ADR 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?	**Inadequate**

Summary of findings

Overall summary

St Nicholas Care 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.

St Nicholas Care Home is registered to accommodate a maximum of 39 people, some of whom may be living with dementia. There were 12 people using the service when we inspected. The care home is one large adapted building, with bedrooms arranged over two floors and a number of communal areas.

We inspected on 5 and 6 February 2018 and the first day of our inspection was unannounced.

A new manager had been appointed at the service in November 2017 and was in the process of becoming registered with CQC. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 (HSCA) 2008 and associated Regulations about how the service is run.

During this inspection, we found that the provider was in breach of seven regulations. You can see what action we told the provider to take at the back of the full version of this report.

The provider had failed to comply with a number of the regulations as required under the HSCA 2008 (Regulated Activities) Regulations 2014. In addition, the provider had consistently failed to sustain improvements where breaches of regulations had been identified during previous inspections.

We found that sufficient improvements had been made with regard to the safe storage, administration and management of medicines. However, there were still shortfalls in other areas relating to people's safety, which meant the provider was still in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems to monitor the service were not accurate or effective, which meant the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people lacked the mental capacity to make a specific decision, the provider had not made sufficient improvements to act in accordance with the requirements of the Mental Capacity Act 2005. Therefore the provider was still in breach regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were still required in respect of providing person-centred care and records relating to people's care were still not consistently written in a person-centred way. Therefore the provider was still in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that that people's dignity was not consistently ensured and people were not always treated with respect. The provider was found to be in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional and hydration needs of people were not always being met. The provider was found to be in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Individual risks to people were identified but risks assessments were not always in place for known risks or, those that were in place, did not always contain sufficient detail about how to manage the risk. Risks within the environment were also not always managed and mitigated.

The provider had a business continuity plan which detailed what should be done in an adverse event such as loss of utilities or fire. People living in the home also had personal emergency evacuation plans in place.

There were mixed feelings regarding staffing levels, particularly around mealtimes, and staff were not always deployed appropriately.

Some staff training updates were overdue, although the manager took action, when prompted, to ensure the required updates were arranged for staff to complete. The service did not always follow robust recruitment procedures to ensure only staff suitable to work in care were employed.

Some aspects of the home were not always clean and staff did not always wear the correct personal protective clothing when attending to people's personal care and hygiene needs.

Assessments of people's needs took place before they moved into the home. Assessments did not all contain sufficient detail and some sections of the assessment form had not been completed.

Accidents and incidents were recorded appropriately and records showed what action was taken immediately after the accident or incident. Appropriate and timely referrals were made to relevant healthcare professionals and these professionals were involved in people's care where necessary. People's preferences regarding the care they wanted at the end of their life were documented in their care records.

Staff missed opportunities to speak and interact with people because their approach was more task led than person-centred. People were not always spoken to according to their needs and staff did not always treat people in an empathic way.

People's relatives were welcome and there were no restrictions on when they could visit the home. People were able to maintain relationships that were important to them and were supported to avoid isolation. People were also able to follow their individual interests, hobbies and activities.

There were regular meetings for people who lived in the home, which provided opportunities to have a say about how the service was run and offer feedback to the manager and staff. Staff meetings were also held regularly. These gave staff the chance to put forward any suggestions about what they could do to improve the service and discuss what processes were not working so well. There was a complaints policy in place and complaints were investigated and dealt with in a timely manner.

Staff, people using the service and their relatives told us that the manager was motivated, caring and visible. We acknowledged that the manager had made improvements in areas such as medicines and there was some work-in-progress in other areas such as care plans. However, we concluded that the manager was not

receiving sufficient oversight and support from the provider, to enable them to complete and sustain all the improvement actions required. This was shown by the continued breaches identified during this inspection.

At this inspection we found there had been insufficient improvements made and some improvements had not been sustained. This resulted in the service being rated inadequate in well-led.

The overall rating for this service is 'Requires improvement'. Therefore the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Individual risks to people were identified but risk assessments were not always in place or did not always contain sufficient detail about how to manage the risk. Risks within the environment were also not always managed and mitigated.

There were mixed feelings regarding staffing levels and staff were not always deployed appropriately. Robust recruitment procedures were not always followed to ensure prospective staff were suitable to work in the home.

People using the service were not always helped to stay safe and well because the service did not consistently follow effective procedures for the prevention and control of infection.

Staff knew how to recognise signs of possible abuse and were confident in the reporting procedure.

People's medicines were stored and managed safely and administered as the prescriber intended.

Is the service effective?

Requires Improvement

The service was not always effective.

The service did not operate within the principles of the Mental Capacity Act 2005. People's capacity was not assessed and decisions made in people's best interests were not documented.

People were not always supported to have sufficient amounts to eat and drink in the home, or to maintain a balanced diet.

