Bupa Care Homes Limited

St Nicholas Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

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. There were 96 people accommodated at the time of the inspection.

This was an unannounced inspection which took place over three days. The inspection team consisted of three adult social care inspectors, a pharmacy inspector and two people who were 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.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected the home in March 2017 and found previous breaches of regulations had been met. We gave a quality rating of 'Requires Improvement'. This is the eighth consecutive time the service has been rated Requires Improvement since January 2014.

We found people were not protected against the risks associated with medicines because the provider's arrangements to manage medicines were not consistently followed. There was a particular risk associated with the use of agency staff.

We observed there was not always enough staff to carry out care in a timely manner. There was a high use of agency staff cover which had inherent risks around the effectiveness of communication and knowledge around people's care needs.

There were inconsistencies in assessing some people's health care needs and delivering effective outcomes.

Most people we spoke with and their relatives said that they (or their relatives) were being treated with respect, dignity and kindness. We found inconsistent standards however and examples evident where people's dignity was clearly compromised.

We found the home had not met regulatory requirements with respect to sufficiency of staffing, consistency of personal care, ensuring people's dignity and ensuring all people living at St Nicholas's were having effective outcomes for their care needs. This raises questions around the ongoing effectiveness of the governance arrangements for the home.

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

Staff were aware of the first aid procedures and equipment used in case of an accident or emergency. People had assessments in place in the event of an emergency fire evacuation of the home.

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

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

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

There 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 to ensure safe and effective care.

We found that the home was clean and hygienic.

For most people reviewed there was support for their health care needs and when needed people were referred for appropriate support to health care professionals.

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

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

Staff told us the training they received was good. The 'training matrix' we saw showed that staff were updated regularly in key areas of care and there was an established induction programme for staff. Some staff training had been identified as needing updating and the registered manager was aware of this.

We saw references in care files to individual ways that people communicated and made their needs known. We also saw good examples where people had been included in the care planning, so they could play an active role in their care. We found care records were easy to follow and to access necessary information.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

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

There was not enough staff, who were competent and experienced, working in the home on duty at all times to help ensure people were cared for in a consistently safe manner.

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

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

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

The home was clean and we found systems in place to manage the control of infection.

Is the service effective?

Requires Improvement

The service was not wholly effective.

There was support for people's health care needs and when needed people were referred for appropriate support to health care professionals. There were inconsistencies in assessing some people's health care needs and delivering effective outcomes.

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

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

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

Is the service caring?

Requires Improvement

The service was not always caring.

We found inconsistent standards and examples evident where people's dignity was clearly compromised.

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

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

Is the service responsive?

Requires Improvement

The service was not wholly responsive.

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

There was good practice regarding the individualisation of care plans and people's care records evidenced an individualised approach to care.

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

Is the service well-led?

Requires Improvement

The service was not fully well led.

The provider had not met regulatory requirements in key areas of care and treatment. There was a continued lack of consistency which raised questions around the on-going effectiveness of the governance arrangements for the home.

Some of the systems to get feedback from people so that the service could be developed with respect to their needs and wishes had not been scheduled. There were examples of some audits not being actioned.

We found improvements to care records so they were more concise and accessible.

There was a registered manager in post to provide a lead in the home and who was supported by a clear management structure.

We found the registered manager to be open and constructive.

St Nicholas Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

St Nicholas Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This was an unannounced inspection which took place over two days on 2, 3 and 6 November 2017. The inspection team consisted of three adult social care inspectors, a pharmacy inspector and two people who were 'expert by experience'. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the visit we visited three of the five units that currently make up St Nicholas Nursing Home [one unit was closed and two other units were subject to an infectious outbreak]. Units visited were Huskinson, accommodating people living with dementia; Canada and Langton units which were both general nursing units.

People living on Huskinson 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 16 of the people who lived at the home. We spoke with six visiting family members. As part of the inspection we also spoke with three health care professionals who were able to give some feedback about the service.

We spoke with 21 staff members including nursing, care/support staff and the home's registered manager. We also spoke with other senior managers in the organisation.

We looked at the care records for 17 of the people living at the home, four staff recruitment files, medication records and other records relevant to the quality monitoring of the service. These included safety audits and quality audits, including feedback from people living at the home and relatives/visitors. We undertook general observations and looked round the home, including some people's bedrooms, bathrooms and living areas.

Requires Improvement

Is the service safe?

