Bupa Care Homes (CFHCare) 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
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. The home is set within a residential area and is close to all amenities and public transport.
There were 75 people accommodated at the time of the inspection.

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

The service had a manager in post who was nearing the completion of becoming registered with the Commission. 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 August 2016 and, although improved in some areas, we found continuation of serious breaches of regulations. The home was rated as 'inadequate' overall; the home had been placed in special measures following an inspection in February 2016 and we continued with this measure. The purpose of special measures is to:

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

We had already taken enforcement action from a previous inspection as we had issued a notice to stop any further admissions to the home. The statutory notice we issued remained in place at this inspection.

At this inspection we found improvements in all areas and all previous breaches of regulations had been met. Because of the improvements the overall quality rating has been raised to 'requires improvement' and the home has been removed from special measures.

At our last inspection in August 2016 we had found the home in breach of regulations relating to safe administration of medicines because people were not always protected by the medication administration systems in place. At this inspection we found people protected against the risks associated with medicines because the provider's arrangements to manage medicines were now consistently followed. The breach had

been met.

Previously we had found some people were not assessed for any risks regarding their health care needs. The risk of not updating changes to people's care plans is that staff might be unaware of their changed care needs and care might not be effectively monitored and reviewed exposing people to unnecessary risk. We now found more consistency regarding this and clinical risks such as, pain assessment and management, assessing risks around people with diabetes, people assessed as risk of falls, and risk of inadequate nutrition were now being consistently monitored. The breach had been met.

We had previously found staff needed to be more aware of the first aid procedures and equipment used in case of an accident or emergency; first aid equipment had also not been checked and maintained. This had been attended to and the breach was now met.

We had previously found that the home was not fully operating in accordance with the principles of the Mental Capacity Act 2005 (MCA). Although there were examples indicating good practice we found some hesitancy and misunderstanding in particular around the use of the 'two stage mental capacity assessment' and when this should be used as part of making 'best interest' decisions for people. On this inspection we found improvements had been made. Staff evidenced a better understanding of the principals involved, including an understanding of the need to assess individual decisions relating to care and treatment.

On the previous inspection we found the systems in place to monitor on-going standards in the home had not been effective. On this inspection the provider had continued to developed systems to monitor the quality of care in the home; these had helped to improve consistency in areas of clinical care management, such as medication safety.

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 although there was recognition that this could be further improved.

Previously we had made comments regarding the accessibility and user friendliness of the care records and care documentation in use. We found care records had improved and were easier to follow and to access necessary information.

Staff told us the training they received was good. We saw that there had been recent training / update around the principles of the MCA following recommendations from the last CQC inspection. 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.

We observed there was enough staff to carry out care in a timely manner. We saw staff were attentive to the needs of people and no one appeared to be in distress through lack of attention.

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

People we spoke with and their relatives told us they felt safe in the home. People knew who to speak with if they felt concerned about anything. We made observations on all units including those specialising in people with dementia and learning disability. We saw that people who could not express their thoughts and feelings vocally were settled and supported. Staff were observed to be attentive to people's care needs as they arose. Nobody we spoke with or observed expressed any issues regarding their safety.

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

We found that the home was clean and hygienic.

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

People we spoke with and their relatives said that they (or their relatives) were being treated with respect, dignity and kindness.

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

We saw that people were provided with a range of social activities and these continued to be developed with particular reference to providing activity for people with dementia.

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 safe.

We found that people were protected against the risks associated with medicines because the provider's arrangements to manage medicines were consistently followed. This was an improvement.

The assessment of care ensured the welfare and safety of people. Changing care needs had been assessed or reflected in the risk assessments and subsequent care planning. This was an improvement.

We found staff were aware of the first aid procedures and equipment used in case of an accident or emergency.
There was enough staff on duty at all times to help ensure people were cared for in a consistently safe manner.

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 how infection control was maintained.

Improvements had been made we have revised the rating for this key question form 'inadequate' to 'requires improvement'. To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for 'Safe' at the next comprehensive inspection.

