Bupa Care Homes (CFHCare) Limited

St Nicholas Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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.

This was an unannounced inspection which took place over three days on 17, 18 and 19 February 2016. The inspection team consisted of two adult social care inspectors, two pharmacy inspectors, a nurse specialist advisor 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.

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.

We last inspected the home in July 2015 and found serious breaches of regulations. The home was rated as 'requires improvement' overall and was rated 'inadequate' when we asked the question 'is the service safe?' Following the inspection we issued a notice to stop any further admissions to the home. The statutory notice we issued remains in place at this inspection.

At our last inspection in July 2015 we had 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. At this inspection we found people were still not protected against the risks associated with medicines because the provider's arrangements to manage medicines were not consistently followed.

At the last inspection we found the home to be in breach of regulations regarding assessment and review of peoples care plans to help ensure responsive care delivery as people's needs changed. We looked in detail at the care received by 12 of the people living at St Nicholas Nursing Home. We found examples of good care and good practice and saw the service had developed better care planning systems and reviews. However we identified shortfalls in care for people who had specific clinical care needs such as wound care, pain relief and the management and care of people who were being fed and given medication via a tube into their stomach [PEG feeding]. We found that assessments and care planning for some of these people had not been updated and implemented to ensure care was safe and reflected peoples changing needs. The risk of not updating major changes to peoples care plans is that new staff might 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 exposing people to unnecessary risk.

We found that there was a lack of support for nursing staff to fully develop their skills and knowledge to effectively manage these aspects of clinical care.

We found the service had many well developed systems in place to monitor the quality of care in the home. However, there were areas of clinical care management that still needed to be improved and these had not been identified by existing audits and systems in the home.

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

At our last inspection in September 2014 we had found the home in breach of regulations relating to staffing. At that time, levels of nursing and care staff were not sufficient to ensure people received a consistent level of safe care. We told the provider to take action. At this inspection we found that overall staffing had been improved. We observed there was enough staff to carry out care in a timely manner. We saw staff were attentive to the needs of people and no one appeared to be in distress through lack of attention.

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. We made observations on all units including those specialising in people with dementia. We saw that people who could not express their thoughts and feelings vocally were settled and supported. Staff were observed to be attentive to people's care needs as they arose. Nobody we spoke with or observed expressed any issues regarding their safety.

There have been a number of safeguarding investigations at St Nicholas Nursing Home since our last inspection. The home had assisted the local authority safeguarding team and agreed protocols had been followed in terms of investigating. This helped ensure any lessons could be learnt.

We found people were assessed for any risks regarding their health care needs. Risk assessments had been carried out to assess people's risk of developing a pressure sore for example. We saw some assessments for the use of bedrails to help ensure people were safe. One person displayed some challenging behaviours that staff were closely monitoring and reviewing with health professionals.

We found that the home was clean and hygienic. We reported to the managers some observations for further improvements.

We found that the home was operating in accordance with the principles of the Mental Capacity Act 2005 (MCA). Although care practices were consistent and this indicated staff were generally following good practice we found some hesitancy around fully understanding the use of the 'two stage mental capacity assessment' and when this should be used.

We made a recommendation in the report regarding this.

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

People we spoke with and their relatives said that they (or their relatives) were being treated with respect, dignity and kindness. Dignity champions were appointed on the units to oversee these standards and

implement 'best practice'.

We saw references in care files to individual ways that people communicated and made their needs known. We also saw examples were people had been included in the care planning so they could play an active role in their care although this was not consistent and generally centred around specific assessments or 'best interest' decisions.

A complaints procedure was in place and most 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.

Special measures.

The rating for this service is 'inadequate'. This means that the service has been placed into 'special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there
is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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 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.

The assessment of care did not always ensure the welfare and safety of people. Changing care needs had not been assessed or reflected in the risk assessments made and subsequent care planning.

There was enough staff on duty at all times to help ensure people were cared for in a consistently safe manner. This had improved from our last inspection.

The home was generally clean and we found systems in place to manage how infection control was maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff said they were supported through induction, appraisal and the home's training programme. We found that there was a lack of support for nursing staff to fully develop their skills and knowledge to effectively manage some aspects of clinical care.

We saw staff understood and were following the principals of the Mental Capacity Act (2005) and could evidence good practice when people made decisions regarding their care. We made a recommendation regarding further developments.

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

People we spoke with and relatives told us the 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.

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

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

Is the service well-led?

Inadequate

The service was not well led.

There were areas of clinical care management that still needed to be improved and these had not been identified by existing audits and systems in the home.

There was a registered manager now in post to provide a lead in the home who was supported by other key personnel.

We found the manager and staff to be open and caring and they spoke about people as individuals. There were systems in place to get feedback from people so that the service could be developed with respect to their needs and wishes. These systems had been improved since our last inspection.