Our findings

We reviewed provision of staff at the home to ensure delivery of safe care. On Canada unit the staff on duty all appeared extremely busy and it was noted that by mid-afternoon none of the staff had managed to leave the unit to go for a break. One person living on the unit stated that the staff were "All fantastic" but there were "Not enough of them". When people were asked if their call bells were answered promptly one person stated that they may be waiting for "More than a few minutes" for someone to answer and assist them to use the bathroom. The same person told us they knew the staff would 'go out of their way' to help, but that sometimes they appeared 'overwhelmed' by the amount of work they needed to do. We were told about 'one aggressive resident' and that at night the staff on duty was so busy attending to the person that other people could not always get their needs met. These comments were echoed by other people and their relatives. One member of the inspection team spoke with ten people and their relatives and only three said there were enough staff to support them at times.

During the three days of the inspection there was evidence of inconsistent care staff numbers. On one day on Canada Unit the afternoon shift was reduced to three care staff to carry out personal care for 22 highly dependent people. Staff were observed not to have a break and comments from people and relatives indicated staff were rushed and not attending to people as promptly as they would like. On Huskinson unit, on the second day of the inspection, staffing was reduced by one care staff [staff did not turn in] which meant three care staff for 17 people accommodated. Care staff were seen to be notably under pressure and the senior carer was taking on the role of lead staff as the agency nurse was involved in medicine administration. This meant care was delayed. One person received no personal care from 0715 in the morning until 1200. Another person was observed to be shouting for assistance for a prolonged period [15 minutes] and became agitated.

We found there was a reliance on covering shifts with agency nurses. Prior to the inspection the registered manager had identified high use of agency/bank staff linked to medication errors; 16 out of 28 medication incidents had previously been linked to agency / bank nurses. This was reinforced on inspection with key medication administration errors linked to agency or bank staff.

There had been four 'whistle-blower' concerns since the last inspection which cited inconsistent staffing levels at times. A full review and response by the registered manager in July 2017 evidenced basic levels of staffing mostly met but there was need to recruit regular staff.

On this inspection the unit manager on Huskinson was on holiday. The second regular nurse was also absent due to sickness. This meant that for the two weeks prior to the inspection there had been an agency nurse in charge on all day shifts. The agency / bank nurse being inducted on day one of the inspection on Huskinson Unit had not worked [nursed] people living with dementia. All of the information asked for by the inspector came from the senior carer on the unit. The agency nurse was unaware of some people's key care needs and gave incorrect information. This posed a risk to people's safety and welfare.

We looked at the 'staff on duty' record for the previous month. There were 420 shifts to cover; 69 shifts were

short by at least one carer which meant 16.4% shifts were short staffed based on the provider's own estimate of staff required. These were all on days. The shortages were fairly evenly spread over units.

A health care professional was interviewed on the inspection. They expressed concern about the level of awareness and knowledge of nursing staff – particular agency staff. They gave an example from their visit on the day in question of the agency / bank nurse showing them the wrong person; the risk of prescribing medication to the wrong person was a concern. They also expressed concerns about nursing staff not identifying clinical issues and following them up as they 'did not 'know the patients'. The lack of effective clinical lead meant the three people the visiting health professional had been called to review had been 'referred' by the senior carer that day. A note had been left in the unit diary three days previously by the same carer who had then gone on their days off. This had not been picked up by the agency nursing staff over the preceding three days.

The registered manager accepted that the use of agency nurse cover was high and had inherent risk. We were told this was being addressed through the recruitment process. There were four nurses due to start in the home over the next month. At the time of the inspection the total nurse hours cover required weekly was 956. Agency staff hours for the week prior to the inspection were 205 [21%]. This figure was forecast to reduce to 155 the following week and 114 the week after that as new nurses came on line.

The concern here was the four nursing staff recruited was the total amount since the last inspection [8 months ago]. When we compared agency staff cover over the past two years – there was little or no change. In July 2015 the agency staff cover was 237 hours weekly and the average agency staff cover for the last eight months [since the last inspection] was calculated at 235.3 hours weekly.

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

Since the last inspection in March 2017 there had been 28 separate medication errors. All of the errors have been picked up and reported by the home's auditing systems. There had been no concerns from other agencies or stakeholders reported. One key theme identified by the registered manager was the number of agency nurses implicated in many of the errors.