People's needs and choices were not always assessed in a way that ensured each person had their individual holistic needs met effectively.

Some staff training needed updating and systems did not clearly identify which staff had shortfalls in their training.

The premises were not completely safe and the overall

environment lacked a homely and comfortable feel to it. People could choose whether they wished to spend their time in the communal areas or a quiet area alone or with visitors.

The service worked alongside other professionals from community healthcare teams to share information about people's healthcare needs.
Appropriate and timely referrals were also made to relevant healthcare professionals where necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity and privacy was not consistently ensured and people were not always treated with empathy or respect.

People were not always able to make choices about their care and were not consistently encouraged and supported to be as independent as possible.

People were supported to maintain relationships with their friends and families and visitors were welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care provided was not always centred on each person as an individual. Records relating to people's care did not give staff sufficient information about people's individual care and support needs.

People were able to maintain relationships that were important to them and were supported to avoid isolation. People were also able to follow their individual interests, hobbies and activities.

There was a complaints policy in place and complaints were investigated and dealt with in a timely manner.

People's end of life wishes and preferences were recorded in their care records.

Is the service well-led?

Inadequate

The service was not well-led.

The service did not have a registered manager in post, although

a new manager had been appointed in November 2017 and was in the process of becoming registered with the Care Quality Commission.

Systems to monitor the quality of the service were not accurate or effective. Action to address any identified issues was not always completed in a timely fashion.

There was insufficient oversight from the provider to ensure all the required improvement actions were completed and sustained.

The service did not consistently promote a positive culture that was person-centred, open, inclusive and empowering.

Regular meetings were held for people who lived in the home and staff, which provided opportunities to have a say about how the service was run.

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.

Following our last inspection on 19 June 2017, we asked the provider to complete an action plan. This was to show what they would do and by when to improve the care provided in the home under the key questions for safe, effective, caring, responsive and well-led. We carried out this inspection to ensure the improvements had been made as required and they had not.

Our inspection was carried out over two days on 5 and 6 February 2018. The first day of our inspection was unannounced and undertaken by an inspector and a member of the Care Quality Commission's medicines management team. The second day was announced and carried out by two inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at all the information we held about the service. This included information about incidents happening within the service and which the provider or registered manager must tell us about by law. In addition, we reviewed information supplied to us from the local authority's quality assurance team and safeguarding team.

During our inspection visit, we observed how people were being supported and how staff interacted with them. We met and spoke with six people living in the home and five relatives. We also spoke with the manager and three members of care and support staff, including a nurse and a senior member of care staff.

We looked at assessments and plans of care for six people and checked how they were supported. We reviewed records associated with the employment of three staff, minutes of meetings and staff training records. We also looked at the arrangements for storing, administering and auditing medicines and a sample of other records associated with the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 19 June 2017, we found a number of concerns relating to the safe administration and management of people's medicines. These finding constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan detailing the actions they would take to meet the regulation and said that these actions would be complete by 30 October 2017. We found during this inspection, that they had improved the management of people's medicines. However, we had concerns relating to other aspects of the safety of people and the premises. Therefore the provider was still in breach of this regulation.

Risk assessments were not always in place for known risks which were referred to in people's care plans. Risk assessments that were in place, did not always contain sufficient detail about how staff needed to manage the risk. For example, we saw from one person's care plan that they could exhibit behaviour that challenged. However, there was no risk assessment to explain what staff could do to mitigate this risk or what situations could increase the risk. In addition, staff did not always follow guidance that was contained in people's risk assessments. For example, we noted that one person had a catheter and the risk assessment for this stated that they should be supported to empty this regularly. We saw from the persons' care records that the staff should encourage the person to drink plenty of fluids but there was nothing to show how much fluid staff should be encouraging.

Risks within the environment were not always managed and mitigated. We saw from the monthly water temperature checks, that seven accessible water outlets, including sinks in people's rooms, were discharging water that was above the recommended 44 degrees centigrade. We saw that the hot water temperature in one person's room was recorded as 49 degrees centigrade and 48 degrees centigrade for two other accessible water outlets within the home. Guidance published by The Health and Safety Executive states that where there is an increased risk of scalding, for example in care services, hot water from accessible outlets should not exceed 44 degrees centigrade. There were no formal health and safety audits in place and an audit carried out by the provider in January 2018 failed to identify the scalding risk posed by the hot water.

There were some risks to people associated with systems for controlling and containing infection. For example, we noted that the bed bumper on one person's bed was very worn and torn and was stained and dirty with food and drink debris. We raised this with the manager who immediately changed the bed bumper. However, this was replaced with one that looked worn. We saw that, when staff attended to people's personal hygiene, they did not always wear the correct personal protective attire. For example, we saw that staff were not wearing disposable aprons when supporting a person with their personal hygiene.

These findings constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for safe care and treatment.