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 three days on 17 to 19 February 2016. The inspection team consisted of two adult social care inspectors, two pharmacy inspectors, a specialist nurse advisor 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.

During the visit we visited all of the units that make up St Nicholas Nursing Home. These included two units supporting people living with dementia. Some of the people living at in these houses 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 of the people who lived at the home. We spoke with 9 visiting family members. As part of the inspection we also spoke with a health care professional who was able to give some feedback about the service.

We spoke with 20 staff members including care/support staff and the registered manager. We also spoke with other senior managers in the organisation including the area manager, the quality assurance manager and the training manager.

We looked at the care records for 13 of the people living at the home, three 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.

Inadequate

Is the service safe?

Our findings

At our last inspection in July 2015 we found the home in breach of regulations relating to safe administration of medicines. This was because people were not 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 management of medicines were safe on three of the units we visited but there were continued failings on the two nursing units which put people's health and wellbeing at significant risk. We found that people were still not fully protected against the risks associated with medicines.

We looked at a sample of medication records and medicines on four of the five units in the home as well as other records and documents relating to the management of medicines. We saw that two new policies had been introduced by BUPA which changed the way that staff recorded the use of creams and thickeners. We saw that the new policies had been implemented throughout the home. We saw that the introduction of the policies meant that the records were not always accurate and they could not provide evidence that prescribed creams and thickeners were applied or used properly. During the inspection these concerns were raised with the manager and clinical services manager who understood the concerns. The manager told us that she had raised the concerns within the organisation but was awaiting further instructions with regard to the policy.

We found medicines on Brocklebank and Huskinson were handled safely. We saw some good practice on Brocklebank which illustrated that insulin had been administered safely. This was in contrast to our findings on Canada where we found that insulin was still not always administered safely.

We saw that medication was still not obtained safely. We found that six people missed doses of some of their prescribed medicines for between one and ten days because there was no stock available in the home. One person missed having 10 of their medicines for one day and another person was unable to have a barrier cream applied for over 10 days. Another person, who had cancer, did not have medication to relieve associate pain because there was none in the home. Another person who was suffering from a severe chest infection did not have their antibiotics in a timely fashion because the system for collection of prescriptions was inadequate. Missing doses of medicines places people's health at risk of harm.

People were still not given their medicines safely. We saw that an improvement had been made in the length of time it took to administer morning medicines on one of the units. We saw that a system had been implemented to record the start and completion time of each round. This was so that nurses could administer medicines which had a minimum time interval between doses such as, Paracetamol, safely. Or give medicines that had to be given at a specific time. However we saw that the times of the medicines rounds were not always recorded, so it was not possible to tell from the records if medicines had been given safely. We saw despite this system being in place that one person was given Paracetamol with an unsafe time interval between doses. On the day of our visit we saw that the time at the end of the lunch time round had not been recorded accurately. This meant that one person who was prescribed a specific medicine to be given at 3pm was given it half an hour too early. We also saw that on other days this medication was

given too early. This meant the symptoms of their illness would not be properly controlled.

We saw that people were not given their prescribed pain relief properly. People who were prescribed food supplement because of significant weight loss were not given the supplements as prescribed. We also saw that people were not given their inhalers properly; the stock counts showed they were given too few doses.

One person was given medicines which had been stopped when they were in hospital when they came back to the home.

We saw that there was guidance for staff to follow when applying creams. As at the last inspection we saw that in some cases this guidance did not always match the prescribers' directions. We saw that people were prescribed dressings and creams which were not used or applied without explanation. We saw that nurses were unsure which dressings to use and sometimes there was conflicting information about where creams should be applied which caused one person's skin to break down.

There were improvements in identifying medicines which needed to be given with special regard to food and most medicines were given at the correct time. However, we saw that two people were given medicines, including an antibiotic, at meal times even though they should have been given on an empty stomach. If medicines are given with food they may not work effectively.

We saw that two people missed doses of their lunch time medicines because they were not in the home at lunch time and no arrangements had been made to ensure they were given all due medication even when not in the home. If people are not give their medicines as prescribed or are given medicines which are no longer prescribed their health is at risk of harm.

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 sent to us to tell us how medicines would be given safely told us that these protocols would all be in place. We found that some information was still unavailable to guide staff how to administer medicines prescribed in this way. We found that other information was of poor quality and failed to give adequate guidance. It is important that this information is recorded to ensure people were given their medicines safely and consistently.

We saw people were prescribed thickening agents to thicken their fluids to prevent them from choking. We saw that the thickness to which the fluids should be thickened was recorded on handover notes, so that staff preparing drinks could refer to them to ensure the drink was thickened safely. However the information on the hand over notes was incorrect for one person. We saw that the information recorded on the tin for this person was also incorrect. This meant there was conflicting information and depending on which guidance staff followed the drinks may be too thick or their fluids were only thickened to half the prescribed thickness placing them at risk of aspiration, pneumonia and chest infections. As at the last inspection the failure to manage thickening agents safely placed people at risk of harm.