Is the service effective?

Good

The service was effective.

Improvements had been made and staff understand understood and were following the principles of the Mental Capacity Act (2005).

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

There was support for people's health care needs and when

needed people were referred for appropriate support to health care professionals.

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

Is the service caring?

Good

The service was caring.

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

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

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

Is the service responsive?

Good

The service was responsive.

The existing good practice regarding the individualisation of care plans and records needs to be extended to all people's care.

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

We saw that people were provided with t range of social activities and these continued to be developed.

Is the service well-led?

Requires Improvement

The service was well led.

There had been improvements in the consistency of the provider's quality assurance process's which had been instrumental to the overall improvements in and development of the service. Areas of clinical care management that needed to be improved had been identified and effectively monitored.

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

There was a manager in post to provide a lead in the home who had applied for registration with the Commission and was supported by other key personnel.

We found the manager and staff to be open and caring and they spoke about people as individuals. There was positive and caring culture in the home.

There were systems in place to get feedback from people so that the service could be developed with respect to their needs and wishes.
Although improvements had been made we have not rated this key question as 'good' as we need evidence of longer term consistency of the effectiveness of governance arrangements at St Nicholas

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.

This was an unannounced inspection which took place over two days on 1-2 March 2017. The inspection team consisted of two adult social care inspectors, a pharmacy inspector and an 'expert by experience'. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We were able to access and review the Provider Information Return (PIR) as the manager sent this to us as part of the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service.

During the visit we visited all five of the units that currently make up St Nicholas Nursing Home [one unit was closed]. These included two units supporting people living with dementia. Some of the people living at in these houses had difficultly expressing themselves verbally. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We were able to speak with 15 of the people who lived at the home. We spoke with 11visiting family members. As part of the inspection we also spoke with two health care professionals who were able to give some feedback about the service.

We spoke with 26 staff members including nursing, care/support staff and the home's manager. We also spoke with other senior managers in the organisation.
We looked at the care records for 10 of the people living at the home, three staff recruitment files, medication records and other records relevant to the quality monitoring of the service. These included safety audits and quality audits, including feedback from people living at the home and relatives/visitors. We

undertook general observations and looked round the home, including some people's bedrooms, bathrooms and living areas.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in August 2016 we found the home in breach of regulations relating to the safe administration of medicines. This had been an on-going breach of regulations since January 2014. This was because people were not protected by the home's medication administration systems which were in place. We told the provider to take action. The provider's action plan told us that systems had been reviewed and improved. On this inspection we checked the improvements and found they were sustained. The breach had been met.

We reviewed medicines and records for 11 people on the Huskisson, Canada and Langton unit. We did not inspect the management of medicines for Brocklebank or Gladstone units as on previous inspections they were found to manage medicines safely. We spoke to six members of staff including the registered manager, regional manager, clinical services manager and three unit managers.

At the previous inspection medicines were not always available to give as they were out of stock; the time interval between paracetamol doses was not always clear and time specific medicines for Parkinson's Disease were not given at the times advised by the person's doctor. Fluid thickening powder for people with swallowing difficulties was not being managed appropriately.

At this inspection, we found that all 11 people had medicines in stock to give. The medicines' room was clean, tidy, well organised and the amount of stock was not excessive. We found care plans were clear and easy to follow; staff were able to explain which people had Parkinson's disease and were on time specific medicines. The recording of when a paracetamol dose had been given was documented, which allowed a nurse or carer to administer the next dose in a safe manner. The recording of how and when a fluid thickening powder was used was clearly documented, which are all improvements since the last inspection.

We observed a medicines' round and noted the nurse administered medicines in a caring way. We checked how medicines were stored in the fridge and controlled drugs cabinet and found these to be stored appropriately. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

One person was prescribed a cream to reduce inflammation, but the record of whether it had been applied was not always completed. The lack of recording had been highlighted by the manager's medicine audits, which were robust. The audits that had been completed following our previous inspection had clear actions and improvements from month to month was seen.

