another person's finances were referred to as 'pocket money'.
- Care plans were not focused on developing people's independence. There was no focus for people who lived in Brocklebank House on moving into more independent living being an aim unless they were able to communication this themselves as a personal goal.

People who used the service were not always treated with dignity or respect. Language used to describe people verbally or in care records was not always respectful. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Although we made these observations, we received positive feedback about the care people received. A relative said, "[Name] is happy here, likes the staff." We also observed some caring practices across the service throughout each day of our inspection.

Supporting people to express their views and be involved in making decisions about their care

- Records demonstrated when people had been involved in decisions about their care or, where appropriate, family members were involved and consulted.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Systems to ensure peoples individual needs were met were inadequate. The provider had repeatedly failed to achieve a rating of 'good' for this key question. When this key question was last reviewed in October 2021 it was noted improvements had been made to promote a person-centred culture in Brocklebank House. However, at this inspection we found previous practices had been reintroduced.
- Uniforms had recently been reintroduced for staff to wear on shift. We also observed a staff member walking around Brocklebank House with a set of keys attached to their waistband, which gave an institutional feel to the environment. Some staff spoke of their displeasure at wearing uniforms. A staff member commented, "I hate them, we are in their home."
- Care was not planned or delivered in a personalised way. The personal history of people was not always known. This meant people's needs and preferences had not always been identified or recorded.
- A person told us how their preference for female only care staff was not always met. They told us, "I don't like men dealing with my very personal care and have told them about this but they [male care staff] still come into me and that really upsets me. It's not dignified, is it?"
- There was a small team of staff who provided day to day activities. However, in Brocklebank House, the activities were inadequate and not personalised around peoples interests and hobbies.
- People were exposed to the risk of social isolation. Unless people received funding for additional 1-1 care, they were offered little in the way of meaningful activity and had no opportunity to go out and access their local community. Some staff who worked in Brocklebank House told us they could not recall the last time they supported people to leave the service.
- The management team in Brocklebank House were unaware of funding for and therefore had not provided agreed 1-1 hours for a person. The failure to provide the additional support meant there should have been numerous occasions this person could have spent time away from the service.
- Although there was an activity plan in place, people told us there was little to do. Comments included, "Nothing, we go to bed" when asked about evening activities. Other people told us, "I have been on this unit for a couple of months. Not been out yet but would like to" and "We used to have a music group but 2 staff left and it hasn't happened since."

Systems had not been established to support people to follow interests and to take part in activities that are socially and culturally relevant to them. Information within care plans was not always personalised and failed to reflect people's personal histories. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded during the inspection and dedicated a member of the activity team to solely work with the people who lived in Brocklebank House. They were also working with the activity team with regards to activities available to people who lived in the other units.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Peoples communication needs were not always met.
- Care plans contained limited information about people's communication needs. For some people, the information was sufficient, however, for many people who lived in Brocklebank House this was inadequate.
- There was a lack of consideration of how to support people who didn't use the spoken word. For example, there was a lack of accessible menus available to assist people to make appropriate choices.
- There was no evidence people were supported to use alternative forms of language to communicate based on best practice guidance such as the Picture Exchange Communication System (PECS) or the use of Makaton or when supporting people with a learning disability and autistic people to make decisions.

Systems had not been established to support people to make decisions through effective communication. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
- A complaints policy was in place and information on how to make a complaint was available.
- People knew how to raise a complaint and felt confident they would be listened to.