We saw that nurses who were giving medication via a PEG tube, a tube inserted into the abdominal wall so that food and medicines go directly into the stomach, were not administering medicines safely. One nurse told us they were unsure of how medication should be administered safely and that they had not been trained to administer medicines via a PEG.

We found that records about medicines were not always accurate. When stocks and records were compared we found that nurses signed for medicines that had not been given. We found that sometimes inaccurate

quantities were recorded when medicines were received or carried over from the previous month. This meant it was not possible to tell if medicines had been given to people as prescribed.

As at the last inspection we found medicines were not stored safely at all times. Waste medicines were not stored in line with NICE guidance because they were not kept securely. When medicines are not kept securely they are liable to misuse. We saw that the fridge temperature was recorded to ensue medicines were stored safely. However for three days medication was stored at below the recommended storage temperature. This meant that medicines in the fridge including insulin may be spoiled placing people's health at risk of harm

This remains a breach of Regulation 12 (1) (2) (f) and (g) of the HSCA 2008 (Regulated Activities) Regulations 2014.

We had received information of concern prior to the inspection regarding how pressure ulcers and wound care was being managed. On Canada Unit we reviewed how three people had their wounds/pressure ulcers treated. Pressure ulcers are caused by 'sustained pressure being placed on a particular part of the body'. We identified a number of concerns regarding the management of pressure ulcers and associated wounds, for example, skin tears and surgical wounds.

For one person who was discharged back to the care home from hospital the staff did not have a discharge letter or information about their condition which included a wound. This information was not sought by the home's staff and they did not put a plan of care to manage a wound for 18 days. Staff were unable to confirm whether there had been a dressing change to the wound or whether the wound had been assessed and there was also no record of whether these had been carried out. When a plan of care for the wound was formulated it did not record the correct information about the wound and the current treatment.

For another person their wound assessment was incomplete and the entries on the wound chart for a pressure ulcer were inconsistent and incorrect regarding the condition of the wound. Staff had recorded the wound was 'almost healed'. During the inspection an appropriate visiting health professional checked the wound which was found not to be healed and still needed a wound dressing. The person also had a pressure ulcer on a different site; there was a wound dressing in place which was inappropriate for the type of wound.

We saw a plan of care had not been updated or re-written for a person who had their wound dressing changed. The staff had received advice from a visiting health care professional regarding encouraging pressure relief however there was no re-positioning chart for this person to record this care. People receive a change of position to ensure their comfort and promote healing. A deterioration was recorded in a two day period for this pressure ulcer.

At the time of the inspection we received feedback from a visiting health professional who raised some concerns around a lack of staff knowledge around recognition of pressure ulcers. Healthcare professionals use a grading system to identify the severity of a pressure ulcer.

We saw a number of people required their dietary intake to be monitored due to an identified risk. For one person who was prescribed a nutritional supplement (given by a percutaneous endoscopic gastrostomy (PEG) feeding tube) there was no record of when this had been given. We also found the staff had not recorded the amount of water which should have been given via the tube in accordance with the instructions from the dietician. It was therefore difficult to ascertain whether the correct amount had been given as stated on the treatment plan.

This meant people were at risk of not receiving appropriate care, support and treatment. The apparent risks to people's health had not been adequately assessed and their health and wellbeing was put at risk.

We raised our concerns about the management of the PEG feeds with the registered manager. We requested advice was sought from the relevant health care professionals regarding our findings and this was actioned immediately. The service also raised our concerns with the local safeguarding team as an allegation of possible neglect or omission of care.

This is a breach of Regulation 12 (1) (2) (a) and (b) of the HSCA 2008 (Regulated Activities) Regulations 2014.

We asked about staffing at the home. At our last inspection in July 2015 we had found the home in breach of regulations relating to staffing. At that time, levels of nursing and care staff, were not sufficient to ensure people received a consistent level of safe care. We told the provider to take action. The provider sent us a series of action plans to tell us how the home was progressing and the most recent action plan dated 8 February 2016 maintained staffing was now satisfactory. At this inspection we found that staffing had been improved in that there were sufficient numbers of staff to maintain effective levels of personal care. The Home had recruited into all active vacancies, including nurse vacancies.

As part of the management plans, at the beginning of January 2016, one of the nursing units was closed down and was amalgamated into Canada unit. This was due to falling numbers of SU's and the need to focus nursing staff in one area for more consistency. Since that date CQC had received a number of concerns from staff, visitors and professional reports that this had been poorly managed and staffing on Canada unit was unstable and insufficient.

The registered manager had confirmed, prior to the inspection, there were issues on Canada Unit – citing poor management of the change at unit level. This had resulted in changes to nursing staff [including the unit manager]. The registered manager acted on these issues and increased staffing [two weeks prior to our inspection] and had moved an experienced unit manager onto Canada Unit who had been in post three weeks at the time of our inspection. We were told the other units were stable.