There were improvements in other areas of clinical practice such as the way people were supported to minimise risk. At our last inspection we had found people who were in pain, at risk of falls or had clinical care needs requiring assessment, had not been appropriately assessed or supported. On this inspection we followed through the care of a number of people living at St Nicholas and found examples were clinical risk was being managed well. The previous breach had been met.

For example, one person chose to go on regular local trips out of the home without support. We saw the risks associated with this had been assessed, with input from care professionals, and the care plan was formulated so that the person could retained this element of independence. We also saw records for people who experienced pain and saw this was being well monitored.

Risk assessments had been carried out to assess people's risk of developing a pressure sore and 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). Weight charts seen had been completed on a monthly basis.

At the previous inspection in August 2016 we found staff had poor knowledge of the whereabouts of first aid equipment for use on an emergency. As part of our inspection we reviewed arrangements for the provision of first aid if required. We saw that staff were aware of the arrangements for first aid and there were notices on each unit as tot the whereabouts of first aid boxes, oxygen and suction machines. We saw these were regularly checked. On one unit, records did not clearly record when checks had been made and this was addressed during the inspection. We were told about a recent incident when a person had a medical emergency and had undergone support and intervention to resuscitate them; which had been successful. A visiting health care professional gave positive feedback to us and said the staff had responded and acted extremely well.

We reviewed the management of pressure ulcers and associated wounds, for example, skin tears and surgical wounds. 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. All of the wound care plans reviewed were clearly written, easy to follow and looked to be appropriate for the documented wounds. Where people had more than one wound, there were care plans for each wound. Nursing staff told us they had received training and all felt very competent to identify and care for people with wounds. We were told when people developed wounds staff had strong links with the Community Matron for advice and support. Communication within the nursing home was good. We spoke with a visiting health care professional who confirmed that this area of care was being managed well.

We made observations which helped confirm how staff kept people safe. On one occasion a person became agitated and distressed whilst being transferred. Staff maintained quiet and caring verbal interactions throughout and the person became calm very quickly. Another person, who liked to smoke, was given several opportunities to do so using a safe area. A staff member told us that this person did not always like having someone in this space with them but that they 'keep an eye' through the glazed sides of the safe area. We saw a documented risk assessment and care plan to help monitor and continually review this.

We spoke with people living in the home and relatives / visitors who told us, "It's very good here; [person] can be challenging and staff are very good with her", "Yes [feels safe] and I never feel frightened. I can use this [walking aid] and it's safe enough if you use it properly. If you wanted to say anything [to staff] you would, but there's no need; everything's good here" and "Yes it's safe; the staff listen to us when they've got the time." There was universal agreement that people felt confidence in the ability of the staff to support them.

We asked about the provision of enough staff at the home to ensure delivery of safe care. We visited all units and found staffing numbers stable at the time of our visit. Interviews with relatives, visitors and staff on the units all confirmed that staffing was settled. When we looked at the duty rotas for each unit we saw that the provider's designated numbers of staff were being met. Staff morale was found to be positive with staff

reporting there was always enough staff to carry out care.

Observations of routine care on all units evidenced a good ratio of staff. Staffing rotas showed this had been consistent over a number of months. We observed there were enough staff to carry out care in a timely manner. We saw staff were attentive to people's daily personal care needs. For example, we observed people living with dementia or had a learning disability were attended to quickly when they became agitated or wanted assistance and also people on the nursing units received routine care in a timely manner.

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 manager of the home. All staff we spoke with about this were confident they could report any concerns, they would be listened to and appropriate action taken.

We had been notified about four 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. Two of these were incidents involving medication errors. These had been picked up by the home's own audits [checks] and notified appropriately. One of the incidents was around allegations of poor personal care and one incident involving a carer allegedly not being respectful 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 looked at fire safety maintenance records and these were up to date. Personal evacuation plans (PEEP's) were available for the people living in the home. These were displayed at the entry to each unit and were checked on a regular basis and maintained for easy reference. 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. Visitors and people we spoke with on the inspection told us they had no concerns about the cleanliness of the home. The management team completed infection control audits, as part of monitoring safe standards in the control of infection. Each of the units had an infection control lead; this role was being reviewed during the inspection to ensure better understanding and liaison with external environmental health professionals such as Liverpool Community

Health (LCH - infection control) in order to learn and share best practice. People we spoke with told us their bedrooms were cleaned every day and that they were happy with the overall cleanliness at St Nicholas.