At the last inspection, there had been an improvement in the management and administration of medicines in the home. No medicines were out of stock, treatment rooms were clean and tidy and information to help staff administer medicines safely was in place. A CQC medicine inspector looked at storage, management and administration of medicines on three units in the home at this inspection, following a number of medicines incidents reported to us by the home. We also looked at records including audits and staff training.

Since the last inspection, a member of staff was given responsibility for medicines management throughout the home. This role included ensuring the correct medicines were received into the home and liaising with the people's GP and local pharmacy to maintain stock levels. They also ensured that regular checks on medicines were completed on each unit and any discrepancies were investigated and actions taken to prevent reoccurrence. Investigations had demonstrated that errors were more frequent when there was a higher number of agency nursing staff administering medicines. An additional handover check had been introduced at the end of each shift to help reduce errors.

Medicines were stored securely in tidy, locked treatment rooms. Processes were in place to check fridge and room temperatures daily, though some days had been missed on one unit. A vial of insulin did not contain

the date that it was first used. This meant that staff could not say when the medicine was out of date, and may not be as effective. Controlled drugs were stored correctly, but there were gaps in the weekly stock balance checks for them.

We looked at the medicine administration records (MAR) for seven residents in detail on three units in the home. On the Huskinson unit, we found errors with the two people's records we looked at. Both residents had administration errors and the amount of stock and the MAR chart did not match. We found one page of a person's MAR chart was missing and there was no record for three medicines being administered for six days prior to the inspection. This meant we could not say if people had received the correct amount of their prescribed medicines. One person was prescribed a medicine with a variable dosage that required regular blood tests to monitor levels. This medicine had been given incorrectly on the day before the inspection by an agency nurse. Staff were alerted and appropriate action had been taken to ensure the person was not harmed.

We looked at records when topical medicines were prescribed for people. Detailed information in the care folders explained when and where the creams and ointments should be applied. However, care staff did not always sign when administered and we found gaps in application records.

There were sufficient staff trained to administer medicines and 22 had undergone medicines competency training in the last 12 months.

This is a breach of Regulation 12 (1) (2)(g) of the Health and Social care Act 2008 in respect of inaccurate medicine administration.

Risk assessments had been carried out to assess people's clinical risk; for example the risk of developing a pressure ulcer. Pressure ulcers are caused by 'sustained pressure being placed on a particular part of the body'. We found this area of care continued to be managed appropriately. The home had low incidents of pressure ulcers overall. The risk of people getting pressure ulcers was routinely and regularly reviewed. There were risk assessments for the use of bedrails to help ensure people were safe. Dietary needs and nutritional requirements had also been recorded and assessed routinely using an appropriate assessment tool (Malnutrition Universal Screening Tool – MUST). Most weight charts seen had been completed on a monthly basis.

We saw that in some people's care files it was noted specific pieces of equipment were needed to ensure their safety and wellbeing e.g. pressure relieving cushions and mattresses. On observation these pieces of equipment were found to be in place and they were being used appropriately. People who required transfers using a hoist were seen being hoisted, and the appropriate number of staff were always present. Equipment such as, shower chairs, commodes and banana boards to assist with mobility were also in place as recommended in the care files.

We spoke with people living in the home and relatives / visitors who told us they did feel safe in the home. One person commented, "You're well looked after and they make sure you're alright." Other people said, "There's always people around and when I go to bed at night the outside doors are all locked," "I feel safe," and "We've not had any incidents". A relative said, "Whenever I come in he's comfortable and his bed has rails on."

We found staff had knowledge of the whereabouts of first aid equipment for use in an emergency. On Huskinson Unit we saw a first aid box in the unit office with a list of contents for checking. Personal Emergency Evacuation Plans [PEEP's] were in place for each person in case of an emergency at the home

such as a fire, so that staff would know what level of assistance each person would need.

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

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

We had been notified about six 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. Many of these were incidents involving medication errors. These had been picked up by the home's own audits [checks] and notified appropriately. The themes for two of incidents was around allegations of poor clinical and personal care and one incident involving a carer allegedly not responding appropriately to a person they were supporting.

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. This approach helped ensure people were kept safe and their rights upheld. We saw that the local contact numbers for the local authority's safeguarding team were available along with the home's safeguarding policy.

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

All units were secure and access could only be gained by inputting the correct code into the key pad at the entrance, the code to exit the unit being different. There was also a signing in book for visitors to the unit and it was observed that relatives signed in and also knew the code to access the unit. The code was changed regularly.