We visited all units and found staffing numbers stable at the time of our visit. Interviews with relatives, visitors and staff on the units all confirmed that there had been concerns regarding the amalgamation of the two units and this had caused unrest and some bitterness – mainly from staff and relatives of people who had been moved [from Alexandra Unit which was now closed]. There was a consensus that staffing was now more settled and improving. Staff morale was overall found to be positive.

We spoke with one relative who told us, ''Things were difficult over the New Year, we (relatives) were unhappy with the move (closing of one unit) but things seem to have settled now and are improving''. People we spoke with who had been involved in the move concurred with this. A person living on Canada Unit said, ''We got notice only a short time before. The move was chaotic but we we're settled now.''

Observations of routine care on all units, and particularly Canada Unit, evidenced a good ratio of staff. Staffing rotas showed this had been consistent over a number of months and had also improved further in the last few weeks after raising the staff numbers on Canada Unit.

We observed there were enough staff to carry out care in a timely manner. We saw staff were attentive to people's needs; no one appeared to be in distress through lack of attention. For example, we observed people living with dementia were attended to quickly when they became agitated or wanted assistance and also people on the nursing units received routine care in a timely manner. When we looked at the duty rotas

for each unit we saw that the provider's designated numbers of staff were being met.

When we spoke with people living at St Nicholas Nursing Home they told us they were settled and felt safe. One person told us, ''I feel safe here. I get support when I need it.'' A relative commented, ''The staff are lovely. They are very open and tell us what's going on. If we had an issue with the care we would feel free to speak up.'' There was universal agreement that people felt confidence in the ability of the staff to support them and felt 'well-looked after'.

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 manager of the home. One staff said, "We do get training and we can report to the managers any concerns we have.''

There had been 11 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. Three of these were incidents involving medication errors. These had been picked up by the home's own audits [checks] and notified appropriately. Four incidents involved alleged reports of abuse by two individual staff members [involving four people living at the home). These had been picked up when staff came forward to managers of the home and were being managed on-going at the time of our inspection.

Following the inspection we have received a further three instances were people have been alleged to have received unsafe care. These are currently also under investigation by Sefton Council safeguarding authority.

We had received two reports from safeguarding investigations by the local authority into the care of people with pressure ulcers. These had various recommendations which we followed on our inspection.

The home 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. We saw that the local contact numbers for the Local Authority safeguarding team were available along with the home's safeguarding policy.

We found that staff had faith in the registered manager who was seen as 'in touch' with events and supportive to staff. The registered manager told us all units had 'settled' managers in post; there were currently one CSM [Clinical Services Manager to support the RM] post to fill; only 36hrs vacant [care] on nights with all other positions settled; sickness rates were falling over recent months and there was an active management plan to review this on-going.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at two 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.

We found there were good examples that people were assessed for any risks regarding their health care needs. For example, risk assessments had been carried out to assess people's risk of developing a pressure sore and 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 and weight charts were seen and had been completed appropriately on a monthly basis. We found, in some instances that care plans were not always routinely updated when these care needs changed however; for example wound care.

We reviewed the care of one person on one of the nursing units who had a history of falls and was therefore at risk. The person displayed some challenges for staff regarding observation to ensure the risk of falling and injury were minimised. We saw that there had been effective liaison with health care professionals to help ensure an effective care plan was put in place. We saw that staff were diligent in their recording of care and all staff we spoke with were fully aware of the need to ensure effective observation levels. This helped the person to be as independent as possible.

We checked some specific maintenance and safety records. A fire risk assessment was in place and personal evacuation plans (PEEP's) were available for the people living in the home. These were displayed on each unit for easy reference.

We carried out a spot check of a number of safety certificates for gas safety, electrical safety, infection control, and safety checks for the temperature of the hot water and equipment such as, bed rails. These were up to date evidencing good monitoring and safety in the home.

Housekeepers were present on the units and the majority of areas seen were clean. Visitors and people we spoke with on the inspection told us they 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. Each of the units had an infection control lead and we spoke with one of these. We were shown the local audits / checks carried out on a routine basis and were told how findings were fed upwards to managers. The infection control lead told us about regular meetings held with Liverpool Community Health (LCH - infection control) in order to learn and share best practice. We saw a recent audit carried out by LCH dated 11 February 2016 which recorded the home were 'compliant' with a rating of over 92%.

During out visit to Canada Unit we did notice some standards of hygiene were not wholly maintained and these were discussed with the unit manager. The unit manager informed us that she was aware of some of these issues and they had been raised as part of a general review of cleaning on the unit.

Requires Improvement

Is the service effective?