We received conflicting views regarding staffing levels. One person's relative told us that they did not feel that there were always enough staff to meet people's needs safely. They told us that sometimes staff's time

would be taken up attending to people who showed behaviour that challenged. This then meant that some people had to wait for staff assistance. Another person's relative said, "Generally there seem to be enough staff, although I think they could do with a few more to help out at mealtimes."

One person living in the home told us, "They could do with a few more [staff] I think. Some people seem to have their fingers stuck on the buzzer, which means they [staff] can take a while to get to you." Another person said, "They [staff] are always around if I need anything and they keep a good watch over us. Yes, I'd say there's enough."

The staff members we spoke with all told us that they felt there were enough staff most of the time but that extra staff would be beneficial at certain times of the day.

The manager told us that they regularly assessed people's care and support needs and we saw from people's care records that their dependency was assessed on a monthly basis. The manager told us that they would increase the number of staff if people's care needs changed. Due to the size of the home and the amount of support that people required, we could not be assured that there were sufficient numbers of staff to support people in a safe way.

We looked at the recruitment records for three members of staff. We saw that there was an incomplete employment history for one member of staff. We also saw that a reference provided for one member of staff was provided by the manager of St Nicholas Care Home. They had been listed as a personal friend of the employee. We could not be assured that objective recruitment of staff was always maintained. The other staff records we looked at showed that appropriate references had been sought and that background checks with the Disclosure and Barring Service had been obtained for all three members of staff.

A member of the Care Quality Commission's (CQC) medicines team looked at how the service managed people's medicines and how information in medication records and care notes supported the safe handling of their medicines.

People we spoke with told us they received their medicines on time and when they needed them. One person told us, "The nurse gives me my tablets and she's always very thorough." Another person said, "Yes, I always have my medication when I should, they [staff] are very good at that." A third person said, "They [staff] look after all the medical side of things, which suits me just fine; I don't have to worry about remembering or forgetting."

Staff who handled and gave people their medicines had received training and had their competence assessed regularly to ensure they managed their medicines safely. Medicines were being stored safely for the protection of people who used the service and at the correct temperatures. Records showed that people were receiving their medicines as prescribed. There were internal audits in place to enable staff to monitor and account for medicines and a monthly audit carried out by the manager. A system was in place to report errors if identified so that necessary actions were taken.

Staff handling people's medicines had supporting information available to them to enable them to give people their medicines appropriately and consistently. There was personal identification and information about known allergies/medicine sensitivities and written information on people's preferences about having their medicines given to them. Additional charts were in place to record the application and removal of prescribed skin patches and these had been completed by staff. There were care plans in place about people's medicines. When people were prescribed medicines on a when required basis, written information was available for all of these medicines to show staff how and when to give people them. When people

managed some of their medicines themselves there were risk assessments in place about this.

During our inspection and, as a result of feedback given to the manager, we saw that the manager had detailed people's preferred way of taking their medicines. This also included what drink they liked to take their medicines with. These details were then placed with people's medicine charts.

People we spoke with told us they felt safe living in the home. One person said, "I feel perfectly safe; that's why I chose to move here. I lived on my own before but couldn't really manage anymore." Another person told us, "Oh yes, they [staff] do their best to help me stay safe."

The relatives of two people also told us they felt their family member was safe in the home. One relative told us, "I don't have any worries about [family member]'s safety here, all the staff seem to keep a good watch on the people here." Another relative said, "They [manager and staff] always let me know if there's any problem or if they are concerned, so I feel happy that [family member] is safe."

We saw from training records that most members of staff had received training in safeguarding. When we pointed out to the manager that one member of staff had not attended their update training in this, they took action to ensure that the member of staff was booked on an online course so they could update their training in safeguarding.

One member of staff said, "I know the procedure we have to follow if we need to report any concerns. I would normally go to [manager] but if I couldn't do that I would report directly to safeguarding or CQC." Two other members of staff confirmed their understanding of what constituted abuse and said they would have no hesitation reporting anything that concerned them.

We saw that an annual check of the water systems stated that there was no legionella bacteria present. We saw that unused water outlets were flushed regularly too, this helped to prevent legionella bacteria from forming. Other utilities such as gas and electrical appliances were tested yearly and regular testing of fire-fighting equipment was carried out. Mobility aids such as hoists were inspected at regular intervals. There were a number of risk assessments for the home which detailed what steps needed to be taken to manage known risks within the environment.

The provider had a business continuity plan which detailed what should be done in an adverse event such as loss of utilities or fire. We saw from people's care records that there were personal emergency evacuation plans in place. These plans guided staff what support people would need in the event of a fire.

One person's relative we spoke with told us they overall they thought the cleanliness of the home was good, but there were some parts that could do with a "Good scrub." A person living in the home said, "Yes I think they [staff] do alright keeping this place clean, especially for the size of it."