Housekeepers were present on the units and areas seen were clean. On inspection visitors and people we spoke with had no concerns about the cleanliness of the home. The management team completed infection control audits, as part of monitoring safe standards in the control of infection. At the time of the inspection two of the units had experienced an infectious outbreak. Staff had liaised effectively with external environmental health professionals such as Liverpool Community Health (LCH - infection control) in order to learn and share best practice. We spoke with a professional from LCH who told us the staff had managed the infectious outbreak effectively and minimised further risk to people.

Requires Improvement

Is the service effective?

Our findings

Leading up to this inspection we had received two concerns regarding the lack of clinical care for people. One person had received an injury from a fall and this had not been followed up over a number of days, leaving the person in pain. Another person was found to not have clinical care needs met involving diet and fluid intake, bowel management and wound management. Following the investigation the registered manager concluded the high use of agency nurses had contributed to the lack of consistent care.

On this inspection we followed through the care of 16 people living at St Nicholas and found, in most cases, clinical risk was being managed well. This was in relation to clinical care needs such as, wound care and management of complex health care needs. We found this was not wholly consistent and there were some examples, particularly when there was a high use of agency nurse's, when people's clinical care was not being consistently managed.

For example, on Langton unit one person was exhibiting low level challenging behaviour, including aggression, when care staff were carrying out personal care. Assessment and care records lacked detail and lack of instruction for staff to support the person. None of staff on this unit had had training in challenging behaviour and thorough guidance in the care records was therefore very important to support staff how to approach care. There were no monitoring charts to assess and evaluate the incidents of challenging behaviour. We spoke with the nurse in charge of the unit on the day of our visit who told us they would implement better assessment and monitoring. We were advised there was a care review planned for this person with input from external health care professionals

On Huskinson unit we reviewed a person with multiple health care needs. Most clinical care was being assessed and monitored appropriately. However we saw a weight loss of 2.8 Kg from 3 September to 9 October 2017. An evaluation on 9 October 2017 stated to 'commence weekly weights and a diet chart'. The person's care plan had not been updated to reflect this information and their weight had not been monitored or recorded. We spoke with a staff member who told us the person was getting regular fortified drinks but this was not recorded. Staff were unaware whether the person was at continued risk though further weight loss. We highlighted this with the nurse in charge.

In another example, also on Huskinson unit, we saw a person mobilising holding onto the unit tea trolley; they appeared very unsteady and at risk. Staff did not respond to support the person. Care records and assessments indicated two staff were to assist with all mobilisation. The accompanying 'falls diary' showed the person had seven falls since April 2017, one of which resulted in a serious injury. A senior carer interviewed stated that the person should not be using the trolley as this was dangerous and did not meet their care needs or provide adequate support. There had been an assessment for walking frame by a physiotherapist and this had concluded the person was not suitable for using mobility equipment due their mental impairment. The lack of support and on-going assessment was a concern. Following our feedback the registered manager referred the person for a further review.

This is a breach of Regulation 12 (1) (2) (g) of the Health and Social care Act 2008 in respect of failure to

assess, follow up and monitor clinical care.

With most of the people we reviewed we found staff liaised with external health and social care professionals at the appropriate time to optimise people's health. This included GPs, speech and language therapy team (SALT), dietician and a community matron. We saw people's medical conditions were clearly recorded and staff followed specific care and treatment plans to support these conditions. We viewed the care records for a person who had a tube for enteral feeding. Enteral feeding refers to the delivery of a nutritionally balanced feed via a percutaneous endoscopic gastrostomy tube (PEG). The PEG is passed into a patient's stomach to provide a means of feeding when their oral intake is not adequate. Staff were providing care which met the person's nutritional needs and also the care required for the PEG site/line. Care records seen recorded the enteral feeds and also care of the PEG site/line.

We viewed documentation around pressure ulcer care and records seen recorded the treatment plan for a person who had a pressure ulcer. The wound assessment and plan of care were current and improvement of the skin area was recorded.

We reviewed a number of care monitoring charts, these were for areas such as, repositioning people being nursed in bed and fluids and diet charts. We saw these were updated during the day and these charts helped to provide a good evaluation of the care provided. Staff interviewed told us the about the importance of these charts and how they would report any concerns, for example, if a person had not eaten their lunch or was not drinking well, to the person in charge of the unit.