Good

Is the service effective?

Our findings

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.

At the last inspection in February 2016 we had made a requirement as staff did not wholly understand were not always following the principles of the MCA; specifically the use of mental capacity assessments as these had been generalised assessments rather than evidencing specific decisions and follow the guidance in the MCA Code of Practice.

On this inspection we found staff had a better 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.

We saw examples where people had been supported to make key decisions regarding their care. Where people may have lacked capacity to make decisions we saw that decisions had been made in their 'best interest'. We saw a good example where a person was being supported to maintain their independence and encouraged to make decisions for themselves even though they had some mental capacity issues. The person was being supported to go out into the community on a daily basis. They had signs of cognitive impairment but wanted to be supported to live as normal a life as possible. We saw that there had been effective liaison with the community mental health team (CMHT) regarding assessment of the person's capacity to make this decision. The assessment was a 'best interest decision' although the person was stated to have capacity at the time of assessment by the CMHT.

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. The evidence varied from unit to unit but overall there was clear evidence that families were consulted with regarding any best interest decisions.

We saw that staff had a clearer understanding of the need to assess 'key' decisions individually using the two stage mental capacity assessment. Use of this was still sporadic but there were good examples. The manager showed us how the two stage assessment tool had been updated to include a box identifying the individual decision under review. Other assessments we saw looking at peoples activities of daily living including the reasons why a person lacked capacity to make decisions around individual care needs; for example one read 'unable to retain information'.

Staff spoken with had all undergone recent training in the MCA. We saw the training information and this was easy to understand and covered the principles of the MCA.

We looked at 'do not attempt cardio pulmonary resuscitation' (DNACPR) for three people on two units. These were completed appropriately and decisions made in people's best interests were supported by additional support plans and 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 a care plan for one person who was on a DoLS authorisation and this was clear and was being regularly reviewed; there were dates recorded when the authorisation was up for review and staff had alerted the Local Authority regarding the need for this. The same person had a relative with a Lasting power of Attorney (LPA) and the care plan explained all of the legalities very clearly.

People we spoke with at the inspection told us they felt staff had the knowledge and skills to support them with their care. The information from the provider (PIR) told us all staff underwent induction training when they took up post. This 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 five day classroom based induction and was quite comprehensive, based around current skills for care standards. The manager informed us that the standards implicit in the 'Care Certificate' were embedded in the induction package.

Training compliance reports and staff training status reports were completed by the training manager and highlighted when refreshers were required for staff. Training was delivered according to a training plan that has been developed in order to reflect mandatory and statutory training requirements. This is led by an allocated regional/area trainer. We spoke with staff and all state that the training provided was good and was regularly updated. One staff member commented, "I've been impressed with the training since I've been here; they remind us when we need updates."

Staff generally felt supported and told us this had improved in that supervision sessions were being held more regularly. The manager had a supervision and appraisal tracker which enabled them to check staff's progress. Unit managers 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."

Care staff were also encouraged to gain qualifications in care such as, QCF (Qualifications and Certificates Framework). At the last inspection in September 2016, 55% of staff had completed their NVQ / Diploma in level 2, 3 or 4 and a further 10% of the staff were actively working through the courses. On this inspection the figure had fell to 45% with two staff working towards qualifications. The manager recognised the need to improve this figure in the future as it provides good evidence of staff having a sound knowledge base for care.

There were a number of staff who had requested their NVQ training as part of their training and development plan and the registered manager told us these would be facilitated to sign up within the next month.