Accidents and incidents were recorded. We looked at some of the accident reports and saw that these were detailed and showed what action was taken immediately after the accident. This included observing people at regular intervals to ensure their safety. The manager told us that they completed a weekly report and this was sent to the provider. Details of any accidents and incidents were recorded on the weekly report. This enabled the provider to identify any patterns or trends and take any necessary remedial action.

Requires Improvement

Is the service effective?

Our findings

We found during our last inspection, that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation is called 'need for consent'. This was because where people lacked the mental capacity to make a specific decision, the provider had not acted in accordance with the requirements of the Mental Capacity Act 2005. We found during this inspection, that sufficient improvements had not been made and the provider was still in breach of this regulation.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The information in people's care records regarding their capacity to make decisions was limited. It did not detail whether people's capacity fluctuated. It did now show what specific decisions people could and could not make for themselves. There was nothing in people's care records to guide staff about making best interests decisions for people who may lack capacity to make decisions. .

We saw for two people, a DoLS application had been submitted to the relevant authorising body. However, we found no evidence that the principles of the MCA had been followed before submitting the application to deprive the person of their liberty. We saw for one of the people that a DoLS had been applied for before they started living in the home. The DoLS application stated that the person's family had informed staff at the service that their relative did not have capacity. There were no further details about what steps had been taken before judging that the person was being deprived of their liberty. The absence of MCA assessments and best interests decisions where necessary meant that we could not be assured that actions taken were in people's best interests and the least restrictive method was being used to ensure their safety.

During our last inspection in June 2017, we saw that two people were potentially restrained in their seats. We observed during this inspection, that this practice continued. We saw that one person was sitting in a tilted chair in a communal area for most of the first day of our inspection. Another person was sitting in a chair with a table placed in front of them and their walking frame was out of their reach. There was nothing in either person's care records to show that the principles of the MCA had been applied and other, least restrictive options had been considered, for example, placing the table to the side of the person.

These findings meant that the provider was still in breach of Regulation 11 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

At a previous inspection in February 2017, we found that the nutritional and hydration needs of people were not always being met. As a result of this, the service was rated 'requires improvement' in this area and the provider was found to be in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for nutrition and hydration. A further inspection in June 2017, found that improvements had been made and the provider was no longer in breach of this regulation.

However, at this inspection, we found that practice had declined and that people were not always supported to eat enough. Therefore the provider was once again in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that one person had half of their lunchtime meal taken away from them without any encouragement to eat some more. The person's relative told us that they would say that they had finished but would eat some more if staff encouraged them to do so. Mealtimes were rushed and desserts were sometimes served to people before they had finished their main meal. This demonstrated that people were not supported to eat at their own pace. One person's relative told us, "[Family member] had jelly and ice cream yesterday, but the ice cream had melted by the time they'd finished their dinner." Another person's relative told us that they preferred to help their family member at mealtimes. They explained that this was because they did not feel the staff were able to spend the time needed to ensure the person ate all of their food. The relative said, "[Family member] has a really good appetite and will eat a full meal but it does take time. They can't be rushed or they won't eat it."

We observed that people did not always get the food they wanted. One person we spoke with told us, "We get cold desserts like jelly and ice cream; it's not what you want in this cold." We saw from another person's care records that they liked to have finger food with tomato ketchup and to eat this with their hands. We saw on the first day of our inspection that they were served mashed vegetables, potato waffles and sausages. There was no tomato ketchup and the meal was served with a knife and fork. Their meal was placed beside them while they were still sitting in a tilted chair. This would have made it difficult to eat and drink being in this position. There was no support given to help the person eat their meal. It was then taken away from them a few minutes later and a dessert placed on the table.

Some people were at risk of malnutrition and staff monitored their food and fluid intake to ensure that they were eating and drinking enough. However, we saw that staff took people drinks but did not always provide support for people to drink them. For example, we saw that one person had a drink placed beside them three times. Each time staff did this, their previous beaker was still full. The records showed that people were given sufficient amounts of fluids, but due to our observations, we could not be sure that all of the fluids documented on the intake chart had been consumed. The recording of people's intake of food was also not clear. We saw that the amount of food given to people was not clear.

We noted that staff had been advised by a community professional to monitor one person's intake and output of fluid. However, we could not be sure that the person's records relating to this were accurate. This was because the records we looked at showed that the amount of fluid output was sometimes four times the capacity of the catheter bag. The records showed that the person was only being supported to empty their catheter bag twice a day.

There were also inconsistencies regarding the recording of people's weights. We saw from one person's records that they had lost almost two kilograms in 21 days. We queried this with the manager. They told us that they had contacted the GP regarding this and the GP had authorised increasing their protein drinks to

two per day. We also queried why the person's weight had then increased by over one and a half kilograms in the space of 10 days. After the inspection, the manager provided us with different recordings of the person's weights for the dates we looked at during our inspection. These new records showed that the person's weight was still not stable. Due to these findings, we could not be assured that people were being weighed correctly.