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

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

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

In another example we saw a person had supporting documentation in their care notes around a relative having a lasting Power of Attorney (LPA) to show they could make decisions for the person. Overall there was clear evidence that families were consulted with regarding any best interest decisions.

One key decision that was not covered in the preadmission documentation / assessments was the decision to be admitted to the home. We discussed this in relation to further development of current assessments.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found this was being monitored well. For example, we saw documentation where people on authorisations were being regularly reviewed; there were dates recorded when the authorisation was up for review.

People we spoke with at the inspection told us they felt staff had the knowledge and skills to support them with their care. Training included shadowing more experienced staff and completion of a probationary period which covered six months. We saw a copy of the induction package for staff which included a four day classroom based induction. The induction was quite comprehensive, based around current skills for care standards. Each aspect of the programme was clearly signed by both the staff member and the trainer. The registered manager informed us that the standards implicit in the 'Care Certificate' [governments recommended blue print for induction standards] were embedded in the induction package.

Staff commented positively on the training provided and told us they were reminded when training updates were due. One staff commented, "Training is fine – we are always getting updates."

Most training updates showed a high compliance level; for example MCA/DOLs 100%, Pressure Care 100% and Medication Management 83%) suggesting that most staff had completed required training/refresher training. Some areas, however, showed a low compliance percentage, for example: 50% compliance with food hygiene, 60% compliance with bed rails assessments, 61% compliance with moving and handling and 45% compliance with safeguarding updates. The registered manager informed us that the training issues were being addressed. Staff who required training had been given the training documents but still needed to be assessed by the senior carers. Until this had been completed the registered manager was unable to record that training had been completed. It was also noted that the overall training compliance level had increased from 80%-86% from October 2016 suggesting that training had been completed by staff.

Unit managers we spoke with told us there had been a change in culture and the need to encourage unit managers' skills had been better supported; one unit manager told us, "I feel we are finally being recognised and being given more support and responsibility." These comments were also made on our last inspection. Other staff did not always feel as well supported. We spoke with some care staff who felt they had not been listened to with regards to recent changes to working patterns involving rotation on to nights. One staff commented, "The manager is very person centred when it comes to the residents but is not always like that with staff."

Care staff were also encouraged to gain qualifications in care such as, QCF (Qualifications and Certificates Framework). At the last inspection in March 2017 45% of care staff had completed their NVQ / Diploma in level 2, 3 or 4. On this inspection the figure had improved to 56.8%. The manager recognised the need to further improve this figure in the future as it provides good evidence of staff having a sound knowledge base for care.

We observed meal times on all of the units. On Huskinson Unit, we observed meals served to some people, eaten at side tables in the lounge wherever they were sitting. People told us "Meals are quite good actually. I've had tea and toast for breakfast and that's what I like," "It's good enough, yes. I don't see the point of getting excited about food, really," "The meals are good, yes" and "Normally, yes, I like the food." A relative commented, "I think the meals here are lovely. [Person] is still losing weight, but staff are reinforcing their food to try to get it back up."

The dining area was brightly lit, clean and attractive. Tables were laid in readiness with cloths, mats and

cutlery; the day's menu was available on tables, with all meals for the day printed out clearly. Lunch was served at places of people's own choice, so a number of people ate at tables brought to their armchairs or in their own rooms. Food served looked appetising and when we sampled part of the main course it was hot and well-flavoured; the pudding offered was fruit cocktail and ice cream, which seemed an appropriate course to follow the two hot first and main courses. Drinks were offered just before food was served, with choices of hot or cold drinks.

A unit hostess (staff allocated to assist with meals) explained they had received and continued to receive all staff training and role-specific training such as, nutrition training. They told us they were responsible for providing and overseeing all snacks and drinks offered through the day on the unit. For people on specialised diets, there was a food diary in which food intake throughout the day was recorded, in collaboration with the carers.

We were only able to view one of the units for people living with dementia. At our last inspection we saw there had been a series of audits carried out by the Admiral Nurse [nurse specialising in dementia care] employed by the provider. The audits were very detailed and covered both the experience of people with dementia, the environment they were living in and the dining room experience. The audits had made some specific recommendations such as, 'No resources available within communal areas for residents to engage or interact with' and the need to develop bathrooms so they are less clinical. On this inspection we saw that no improvements had been made with respect to these recommendations. The Admiral Nurse had revisited but had not completed another environmental audit.