People had a plan of care to identify care needs. A nursing care plan provides direction on the type of care an individual may need following their needs assessment. Care planning is important to help ensure people get the care they need when they are at a care home. An initial care needs assessment had been completed and people's plan of care contained information and guidance for staff on people's health and social care needs, for example, safety, moving around, skin care, eating and drinking, mental health and well-being and

breathing. Information was also recorded around preferred routine, choices, daily records of the care given by the staff and input from external health and social care professionals to oversee people's health and wellbeing.

Medical conditions that required clinical intervention were recorded and treatment plans were followed by the staff. We saw this for a person who was receiving treatment for a surgical wound and for another person who had was receiving 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. We saw the staff were following a plan of care for both and were able to tell us how they provided this care and support. We did note that the PEG care plan lacked some detail around the actual care of the PEG tube however this was actioned by the registered manager during the inspection.

For a person who had required hospital treatment we saw plenty of information in respect of the treatment and support needed at this time. This included, further monitoring by the unit staff and also follow up appointments at the hospital.

Additional care plans were put in place should a person required more in depth support from the staff to help monitor their condition. We saw this for a person who needed support with their eating and drinking and the provision of thickened fluids to reduce the risk of choking.

We observed meal times on all of the units. On the dementia care (nursing) unit we observed breakfast being served to some people, eaten at side tables in the lounge wherever they were sitting. People were given whatever they chose from a range of cereals including porridge, plus toast and choices of hot and cold drinks. After this, and on-going throughout the day, people were offered drinks and actively encouraged or supported to have these; if someone's drink went cold a warm replacement was quickly offered. Staff offered support appropriately and courteously on all occasions. For example, one carer supporting a person with a thickened drink chatted gently throughout, addressing the person by their name, talking about family members and commenting on the person's reactions: "Ah, you're smiling – do you like that? Would you like another drop?"

The dining area was light, well-designed and attractive, with cloths, place mats and flowers on tables. Only two people chose/were supported to sit at a table in this area for lunch. All others remained/ chose to remain in the chairs they were sitting in throughout the morning, with side tables brought for them to eat from where appropriate. Lunch was snack-based (home-made sausage rolls, tinned spaghetti) followed by a light pudding. The main meal is served in the evening. The food looked appetising and seemed to be enjoyed. One person was being supported in their room to eat a pureed lunch.

Each person's meal was prepared and presented as needed for their dietary needs or capacities. This include, for example, food being cut up before serving; food served pureed; spoons offered in place of knives/forks; drinks offered in cups with handles/lids to promote independence; thickeners used to make drinks safe; and a plate guard offered [but refused] to support one person in managing their food more easily.

A unit hostess (staff allocated to assist with meals) explained they had received and continued to receive all general 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. People's weights were taken weekly and any variations reported.

People's comments were all positive. One person who was unable to answer with words was asked by the carer supporting them if they were enjoying their lunch and responded 'Mmm' with evident pleasure. One person said, "It's nice food here; lovely. [For breakfast] If you want cereal you can have it; you can have porridge or whatever."

Visitors/relatives were very happy with the food offered to their family members. One relative commented, "[Person] is being fed regularly now and they've [staff] been wonderful. They still ask [people] what they'd like to eat or drink, even if they're unable to answer, so they feel that they have a choice in it."

On one of the dementia care units we made some observations of good attention to design but saw that this could be further developed in light with good dementia practice. The corridors had a selection of tactile murals on the walls and framed prints of old Liverpool and movie stars from the past. There were memory boxes on the wall next to each respective door [of rooms occupied].

We saw 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 general experience of people with dementia, the environment they were living in and the dining room experience. The audits were conducted over a six month period on the two dementia care units and helped identify areas for further improvement. For example, 'No resources available within communal areas for residents to engage or interact with' and the need to develop bathrooms so they are less clinical. The audits also highlighted many areas of good practice in the environment. The manager explained the development of the environment on both units was on-going.

Good

Is the service caring?