These findings constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our inspection, we spent time in the dining room with people, while they had their lunchtime meal. Three people sat together at a table in the dining room, whilst another person sat in a chair with their relative beside them for support. We noted that one of the people only ate a very small amount of their shepherd's pie before pushing it away saying, "I can't eat that, it's stone cold again; it's horrible." When we chatted with people about this, they all stated that the food was never very warm by the time staff served it to them.

Another person told us, "The food is mostly okay, though it's not always very warm, which spoils it a bit." A third person said, "Yes we do get a choice but, to be honest, there's not much I don't like so I'm usually happy with whatever turns up." One person's relative told us, "I have asked if they can warm the plates first but they [staff] say they can't because of health and safety. The plates are freezing cold, so it's no wonder the food doesn't stay warm." We noted that staff did not enquire as to whether there was anything wrong when people did not eat their meals. Staff just took people's plates away and did not offer them an alternative.

From our observations, we concluded that mealtimes were not a pleasurable experience. On one occasion we saw that when two people were served their lunch in the conservatory, there were no staff present to support them and there was a lack of ambience in the room. On the occasion we spent time in the dining room we noted that the table was bare, with the exception of a salt and pepper pot. No effort had been made to create a pleasant dining environment, with things such as place mats and napkins. The three people we saw at the table chose to eat together at the dining table and could have benefited from a better quality environment.

Assessments of people's needs took place before they moved to St Nicholas Care Home. However, we saw that these assessments did not contain sufficient detail and saw that some sections of the assessment form were not completed. For example, we saw that a section relating to one person's sight, hearing and communication was left blank. There was also nothing on the assessment forms to detail what people could do for themselves and what support they required from staff to maintain their independence.

Staff working at the service were expected to complete mandatory training decided by the provider. We saw from staff training records that most staff were up to date with their training. We noted that there was no mandatory training for supporting people with their nutritional needs or for end of life care. When we pointed out to the manager that some staff were out of date with certain courses, they took immediate action and enrolled the staff members on the required training. In addition to the mandatory training, staff could access additional training relevant to their role. This included training in the administration of medicines and management of pressure ulcers.

We saw from staff records that staff received regular supervision. Supervision gives staff the opportunity to discuss their performance and training needs with their manager.

The members of staff we spoke with told us they received appropriate training for the work they did. One

staff member told us, "I've worked in care for years, so I've had lots of training. I find the training is very good here and if I feel we need something extra [manager] will arrange it for us." Another member of staff said, "This is my first care job and I've learned a lot from the training I've done."

New members of staff were expected to complete an induction. This included becoming familiar with people's care needs and how to report accidents and incidents. Records we looked at confirmed that staff received an induction soon after starting their employment at the home.

The service worked alongside other professionals from community healthcare teams to share information about people's healthcare needs. We saw from people's care records that community healthcare professionals had been contacted when a person was being discharged from hospital. This meant that the person could continue to have their care needs met after being discharged.

Appropriate and timely referrals were made to relevant healthcare professionals. We saw from people's care records that other professionals such as the GP, district nurses and occupational therapists were involved in people's care where necessary. Staff knew how to report any concerns relating to people's health or wellbeing and who to contact for advice.

The home is large, with communal areas in various parts of the building. There was little signage to help people orientate around the home. The overall environment lacked a homely and comfortable feel to it. For example, in the large conservatory there were chairs positioned around the edge of the room, with a TV on one side of it. During our inspection we noted that this room was cold and some of the people sitting in it had a blanket over them.

One person's relative commented that they felt décor of the home could do with being updated and that little money had been spent on this. They added that some of the rooms were now being decorated. There was also a large garden, about which we noted that some people and their relatives had given feedback to the manager saying that they would like to see this tidied up. The manager told us that when the weather allowed, they planned to make improvements to the garden and create a nicer space for people to enjoy sitting outside.

Requires Improvement

Is the service caring?

Our findings

At a previous inspection in February 2017, we found that the service did not treat people with dignity and promote their independence. The service was rated 'inadequate' in this area and the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A further inspection in June 2017 found that improvements had been made and the provider was no longer in breach of this regulation. However, at this inspection, we again found that people were not treated with dignity and respect.

During our inspection, we noted that staff missed opportunities to speak and interact with people. Their approach was very task led rather than person-centred. For example, we saw that a member of staff was taking drinks around to people. They just gave people a drink rather than taking the opportunity to engage them in conversation. We observed that staff frequently spoke to each other and people's relatives rather than the people they were caring for. On the first day of our inspection, we saw in the conservatory that one member of staff was speaking with a person who was upset. Another member of staff came in, interrupted the conversation and started arranging their break time with the member of staff comforting the person.