Our findings

People we spoke with at the inspection told us they felt staff had the knowledge and skills to support them with their care. However, at the inspection we raised some concerns around specific aspects of care which we found placed people at risk. For example, pain management, wound care and care for people who had a percutaneous endoscopic gastrostomy (PEG) feeding tube. This is used when people are unable to swallow or eat and drink enough and is a means of providing nutrition and medication. Our findings indicated that a number of people were placed at risk as the nursing staff showed a lack of clinical knowledge and expertise in these areas of care to support people safely and effectively.

We looked at the training and support in place for staff. The training manager told us about the induction programme for new staff. This was covered over an initial four to five day programme covering subjects such as; role of the care worker, equality and diversity, dementia awareness, medicines and health and safety issues. New staff worked with more experienced staff as they became familiar with the service and got to know the people they supported. We saw staff had access to a training programme which included training in areas such as, moving and handling, first aid at work, health and safety, medication, safeguarding, infection control, food safety and fire awareness. Following the inspection we were provided with more training details and this included more specific training for staff in areas such as, falls prevention, nutrition, 'behaviours that we find challenging', pressure ulcers, person first dementia and mental capacity.

Staff were encouraged to gain qualifications in care such as, QCF (Qualifications and Certificates Framework). The training manager advised us that 36 staff had obtained a formal qualification in care and training records showed 15 staff were enrolled on a formal care qualification.

We looked more specifically at the skills, qualifications and knowledge of nursing staff employed in the home and how they were supported to develop there competencies. This given the concerns raised before the inspection around nursing management of clinical issues and our findings on the inspection visit.

We found there were a lot of RMN [Registered Mental Nurse) trained nurses in the home. This included four RMN's on the two general nursing units. There was little evidence of updates / training for these staff in general nursing or clinical care apart from 'six steps end of life care' and four nurses updated in male catheterisation [although these staff could not currently practice this as they had not been 'signed off' as competent. One nurse we spoke with told us they were keen to acquire specific training and knowledge in wound care as this would help increase their effectiveness to manage these care needs.

There was a lack of knowledge around wound care. The registered manager gave us some statistics regarding nursing staff skill base and only one nurse in the home had previously attended accredited training on wound care [some time ago]. When we asked what tissue viability training one nurse [RMN] had had we were told 'quite a lot' but when we further questioned this further we found it was sessions with a wound dressing company representative and a few hours with an in-house BUPA trainer on pressure ulcer grading.

The one current Clinical Services Manager (CSM) was also an RMN nurse. We found there were good practice around issues identified as 'mental health' but we questioned the reliability of various audits including wound care audits that had not tracked the reliability of the data recorded or questioned why, when dressing regimes had been changed, the care plan had not been re-written. We questioned the necessary clinical background of the CSM to be assessing best practice in general nursing care. The registered manager agreed to look at this following our feedback and told us this would be addressed with the introduction of a general nurse trained CSM [normally the home has two CSM's] in the near future.

The provider, BUPA, have developed a revalidation support programme for nursing staff but this has not been rolled out yet. The registered manager sent us an updated training plan following the inspection which included dates for 4 RMN's to attend 'skin integrity' training for 15/3/16.

This was a breach of Regulation 18(2) (b) of the HSCA 2008 (Regulated Activities) Regulations 2014.

Some staff told us they had regular support sessions with their line managers such as supervision sessions and staff meetings. Unit managers told us they were now better supported to ensure they could take their allocated 'supernumerary' time to complete these. Likewise, we found support systems such as staff meetings [at house level] were increasing in frequency and were more consistent.

We looked in detail at the care received by some of the people living at St Nicholas Nursing Home. One person, who lived with dementia, had highly dependent and complex care needs. We saw that they had received input from a ranged of social and health care professionals who had linked in effectively with the home. Professional support had been documented by the Community Mental Health Team [CMHT]. There had been a recent review of care and this had also included the input of the relative of the person concerned. The relative told us, ''I'm happy with the care; I feel [person] is well looked after and settled as could be.''
We reviewed the care of twelve people and also reviewed their medication; some of whom were experiencing pain, or had ongoing health conditions that required constant monitoring. We found referrals had been made to provide appropriate health care professionals when needed. The home benefited from regular [daily] input form a community matron who was available to provide support when asked. We were also told about the 'Tel-med' (Telemedicine pilot system) whereby staff in the home could access local GP surgeries for support regarding people in the home.

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We saw examples where people had been supported and included to make key decisions regarding their care. Where people had lacked capacity to make decisions we saw that decisions had been made in their 'best interest'. We saw this followed good practice in line with the MCA Code of Practice. For example, for one person, we saw the decision taken for DNACPR (do not attempt cardio pulmonary resuscitation] had been reviewed in line with best practice as it was thought the person mental capacity had changed and they were now able to be consulted regarding this decision. We also had some discussion with staff on Huskinson Unit, which specialises in nursing people with dementia, regarding their understanding of the MCA. We found the unit manager had a good understanding of the principals concerned. We were shown some assessment around individual decisions regarding admission to the home and involvement in the care

planning which were now standard for all people admitted to the home.