Our findings

Staff were observed to listen and speak with people appropriately. Staff were seen to be very caring when talking to and assisting people. For example, we made observations on a dementia care unit. Throughout the day, interactions between all staff and the people living on the unit appeared to be person-centred and not task-led, with carers and other staff taking any opportunity to engage with people in meaningful exchanges that demonstrated good knowledge of them 'as people' and which respected their differing personalities, wishes and needs.

People commented positively on the approach by staff on all units. Comments made were; "Yes, staff are very kind", "Those [staff]; they're all doing their job well looking after people. You'd tell them about it if they weren't, wouldn't you? I would!", "Yes they are [kind and caring]", "They're lovely – especially that one [indicating one carer]" and "Yes, with maybe one or two exceptions. They're there to support you if you need them, all the time. If you need any help, they'll give you help."

Similarly visitors and relatives of people we spoke with were pleased with the way staff approached care. One relative commented, "They [staff] look after them very well; patient, you know? Staff are very good." Other comments included, "Absolutely lovely, so caring – they're really caring. Everybody's [staff] been here for years and they turn up for people's special events, all unpaid. We'd say that was overall the way they are. You couldn't ask for more."

People spoken with and their relatives felt there had been on-going improvements to the consistency of care staff attention to personal care and also the way staff and managers listened to any concerns and acted on them. These improvements had been noted prior our last inspection and had been continued with the new manager of the home.

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 good and appropriate personal care and staff were observed in most cases to provide appropriate and timely care. For example, we saw many instances of staff assisting people to the toilet and they did so in a very supportive and kindly way walking at the pace of the person and giving reassurance.

We discussed with staff people's care needs. Staff showed a good understanding and knowledge of how people wished to be supported and the level of care they needed to maintain their health and wellbeing. One staff explained in great detail a person's medical condition and how this affected their daily life and the support needed. Staff also showed an understanding and knowledge of people's family and social histories. Staff commented on the extra time they could spend with people due to the home having a reduced occupancy.

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

For people who had no family or friends to represent them, contact details for a local advocacy service were available. People could access this service if they wished to do so with or without staff support. We saw examples of people having representation from local advocacy services in Sefton. The units had the contact numbers of local advocacy services.

Good

Is the service responsive?

Our findings

We looked to see how people were involved with their plan of care and how relatives were included in this process. We saw some evidence of their inclusion though this was not always consistent on all of the units. Staff were however able to tell us how people and relatives were involved and kept up to date regarding any changes in care, support or treatment. A unit manager discussed with us decisions made for people with relative involvement and said they would look to better evidence relatives' inclusion when undertaking care reviews. A person said, "If I need a new tablet or not feeling well the staff get the doctor for me and also let me know that I may need some more help if not feeling too good." Likewise a relative told us, The staff always phone to make sure I know how (relative) is doing, I know what care my (relative) has." We saw care reviews took place and this involved input from individuals and their family members. Any changes in care were recorded in the plan of care and shared with the people concerned.

'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, such as a cuddle to provide reassurance. Talking with staff confirmed their knowledge regarding people's needs and how they responded to the different ways people liked to communicate. A staff member told us they knew the people they supported so well and would know straightaway if they were unwell.

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.

During our inspection we observed very good interaction by staff based on people's individual needs and requirements. When people needed assistance this was provided in a timely manner, people were not left waiting.

We looked at the type of activities people engaged in. The designated activities room for people living with dementia on one unit appeared to be out of use and we were told it was now used only for private meetings. The activities room on the residential unit for people living with dementia was equipped as a 'kitchen' using a pop-up background, plus table and vintage-style kitchen equipment.

We spoke with the lead activities co-ordinator and were told St Nicholas has five activities co-ordinators, including the lead person; three work almost full-time and two part-time. The lead person has a background in voluntary work with relevant organisations and holds a Level 2 NVQ in Social Care, training towards Level 3 in management. All activity staff were included in the general staff training programme for safety and care (but had not had any specific training in their role).