People were not always spoken to according to their needs. We saw from one person's care plan that they understood what was being said to them if staff used short and simple sentences. We saw that staff bombarded this person with a number of questions when offering them a drink. This included, "Do you want a chocolate milkshake?", "Do you want a cup of tea?", "A Milky Way?", "Some chocolate yum yums?" The person was neither given time to comprehend what they were being asked, nor given the time to respond. The staff member returned with the person's drink and made no further efforts to engage with them.

Staff did not always treat people in an empathic way. We saw that one person was becoming distressed and said to a member of staff that they were, "In a muddle." The member of staff said that they were going to get some tissues and would be back to have a chat with them. They came back into the conservatory, did not talk to the person and proceeded to ask people if they would like to watch a war film. They put on what they thought was a channel showing films and walked out. However, the selected channel was a teleshopping channel.

Staff did not do everything practicable to uphold people's dignity and privacy. We saw one person receiving personal care in the conservatory. The staff pulled a screen around them and attended to the person's care needs whilst announcing to the person why they were attending to them. The screen was old and tatty and did not fully maintain the privacy of the person. At this time, there were other people in the conservatory. On the first day of our inspection, we heard one person tell a member of staff that they wanted to go to the toilet. The member of staff replied, "You have a catheter in; unless you want to go for the other one." This exchange happened in front of other people in the conservatory, which demonstrated a total lack of respect for the person and compromised their dignity.

People were not supported to eat their meals in a dignified way. We saw that one person wiped their face on their blanket as a napkin was not provided with their lunchtime meal. Another person's meal was cut up in

front of them and just left beside them. They were not asked if they would like any support with eating their food. People were also not given choices of what they wanted to drink. We saw a member of staff bring a drinks trolley into the conservatory. One person was offered tea or coffee, another person was just offered tea and then a third person was offered no choice at all.

These findings constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst improvements were needed to be made in delivering empathic, person-centred care, we did observe some caring interactions that staff had with people. We saw that one member of staff came on shift and went around to say hello to everyone who was sitting in the conservatory. They engaged people in a conversation about the cold weather and explained the activities that were on offer for them to take part in during the coming week. We saw one person being supported to mobilise and observed that the member of staff was encouraging and patient with the person.

One person living in the home told us, "I'm very happy here and I've got everything I need." Another person said, "They [staff] always treat us very well; they're all very kind." People's relatives told us that the home had been through a lot of staff changes but that the new manager and staff team were kind and caring.

We saw evidence that people were involved in developing their care plans. For example, we saw from one person's care plan that they liked to have a bath. When we spoke with them, they confirmed that they were supported to have a bath.

We saw throughout our inspection that staff were welcoming to people's relatives. Relatives we spoke with told us that there were no restrictions on when they could visit the home and they were able to also spend mealtimes with their family members.

One person's relative told us, "I come every day and staff are always very welcoming and accommodating." A person living in the home told us, "I really look forward to [Relative] coming to see me; it's the highlight of my day."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because records relating to people's care were not written in a person-centred way. We found at this inspection, that improvements were still required and that the provider was still in breach of this regulation.

The manager was in the process of reviewing people's care plans, risk assessments and daily care records relating to their care. We looked at both the recently reviewed care plans and some that had not been reviewed. We found that these were not consistently person-centred. We saw that some people's care plans did not give staff sufficient information about people's individual care and support needs. For example, we saw that two people's care plans for supporting them with their dementia, only listed the symptoms of the illness. The care plans did not provide clear or detailed information explaining how each individual person's health and wellbeing was affected by living with dementia or how staff could best support them.

We looked at daily notes staff recorded. These did not give a detailed account of how people had been throughout the course of a day and they were repetitive. For example, people were often referred to as being 'settled' and we saw two entries on consecutive days for one person, which were almost identical.

Records relating to people's care were not always completed correctly. For example, people's weights were not recorded accurately or consistently, with different weights for the same person being recorded on the same day.

We looked at the 'daily allocation sheets' that the manager had introduced and saw that specific tasks were delegated to the staff who were working that day. These included who was responsible for people's personal care and making people drinks throughout the day. We saw that every two hours there was a reminder on the sheet which stated 'pad checked'. We saw that staff would sign to confirm when they had checked a person's continence pad. We noted that a member of staff had signed to confirm that they had checked two people's continence pads and had stated on the daily record that neither person had required their pad to be changed. We queried this with the manager as we had not seen either of the people attended to in this way. The manager raised this with the member of staff. The member of staff stated that the person was asleep and that they had not checked their pad as originally stated. The manager asked the staff member to amend the record to show that the person was asleep. However, we saw this person being given drinks during the time that they were recorded as being asleep. This meant we could not be assured that people's care needs were accurately recorded or attended to.

Staff did not demonstrate a good understanding of people's care needs. For example, we saw that when one person had asked to go to the toilet, a member of staff did not give them the opportunity to visit the toilet.