End of life care and support
- Care plans demonstrated people's end of life wishes were documented.
- Where appropriate, Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) orders were identified clearly in care plans.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to ensure systems were robust enough to assess the quality of the service and to ensure robust records were maintained about people's care. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Since our last inspection, there had been multiple changes in the management at St Nicholas Care Home. This had led to significant shortfalls and ineffective leadership of the service. The current manager was new and had not yet applied to register with CQC.
● Some of the failures we identified at the last inspection had not been addressed. For example, no action had been taken to address a lack of learning from safety related events which occurred in the service. No actions had been taken to address the repeated shortfalls in previous inspection reports in meeting the principles of right support, right care, right culture.
● Governance systems were inadequate. There was a provider led governance system which consisted of audits and routine checks. However, some audits and other checks had not been completed for significant periods of time. For example, care plans audits were not up to date. This meant opportunities to identify shortfalls in the quality of the care and poor language used in care plans we identified at this inspection where not identified or addressed.
● The failure to operate effective systems to monitor and improve the quality and safety of the service had resulted in continued breaches of regulation as well as several new breaches being identified.
● The experiences of people who used the services varied from unit to unit. There was a lack of consistency in the care being delivered and a lack of overall oversight by the management team. For example, systems such as applying for DoLS were delegated to the unit managers with no additional checks put in place to ensure the correct process was being followed.
● Through the changes in management the provider had failed to evidence an effective improvement plan to mitigate the risks.

Systems had not been established to ensure governance systems were robust enough to monitor the quality of the service. This placed people at risk of harm. This was a continued breach of regulation 17 of the Health

and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

● There was not a consistent and positive person centred, open and inclusive culture promoted throughout St Nicholas Care Home.

● Some relatives told us they did not feel able to freely access areas within the units to make their loved one's drinks and snacks. Comments included, "The units seem to work differently, I could make drinks when [Name] was on that one but can't go in the kitchen now" and "I asked about being able to make my mum and me a cuppa when we come, to relax it a bit but I was told we couldn't."

● The willingness and effectiveness of working with other agencies also varied across the service. We were told by 2 professionals they frequently faced resistance when offering professional advice to the manager in 1 unit. Advice they provided was not shared with the care staff.

● Care was not always delivered in a way which delivered good outcomes for people. There was a lack of knowledge about best practice approaches when supporting people with a learning disability and autistic people.

Systems had not been established to ensure stakeholder advice and nationally recognised guidance had been considered or implemented to ensure the quality of the care and experience of people who used the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Throughout our inspection, the new management team was open and transparent when responding to all the issues we identified. We observed the new manager holding meetings to introduce themself and to listen to the feedback of relatives of people who lived at St Nicholas Care Home.

● The relatives we spoke with told us they felt confident improvements would be made. Comments included, "It's okay. Wouldn't say it is fantastic. I feel quite optimistic about the new manager. She has good ideas" and "We have had a few problems. Had a meeting with the manager and feel confident."

● We also spoke with several staff who were candid in their views about working at the service. The told us the unit managers were supportive however they spoke of recent difficulties due to the recent management changes. Staff comments included, "I love working here. It's a nice place. Staff are great", "[The manager] seems to know what she is doing, things are much better already" and "I enjoy it. I get to do my job and see the residents."

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 10 HSCA RA Regulations 2014 Dignity and respect People who used the service were not always treated with dignity or respect. Language used to describe people verbally or in care records was not always respectful. Systems had not been established to support people to make decisions through effective communication. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems were insufficient to ensure care was delivered in line with the Mental Capacity Act 2005. Regulation 11(1)

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 Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed to meet the needs of people who used the service. Training delivered to staff in how to interact appropriately with people with a learning disability and autistic people was not applied sufficiently as it did not inform staff practice in

this area of support.

Regulation 18(1) (2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations 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 9 HSCA RA Regulations 2014 Person-centred care Restrictions were imposed on the environment which were not always necessary and restricted people's freedom of movement and access to areas within the home. The mealtime experience of people was not always person centred and staff took a task based approach to delivering care during mealtimes. Systems had not been established to support people to follow interests and to take part in activities that are socially and culturally relevant to them. Information within care plans was not always personalised and failed to reflect people's personal histories. Regulation 9(1) (2) (3)(a)(b)(c)(d)(i)

The enforcement action we took:

Warning Notice

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 Systems had not been established since our last inspection to ensure accidents and incidents which occurred at the service were sufficiently analysed. This placed people at risk of harm as there was limited evidence of learning lessons from such events. Systems had not been established to ensure governance systems were robust enough to monitor the quality of the service.

Systems had not been established to ensure stakeholder advice and nationally recognised guidance had been considered or implemented to ensure the quality of the care and experience of people who used the service.

Regulation 17(1) (2)(a)(b)(c)(e)(f)

The enforcement action we took:

Warning Notice