Although care practices were consistent in indicating staff were generally following good practice we found some hesitancy around fully understanding the use of the 'two stage mental capacity assessment' and when this should be used. For example we saw the standard assessments to assess capacity also included an outcome of 'variable'. This was confusing as the test should indicate clearly if the person had capacity at the time of the test for that particular decision - or didn't.

The form also included a section called 'capacity decisions over care planning process' and this covered sections on all the activities of daily living in the care plan. This was completed for the people we reviewed but again, was confusing as the 'evidence' section did not contain any evidence of the two stage mental capacity test having been carried out for these 'decisions'. In other, more specific examples, where a mental capacity test would have been evidence of good practice – for example the use of bedrails which can be interpreted as a restrictive practice. We did not find any evidence of consent or individual mental capacity test for this specific decision. We discussed these findings with the registered manager who said they would take on board our comments and review this ongoing.

We would recommend the current assessments around mental capacity are better evidenced regarding specific decisions and follow the guidance in the Mental Capacity Act Code of Practice.

Staff were able to talk about aspects of the workings of the MCA and discuss other examples of its use. We found the home supported people who were on a deprivation of liberty authorisation [DoLS]. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found the registered manager and senior staff knowledgeable regarding the process involved if a referral was needed. We reviewed the authorisations in place for some people and found the process had been followed and was being monitored in liaison with the local authority.

We discussed with staff and the people living at the home how meals were organised. We recorded mixed opinions but generally people told us the meals were good and well presented.

One person said, "You get plenty of food and a nice choice as well – I always enjoy it.'' Another person said, "I like the food, you get a choice. There's enough to eat.'' One criticism was that though food was plentiful the quality was not consistent and they would have preferred less food of a better standard.

We observed the dinner time meal on some of the houses and saw that meals were served appropriately and the portion size was also appropriate. We saw that people who needed support to eat had sufficient staff time allocated and that staff took time to talk to and socialise with people. There were staff on hand for people who required support with. All of the nursing units had a designated 'hostess' who provided extra support with meals. Nobody was rushed. We saw staff asking people if they wanted an alternative to what was being offered. We also saw staff, at one point in the day canvassing people for their choice of future meals.

Good

Is the service caring?

Our findings

People told us the staff were kind and caring. Their comments included, "Really nice staff", "Superb care staff", "Level of care is fantastic" and that they felt very well supported by staff were "Pleased" and had "Never had to worry" and "They treat me like a queen." Relatives visiting one unit said, "Superb care staff" and "Level of care was fantastic." One relative, on Canada Unit, told us that there had been issues with the way care was being delivered following the amalgamation of the Unit with another that had been closed down. They also felt there had been little consultation regarding this move and this had not been very 'caring' of the management at the home. This was acknowledged by the Home Manager. However, although things had been 'disorganised' we were told the staff worked extremely hard to ensure people were cared for. We were also told that overall, since the new unit manger had started, things had improved and communication was better.

We spent periods of time throughout the day observing and listening to staff to see how they interacted with the people they supported. This interaction was positive and people appeared at ease and comfortable in the presence of the staff. When the 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 explained to people what they were going to do, sought their permission before assisting and ensured people's comfort before leaving them. We saw many examples of this including staff support over lunch and assistance with aspects of personal care. This support was offered at the appropriate time. We saw staff offering people choices. This included what time people wished to get up, where 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.

Relatives told us they felt the staff were very kind and staff demonstrated a high level of respect in all aspects of care. Relatives comments included, "The staff are very good indeed, always polite" and "Nothing is too much trouble (for the staff)." A number of staff were appointed the role of dignity lead. This was to help monitor adherence to people's rights and promote good standards of dignity and respect when supporting people.

People's dignity was observed to be promoted in a number of ways. For instance, staff were observed to knock on bedroom doors seeking permission before entering, personal care was provided with the bedroom door closed and visiting health care professionals saw people in private to carry out medical treatments. If people needed staff support this was provided in a timely manner. We saw an example of where a person was unable to use their call bell and therefore the staff carried out checks regularly to ensure their comfort and wellbeing. These checks were recorded.

We discussed with staff people's care needs. Staff showed a good understanding and knowledge of how people wished to be supported and the level of care they needed to maintain their health and wellbeing. A staff member said, "An important part of what we are about is making sure we listen to our residents and knowing them so well really helps us to give the right care." For example, staff told us about the strategies in place to support people who have a behaviour that may challenge. Staff were very aware of triggers or factors that may cause distress or anxiety and how to support them during these episodes.

Care files contained details about people's preferences and choices around how they wish to be supported. There was also information about people's daily life prior to coming to live at the home and family and friends' involvement. Advocates such as, family members, were involved (where appropriate) with the care reviews, as part of evidencing their inclusion in the plan of care.