We observed that staff did not consistently provide the encouragement and support that one person needed, in order to maintain a healthy nutritional intake. We also saw that another person's preferences around eating their meals were not catered for. In addition, we noted it was stated in this person's care plan

that staff should ensure the person's hands were cleaned before they ate, as they liked to eat with their hands. However, we were observing people in the conservatory and saw that the person was not supported to wash their hands before they were given their food.

These findings meant that the provider was still in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to maintain relationships that were important to them and were supported to avoid isolation. People were also encouraged and supported to follow their individual interests, hobbies and activities. One person we spoke with told us, "Oh no, I don't get bored; I've always got something to do. I'm reading this book at the moment, it's very good. I like reading and having the music on. It's also nice to have a chat now and then." A member of staff told us, "I enjoy talking to people about their lives. I try to do that as much as possible. To me, everybody is like a book; everyone has a different story to tell."

Another person living in the home said, "She [activities coordinator] is a good one, she always asks but never tries to make you do anything if you don't want to." A third person told us, I like to have a wander round and see who's about. I'll be glad when the weather's better, so I can get out in the garden again."

There was a complaints policy in place and we saw that complaints were investigated and dealt with in a timely manner. One person living in the home told us, "I've got no complaints at the moment but I know I can talk to the staff or the manager if there is anything wrong and I'm sure they'd soon put things right." Another person said, "I soon say when I'm not happy about something and they [staff] usually sort it out quite quickly."

One person's relative we spoke with told us that they felt comfortable with raising a complaint. They added that they had complained before and their complaint was dealt with satisfactorily. Another person's relative said, "This new manager is much more approachable and is always willing to listen if I've got any concerns. I'm quite happy with the way things are at the moment and I certainly haven't got anything to complain about."

We saw that people's preferences regarding the end of their life were documented in their care records. We noted that some people had forms in place to show that they did not wish for resuscitation to be attempted in the event of a cardiac arrest. Some people had specified which funeral directors they would like to be contacted and details of these were readily available to staff in people's care records. We noted from the provider's list of mandatory and non-mandatory training that staff were not expected to complete training in supporting people at the end of their life.

Inadequate

Is the service well-led?

Our findings

There have been ongoing concerns regarding the provider's ability to make and sustain improvements at St Nicholas Care Home. At an inspection on 17, 18 and 20 November 2014 we found multiple breaches of the regulations and rated the service 'inadequate' in all key questions. The provider subsequently employed a crisis manager to provide support with making improvements.

On 18 December 2014 we were notified by the crisis manager that they had significant concerns regarding the competency of three of the nursing staff. As a result, we undertook focussed inspections on 19, 21 and 29 December 2014.

On 19 of December we found serious concerns about the safety of people living in the home. This was because sufficient numbers of competent nursing staff were not available. The provider's staff worked with the local authority and North Norfolk clinical commissioning group to ensure that nursing cover would be provider over the coming days.

At our inspection on 21 December 2014 we found that whilst there was nursing cover, this was being secured on a day by day basis which was not sustainable or safe. A decision was taken by commissioners to relocate people with high care needs to other nursing homes where the care was of a safe standard. This action was carried out over 23 and 24 December 2014. CQC carried out urgent enforcement action under Section 31 of the Health and Social Care Act 2008 on Tuesday 23 December 2014. This meant that the providers were not allowed to provide nursing care at the service with immediate effect.

We carried out a further focussed inspection on 29 December 2014, to ensure that the people who remained living in the home were supported by adequate numbers of staff. We were satisfied that people were being supported in a safe way and that their needs were met.

We inspected the service again on 3 February 2015 and found that improvements had been made under the key question of 'safe', 'effective', 'caring' and 'responsive'. We rated the 'well led' key question as 'inadequate'. We issued the provider with a warning notice for Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This set out what improvements the provider was required to make.

At an inspection on 28 May 2015, we found that significant improvements had been made and the service was rated as 'good' in all of the key questions and was no longer in breach of any of the regulations.

We found during an inspection carried out on 30 January 2017 and 1 February 2017 that the improvements had not been sustained and the service was rated as' inadequate'. We found that there were multiple breaches of the regulations and placed the service in special measures.

At our previous inspection on 19 June 2017, we found that the service was not well-led and it was rated 'inadequate' in this area. The provider was again in breach of Regulation 17 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014 and remained in special measures. This was because systems in place to assess and monitor the quality of service being delivered were ineffective.

Since the service registered with the CQC in 2010, there have been six managers-including the current manager- employed. This meant that the provider had not managed to maintain consistent and stable leadership within the home.

At this inspection in February 2018, we found that sufficient improvements had still not been made and the provider remained in breach of this regulation. The provider also remained in breach of Regulations 9, 11 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, we identified breaches of regulations 10 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, the provider had consistently failed to sustain improvements where non-compliance and breaches of regulations had been identified during previous inspections.