The doors to people's rooms were painted in the same colour, with only the number visible plus a very small name plate, which was high up and hard to notice. Other than the few memory boxes that were located next to people's rooms, there was little to distinguish one person's room from another's and to inform the people living at the home that the room they were going into was theirs. Only one person was able to tell us their room number when asked. There was little if any signage in the lounge/dining space or on any corridor that would help people living on Huskisson Unit to establish where they were or how to find the way, or to be stimulated mentally by such engagement with their surroundings.

Requires Improvement

Is the service caring?

Our findings

Prior to our inspection we had received some concerns regarding lack of attention to people's personal care. These concerns had been substantiated following investigations by the local authority safeguarding team and by the registered manager's own investigations. The concerns raised issues around people not having baths / showers and being found by relatives in an unclean state with stained and soiled clothing displaying a lack of attention to upholding people's dignity. One of these investigations linked the lack of personal care to lack of staff at the time.

During our inspection we observed most people's personal care to be appropriate with examples of good attention by staff. There were no examples of poor personal care observed on the two general nursing units. We found inconsistencies however.

On Huskinson Unit we saw there was a reduction of staff one of the days of the inspection. This compromised staff who were observed to be under some pressure to attend to people during the morning. We saw that one person received no attention for their personal care for a long period [0715 – 1200]. We observed the person at 11.45am and found a strong smell of urine in the room with the person in a dishevelled condition. The person was not 'at risk' clinically but their dignity was compromised by delayed input from staff.

We spoke with a visiting health care professional during the inspection. They reported a recent incident on Gladstone Unit [also for people living with dementia] which had been reported and investigated by the local authority safeguarding team. This involved reviewing a person whose was described as being "Very unkempt and had food down [their] top. [Their] hair wasn't brushed, and they had dirty nails. [They] didn't look cared for." The person had also been incontinent and had not been attended to. The health care professional was concerned that the person had been left in this condition for an extended period of time.

On the nursing units we received some comments from people which also reflected an inconsistency of attention to people's personal care needs. One person told us they had to wait for long periods to go to the toilet; "If you want to go to the toilet desperately they're already busy with somebody else." A visitor said, "It's hit and miss, it depends. [Person] is doubly incontinent; a few times we've come to visit and [person's] pad is soiled or sodden. They could check [person] more often." Another visitor echoed this, "Sometimes [person] has to wait for attention; sometimes [person] is left in faeces for a long time. It's mainly weekend when there's less staff on."

On one occasion we saw a person on Canada Unit eating with their fingers. We pointed this out to the staff but there appeared to be an acceptance of this with staff. There was a lack of any consideration for assessment for eating aids that may have helped the person.

This is a breach of Regulation 10 (1) of the Health and Social care Act 2008 in respect of lack of consistent standards of care respecting people's dignity.

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

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. We saw staff offering people choices such as was they would like to sit in the lounge, what they would like to eat and drink at lunch and encouragement to take part in social activities.

We saw that advocates such as, family members, were involved (where appropriate) with the care reviews, as part of evidencing their inclusion in the plan of care. During a visit to the Langton Unit it was noted that there was an information pack attached to the notice board that explained what advocacy was, who was entitled to advocacy support and who to contact if staff/relatives felt it was required. Whilst there were no people currently with advocacy support on this unit, the information was available for staff and relatives should this support be required.

Requires Improvement

Is the service responsive?

Our findings

We looked at the type of activities people were engaged in. We found these to be inconsistent and in need of further planning to provide stimulation for people.

On Huskinson Unit the seating in the lounge/dining space was grouped in areas that could potentially stimulate and support positive interaction and communication between people. We saw the allocated member of the activities staff interacting with people throughout the day, mostly giving personalised attention by engaging people in a preferred activity such as, painting a picture and giving a 'manicure' but also by providing support during key times such as, the lunch period.

We were told that activities were planned according to information given by people and/or their family members when entering the unit. Activities were provided at a personalised level, recorded after provision and reviewed along with all other care plan reviews; we saw relevant entries made in one person's file. The activities coordinator told us that group activities were "Not always possible, because people may not be in the mood," hence the decision to provide one-to-one attention. We were told staff sometimes took a few people to other units, for bingo, arts and crafts, and music afternoons.

Memory / 'this is me' boxes were available alongside the door of each person's room. These were mostly unused but we were told that staff would be completing one a week until all held personal items which were important for each person. A TV screen showed a family film during the morning, which people did not watch. A CD player was used in the dining area, but again people were not listening to the music being played. We did not hear the staff discussing with people whether they wanted the film or music.