We saw friends and relatives visiting during the inspection. Visitors were warmly welcomed by the staff and it was evident staff knew families well. A relative told us they could visit any time and were always able to speak with the staff.

For people who had no family or friends to represent them, contact details for a local advocacy service were available. People could access this service if they wished to do so with or without staff support.

We spoke with a member of staff who had been appointed a lead role in 'end of life care'. This role was to oversee the care provided to people in their final days. A programme known as '6 Steps' was being rolled out to staff to help ensure people's care was provided in line with their and their loved one's wishes. This programme included staff training in 'end of life' care. We received positive feedback from a visiting health professional regarding this aspect of care and also the support given to families at this time.

Requires Improvement

Is the service responsive?

Our findings

At our last two inspections in January 2015 and in July 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 further development of a move towards a new system of assessment and care planning to focus the care in a more personalised way.

We found on inspection that there had been improvements in the care planning system so that overall the breach had been met. We looked at how people were involved with their care planning and saw some evidence that people's plan of care had been discussed with them and/or their relative to evidence their inclusion. A relative told us about their involvement with their family member's care including regular care reviews. We saw a plan of care on Canada Unit where the family had been involved in key decisions regarding the care of a person on the unit and the persons changing care needs had been discussed.

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. We spoke with two visiting relatives who told us they had been fully involved in the care planning and had viewed and discussed the care plan with the staff. 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 looked at the care records for 5 people who lived at the home. We saw people had a plan of care for daily activities such as washing and dressing, personal hygiene and communication. These held detailed information regarding people's care and how they wished to be supported. We saw that care plans were regularly reviewed by staff. This standard was not wholly consistent however. Some of the care plans either omitted key areas of care for people or care plans had not been updated including clinical care such as wound care and percutaneous endoscopic gastrostomy (PEG) feeding.

We looked at how social activities were organised and asked the staff to tell us about how people liked to spend their day. The staff informed us that people enjoyed the social programme and were able to take part in a variety of social activities on all the units. An activities coordinator was present on most of the units during our inspection. When we saw people taking part in activities they appeared to be enjoyed and the activities coordinators displayed good skills in encouraging people to participate. Organised activities included arts and crafts, board games, cake baking, singing, music, movie afternoons, gentlemen's and ladies club and use of a hydrotherapy pool and snoezelen. This is a room which provides a multisensory environment to provide therapy for people with autism and other developmental disabilities or dementia.

For example 'Chat boxes' were used on a dementia unit and these included photographs and items of importance for people to encourage general conversation and reminiscence.

There was a pleasant relaxed atmosphere and for people who wished to stay in their room, the staff visited them on a regular basis to reduce the risk of isolation.

People were supported to continue with their chosen faith. This appeared to be in the form of visitors from the church rather than attending. Two residents expressed they would like the opportunity to attend church. Some residents expressed loneliness and said that they would like more visitors and to access the community more.

The home had a complaints procedure in place. Following the amalgamation of two of the units at the beginning of January 2016 the service had received a number of complaints from families of people living at the home about the way this had been managed and the effect on some of the people now living on Canada Unit. The Care Quality Commission [CQC] had also received some of these complaints and we liaised with the registered manager at the time and we were able to monitor the registered manager's response to these complaints. For example we received information from the registered manager on 2 February 2016 that two separate meetings had been held with family members of two people living in the home to listen to and address their concerns.

Residents' and relatives' meetings took place to enable people to raise their concerns regarding these issues and any further issues or comments regarding the service. A relative told us meetings were held regularly. A meeting was held on 12 February 2016 with relatives and following continued concerns re staffing on Canada Unit the manager ensured additional staff where allocated.

We were told that such meetings were held approximately every three months. We saw minutes of a meeting held in September 2015 which had been attended by senior management staff and eight relatives or representatives of people living at the home. There had been discussion and information shared regarding staffing, new care documentation and relatives involvement with this, completing a relative survey, laundry issues, protected meal times and the role of the Admiral Nurse [dementia care specialist] in the home.

Inadequate

Is the service well-led?

Our findings

Being a large national provider BUPA had established systems in place to monitor the running of the home. The home had an on-going service improvement programme (SIP) which has been regularly updated and sent to us (Care Quality Commission).

However, we found on the inspection that key clinical issues had not been effectively monitored and systems in place had been ineffective in some areas. For example, the clinical auditing process seen was based on daily monitoring visits by the Clinical Services Manager (CSM) to the units and included clinical issues such as wound care. Issues had not been picked up however on the audits. We found concerns around the management and care of people who were being fed and given medication via a tube into their stomach [PEG feeding] that had not been included on the current audit tool. Other concerns identified by us such as management of pain and safety of medication administration had also not been picked up. There was therefore a lack of feedback from the units to the registered manager. Current systems had not identified the lack of expertise amongst nursing staff in managing some clinical care and there had been no effective plan to support nursing staff clinical development.