At this inspection in February 2018 we found that audits that were in place were ineffective at identifying shortfalls within the service and there was no oversight of this by the provider. For example, the monthly provider's audit had failed to identify the scalding risk posed by a number of hot water outlets. Care plans were not audited and therefore the lack of information around people's mental capacity and recording of best interest decisions had not been addressed. In addition, the staff training matrix was unclear as it did not highlight which staff required updates with their training.

The competency of staff in their role was also not adequately assessed. Whilst the manager told us that they worked alongside staff and observed them in their work on a day to day basis, we saw that staff did not always demonstrate the necessary skills within their role.

Staff were not always adequately deployed to ensure more experienced staff worked with newer staff who may not have had much experience working in this type of service. For example, on the first day of our inspection we saw that all three care staff on duty had limited experience in caring for people who may be living with dementia.

There was a lack of oversight of records kept in relation to people's care and treatment. For example, processes used to monitor people's weights were not robust and produced inconsistent information about people's fluctuations in weight. Food and fluid records were vague and did not provide a clear record of people's nutritional intake. Some of the recording we saw was factually inaccurate. Therefore there were not always complete and accurate records in relation to each person.

Staff recruitment records were not complete and there was no system in place to ensure that employment history and suitable references were obtained before staff started working in the service.

These findings constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of this inspection there was no registered manager in post. The previous manager left in August 2017. A new manager had been appointed at the service in November 2017 and was in the process of becoming registered with CQC.

The manager told us that they received regular supervision with the provider and they were supportive. They went on to say that the provider was supportive with the changes that they were trying to implement within the home.

Staff, people using the service and their relatives told us that the manager was motivated, caring and visible. Staff said they felt respected, supported and valued and that their wellbeing was also promoted. All the staff we spoke with made positive and complimentary comments about the new manager such as, "[Manager] is very supportive and her door is always open." And, "It feels like she's one of us; like we're a team. She doesn't shut herself away in the office; she's always around and helps us on the floor if we need."

Relatives and people living in the home also spoke well of the new manager. One person's relative told us, "I know they've had some problems here over the last couple of years and there have certainly been some changes with the staff but I can see things are improving now; I do hope they keep it up." One person living in the home said, "She's alright this one, we often have a little chat and a bit of a laugh."

The manager told us that they felt fully supported by the provider and that they had been working hard to address the shortfalls identified during our last inspection. We acknowledged the improvements that had been made in areas such as medicines and we also acknowledged some work-in-progress in other areas such as care plans. However, we concluded that the manager was not receiving sufficient oversight and support from the provider, to enable them to complete and sustain all the improvement actions as required. This was evidenced by the continued breaches identified during this inspection.

We saw that there were regular meetings for people who lived in the home. These gave people the opportunity to have a say about how the service was run and offer feedback to the manager and staff. We saw from the meeting minutes that people could put forward ideas about what activities they would like to take part in and make suggestions about the menu.

In addition to these meetings, the manager had recently introduced a quality assurance questionnaire. The manger told us that they planned to give people and their relatives the opportunity to complete this questionnaire every six months. We saw from the results of the questionnaire that the manager had identified themes of what areas of the service needed improvement. This mainly involved tidying the garden and improving the quality of the food. The manager told us that a new cook was due to start working at the home once their pre-employment checks had been completed. This would hopefully help address some of the issues around the food quality.

Staff meetings were also held regularly. We saw from the records of the meetings that any changes to people's care were discussed as well as any changes as to how the service was run. These meetings gave staff the chance to put forward any suggestions about what they could do to improve the service and discuss what processes were not working so well.

Both the manager and the provider worked alongside other services such as community healthcare and the local authority. We saw that the provider and manager were in contact with the local quality assurance team and provided them with regular updates on the service. The manager told us that they had invited a member of the quality assurance team to visit St Nicholas Care Home so they could show them some of the improvements they had made to the service.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA RA Regulations 2014 Person centred care The provider had failed to ensure that the care people received was appropriate, met their needs and reflected their preferences. Regulation 9 (1), (3) (a) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were treated with respect and have their dignity and privacy upheld. Regulation 10 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked the mental capacity to make a specific decision the provider had not acted in accordance with the requirements of the Mental Capacity Act 2005.

Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure accurate and effective assessments of risks to the health and safety of people using the service. The provider had also failed to do all that is reasonably practicable to mitigate any such risks. The provider had failed to mitigate the risk of the spread of infection and ensure effective infection prevention and control. Regulation 12 (1) (2) (a) (b) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure the nutritional and hydration needs of people were consistently met. Regulation 14 (1) (2) (a) (b) (4) (a) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement systems

and processes that effectively assess, monitor and determine risks to people or maintain accurate, complete up to date records.

Complete records were not kept relating to staff employed by the service.

Regulation 17 (1) (2) (a) (b) (c) (d)(i)