We carried out a SOFI observation on this unit over a 45 minute period; out of the five people involved in the observation there was no staff interaction for three of the people observed over this time. Other than the engagement and interaction provided by the activities coordinator to individual people, there was little staff interaction with people living on Huskisson Unit, other than task-oriented, such as welfare/support questions. We saw staff members occasionally sitting with people and having a short conversation with one or two; these were in general more 'vocal' people, who were able to be more demanding of staff attention. There was almost no interaction between people who were less vocal and few opportunities offered for this by staff. Almost all of the people sat very quietly throughout the day, several in the same place for the whole of the day, with little to occupy or stimulate them.

On the nursing units we fund little in the way of activities for people on the days of our inspection. One person said "I go out, there are no activities, but there used to be." Other people commented, "I watch the telly and sometimes I read. We have bingo and quizzes now and again, that's about all," "There's not a lot to do; some bingo, I just sit in my bedroom and read and watch television" and "Just sitting here watching the telly." Visitors commented, "The activity coordinator tries to involve [person] in the activities" and "[Person] sits in the big chair and chats with other residents. There are some games, chess, draughts and bingo." Another visitor said nothing had changed since the last inspection. Their comment was there was 'nothing for the residents to do."

We looked to see how people were involved with their plan of care and how relatives were included in this process. We saw evidence of people's inclusion in their care planning and this was better evidenced than on previous inspections. For example, we saw that many of the assessments included reference to peoples direct input, including relatives where appropriate. We also saw examples of care reviews carried out which included people's input. Relatives we spoke with said staff communicated with them and updated them with any changing care needs. Overall, people felt they had input onto their care planning. One person told us their care gets reviewed, "Yes, a couple of times a year." Relatives commented, "Yes, it's reviewed [care plan] every 12 months" and "It's been reviewed once" (in 6 months).

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

Daily clinical notes were made for every person and these were noted to be written in a positive way and include essential information. For example 'spent a sociable day', 'nurse call within reach', 'assisted with all personal care', 'has eaten all meals'. It was noted that daily entries were written after lunch and again after tea; we questioned whether this was always necessary and appeared to add to the workload of the staff, taking them away from the direct care of people.

Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily handovers between staff and through viewing people's care files. Staff also told us how they completed care records, for example, people's food and fluid intake. They told us the importance of these records for monitoring people's health and welfare. We looked at a sample of these records and they were kept up to date by the care staff.

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

We saw examples of complaints made. Each complaint was recorded, and if required a safeguarding referral was made. All written complaints were managed quickly and effectively with a written response sent from the home within 21 days.

We reviewed one recent complaint regarding a person's level of personal care. There had been a thorough investigation by the registered manager and a response made. During the inspection we received a complaint form a relative regarding the provision of meals for a person in the home. The manager responded to this complaint and copied us into the reply [previously agreed with the complainant]. We saw this was a detailed reply and was within the time scales of the complaints' procedure.

Requires Improvement

Is the service well-led?

Our findings

St Nicholas Nursing Home has had a fluctuating history of compliance with meeting essential standards of care since 2014. On only one previous inspection out of eight inspections since that date has the service not been in breach of regulations; this was the case at the last inspection in March 2017. As part of our feedback to the home manager at that time we had discussed the on-going development of the service. They felt at that time there was now a solid base for continued improvement. They realised that at that time the home was less than half full and the test of the overall management and governance arrangements would be to meet standards when the home was at increased capacity in terms of future admissions. Although improvements had been made we had not rated this key question as 'good' as we needed evidence of longer term consistency of the effectiveness of governance arrangements at St Nicholas.

On this inspection we found the home has not met regulatory requirements with respect to sufficiency of staffing, consistency of personal care, ensuring people's dignity, and ensuring all people living at St Nicholas's were having effective outcomes for their care needs. This raised questions around the on-going effectiveness of the governance arrangements for the home.

We found established and well developed systems of management in many areas. Being a large national provider BUPA ensured there were systems in place to monitor the running of the home. The home had an on-going Home Improvement Plan (HIP) which has been regularly updated and sent to us (Care Quality Commission) when we requested. The HIP concentrated on the previous key areas for development such as medicines management, care planning and provision of activities and had planned management interventions for all of these. We found, however, that in all of these areas the home had not met regulatory standards; albeit we assessed the risk level as decreased from previous inspections. The management of the home had not sustained care standards.