This is a breach of Regulation 17(1) (b) of the HSCA 2008 (Regulated Activities) Regulations 2014.
The service had a registered manager in post. We spent time talking to the registered manager and asked them to tell how to define the culture of the home and the main aims and objectives. Since being appointed as registered manager, there was feeling that standards in the home were more consistent. Staffing numbers had been a major issue, particularly nursing staff numbers, but a programme of recruitment and internal rationalisation (closing one unit) had meant that there were now sufficient staff numbers to maintain care.

We also discussed the change in culture in the home over the past year. Staff spoken with told us that all levels of management were more consistent in their approach and were more 'visible' around the home. This positive feeling had been disrupted with the amalgamation of two units in the home. Some staff, visitors [relatives] and people living at the home felt this had not been managed well and this had affected care standards on Canada Unit in particular. The registered manager had addressed the issues by further rationalising staff and moving an experienced unit manager onto Canada Unit. We found on the inspection that the staff and people we spoke with were now more positive as they felt things 'had settled down' and 'were improving'.

Overall we received positive feedback about the management of the service. Staff told us the manager was approachable and ensured us the home ran well. Staff said the manager was open to suggestions and new ideas to help improve the service. Staff comments included, (The manager) is very good and always coming round on the units" and "Really good support from (the manager)." A relative said, "I have absolute trust in the manager, they are very capable."

Staff told us they were aware of the whistleblowing policy and would feel confident to use it. This also helped to promote an open culture in the home.

We reviewed some of the other quality assurance systems in place to monitor performance and to drive continuous improvement. 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. 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; we saw any required actions were then completed. The registered manager discussed a key management tool used to monitor the service. This was the 'Quality Metrics' report reflected in the companies 'Enhanced Quality Model' which had four key themes- 'quality of care, quality of life, quality of leadership and management and quality of the environment'. We discussed the Quality Metrics and the key indicators within this. These covered pressure ulcers (showing an increased in in-house incidents since October 2015), Nutrition (including people weight loss), Medication errors, safeguarding referrals, Deprivation of Liberty referrals, infection rates, care plan auditing, accidents and incidents (current low rate for these) and quality assurance feedback from people living at the home and their relatives.

The registered manager told us the review helped them to focus on areas of improvement, for example, more resident involvement around care planning which had been addressed over the past six months to good effect.

The registered manager had introduced a clinical indicator board. 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 and clinical services 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 based around individual need.

In December 2015 people who lived at the service were given the opportunity to complete satisfaction surveys in the home. The surveys covered areas such as, food, staff support, bedroom, communal space, housekeeping and changes to improve resident life at the home. The feedback measured strengths of the service ('Happy and content to live in the home', 'staff know residents and there needs', 'warmth and friendliness of staff') as well as areas for improvement ('quality of care', 'staff available when needed').

Resident/relative meetings were taking place on the units and minutes seen showed a range of topics discussed including how the home was now operating.

Through their day to day management the registered manager and clinical services manager (CSM) undertook a morning 'walk round' on the units to meet with the staff, visiting health professionals and people living at the home. This we observed during our inspection and confirmed through staff discussions. The registered manager told us the visual checks were an important part of monitoring standards and improving the service provision. Following our feedback the manager told us that a new (CSM) would be appointed to improve the clinical interface on the general nursing units.

As part of our feedback to the registered manager and senior managers of the organisation, we discussed the on-going development of the service with respect to our concerns. We were told the home qualified for support from a newly developed 'Service Recovery Team' who would be supporting the registered manager over the forthcoming period to help raise standards. We spoke with the manager of the team who also told us that the provider are currently undergoing a 'redesign project' which will look at the way the providers larger services (such as St Nicholas Nursing Home) are configured and managed. This is to evaluate if changes to overall management structure, including possible registration, could help develop the service

and promote positive outcomes.

The 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.

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 12 HSCA RA Regulations 2014 Safe care and treatment 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) (f) (g) The assessment of care did not always ensure the welfare and safety of people. Changing care needs had not been assessed or reflected in the risk assessments made and subsequent care planning. Regulation 12 (1) (2) (a) and (b)

The enforcement action we took:

We have continued to impose a condition on the provider's registration to suspend any further admissions to St Nicholas Nursing Home.

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 There were areas of clinical care management that still needed to be improved and these had not been identified by existing audits and systems in the home. Regulation 17 (1) (b)

The enforcement action we took:

We have continued to impose a condition on the provider's registration to suspend any further admissions to St Nicholas Nursing Home.

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 We found that there was a lack of support for nursing staff to fully develop their skills and knowledge to effectively manage some aspects of

clinical care.
Regulation 18 (1) (2) (a)

The enforcement action we took:

We have continued to impose a condition on the provider's registration to suspend any further admissions to St Nicholas Nursing Home.