For example, staffing was, overall, more settled than two years ago but the high use of agency nursing staff continues and is similar to 2015. This raised risk factors, both clinically and in terms of leadership on the units; evidence by findings on the inspection. The HIP had included reference to measures such as 'sickness and absence to be robustly managed' and 'rotas to be managed effectively' and 'nurse recruitment will continue'; these had been implemented but had not, as yet proved overall effective in meeting requirements.

In addition some key audits carried out previously had not been continued or had not been followed up on. For example, the service had previously sent out questionnaires to people living at the home and their relatives to get feedback; none of these had been sent out in the last year. The reasons for this were given as the forthcoming change of ownership of the home. This did not support the home's Statement of Purpose [SOP] which was clear around the culture and values of the home including, 'involvement of service users' at all levels'. The 'quality model' highlighted in the document included the 'resident' at the centre. The registered manager had organised alternative ways of getting feedback and had chaired a number of relative meetings but the, potentially important, feedback from surveys could not be a source of information for the registered manager. Following the inspection we were advised by the registered manager that

surveys have subsequently been sent to people.

In another example the audit conducted by BUPA's professional advisor for dementia care prior to our previous inspection in March 2017, had not been followed through with respect to recommendations made.

This is a breach of Regulation 17 (1) (2) (a) of the Health and Social care Act 2008 in respect of lack of consistent standards of care respecting people's dignity.

Following our feedback to the registered manager and other senior managers for the provider we received an urgent action plan to reduce the risk on one of the units and with respect to risk around agency staff usage and medication management.

The service had a registered manager in post who had started at St Nicholas' in December 2016. 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. The registered manager told us some key aims for the home which included further embedding management systems by, for example, giving unit managers more accountability and support so they 'owned' a larger stake in the running of the home. This approach was supported by comments from unit managers who felt this was positive.
The registered manager had also identified nurse recruitment as an on-going concern and could see how this related to failings in some areas such as medication management. The registered manager felt there had been recent improvement with new nurses recruited and this would improve consistency of care.

People we spoke with said they knew the registered manager. One person said "Yes, [registered manager's] been and spoken to us. When he's around he'll come and have a chat to everybody." Others commented, "Yes, I've been over to chat to him," "Yes, he pops in now and again and we go and see him," "I know him by sight. I've seen him a couple of times" and "Yes I know who he is. He doesn't come over very often, but he will ask us now and again."

Staff we spoke with were overall positive in their comments about the registered manager and cited a consistent approach as an important factor. Some care staff felt the registered manager could be more approachable. Senior staff, including unit managers, were positive in their comments about the current management style. Staff told us they were aware of the whistleblowing policy and would feel confident to use it; this has been evidenced in the past. This also helped to promote an open culture in the home. The Commission [CQC] had received whistle-blower concerns since the last inspection and these were around staffing issues. The registered manager had responded to these concerns at the time and had reviewed staffing.

We reviewed some of the 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. The systems, processes and audits had been developed to capture as full picture of the home as possible. Staff had a good knowledge of the current auditing systems and how these fed into the overall analysis of how the home was operating. Findings from the audits and clinical risk reviews were discussed at clinical risk meetings with the heads of each unit.

The key management tool used to monitor the service was the 'Quality Metrics' report reflected in the company's '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 low incidents currently), nutrition (including

people weight loss), medication errors, safeguarding referrals, deprivation of liberty referrals, infection rates, care plan auditing and accidents and incidents.

There was a clinical indicator board in the registered manager's office. This provided an anonymised over view of people's clinical care and dependencies based on the audits and staff's professional judgement. The registered manager told us this was a valuable tool which provided an accurate overview of people's current health and wellbeing and was a valuable aid to ensuring people received safe, effective care as continued monitoring was made easier.

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

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect We found inconsistent standards and examples evident where people's dignity was clearly compromised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found that people were not protected against the risks associated with medicines because the provider's arrangements to manage medicines were consistently followed. There were inconsistencies in assessing some people's health care needs and delivering effective outcomes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not met regulatory requirements in key areas of care and treatment. There was a continued lack of consistency which raises questions around the on-going effectiveness of the governance arrangements for the home. Some of the systems to get feedback from people so that the service could be developed with respect to their needs and wishes had not been scheduled. There were examples of some audits not being actioned.

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