Activities named were: Bingo; 'gentlemen's club' (to provide more tailored socialising opportunities for

men); hairdressing and manicure ('for the ladies'); singing; outside entertainers/singers; and supporting people to visit shops, local social centres, for example. We asked what was provided for people who could not take part in these and we were told people could have one-to-one socialising and activity including discussion; music (put on CD player for them) and hand massage.

Records of each person were kept by the co-ordinators to keep track of provision and involvement [although we did not see these]. There was no home-based transport, so this was hired this from outside providers. People were also escort on public transport, with the recognition that this can in itself be a stimulating yet familiar experience for people able to do this.

Future plans included: seeking training in chair-based exercise; seeking training in medicines administration, to enable activity staff to take people out without the need for a nurse to accompany the group [to administer medicines].

People we spoke with felt the home was relaxed and provided a variety of stimulus / activity. One person said, "I go to the hairdresser every week, and I have my nails done. The rest of the time, I just like to watch telly really. I'm quite happy to sit here with a cup of tea or coffee watching telly; not bothered about Bingo and that." Another person commented, "I'd like more indoor games, like carpet bowls and I've asked about darts but they've not got a place to put a board up. We're given anything to do that we can cope with – making birthday cards, Christmas cards; Bingo, throwing a beach ball...I've been to the gents' club, yes. You get taken outside in the summer, for a walk or down to the shopping square to see if you need anything, or into one of the cafes there for a cup of tea."

Visitors and relatives were also generally positive; "Staff will read a book to them [people] or play Bingo. People can have what they like in their rooms to make it feel like home. [Person] has photos, own TV and radio; quite a few personal bits and pieces so they're happy there" and "They get entertainers every few weeks; Christmas was superb. They've (staff) done baking and cake decorating in the past; play catch, bowls, singing, quizzes, Bingo...They go outside a lot in summer when it's nice and they've had the people planting things and watching them grow. What they don't do is just leave [people] in front of the TV...and they've redesigned the lounge lots of times. Just lately, they've got the seats in groups of four, to get people talking to one another."

We spoke with a visiting nurse specialising in dementia [Admiral Nurse] who told us activities as yet were not wholly meaningful to individuals but continue to be developed. The audits carried out by the Admiral Nurse highlighted some improvements needed.

The home had a complaints procedure in place. The PIR sent by the provider told us, 'A robust complaints (Customer Feedback) policy is in place. Complaints are thoroughly investigated and the complainant is provided with a written outcome which may include apologies where there are failures or learning's needed by the Home. Each complaint is recorded, and if required a safeguarding referral will be made. All written complaints are managed quickly and effectively with a written response sent from the home within 21 days'.

The manager showed us a log of complaints since the last inspection. We reviewed one complaint from January 2017 regarding a person's level of personal care. There had been a thorough investigation by the manager and a response made. The response included an interview with the complainant.

'Residents' and relatives' meetings took place to enable people to raise their concerns regarding these issues and any further issues or comments regarding the service. We saw minutes of meetings displayed on units. There had been discussion and information shared regarding staffing and relatives involvement with

relative surveys.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found the service in breach because the provider's governance / management arrangements had failed to identify and ensure care standards were being maintained in the home. On this inspection we found governance arranges had been 'tightened' and further embedded which helped ensure previous failings in care, such as medicines management, were now being met and the home was being managed affectively. The breach of regulation for governance had been met.

Although improvements had been made we have not rated this key question as 'good' as we need evidence of longer term consistency of the effectiveness of governance arrangements at St Nicholas.

The home has been in 'special measures' for the past two inspections following the overall rating of inadequate. This means the home needed to improve standards. BUPA's approach to this was to support the home manager by the utilisation of a 'Service Recovery Team' which had been in place from February 2016. We saw the team members had been reviewed and changed from the last inspection. On a practical level this meant visits by members of the team to support the home manager and staff. On this inspection we saw and spoke with members of the support team who were visible in the home. Staff told us the support team had been more supportive.

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). The HIP concentrated on the previous breaches for the inspection in September 2016. We found the concerns we had previously regarding medication management, the staff understanding and working of the MCA and the provision of personalised care for people at St Nicholas and the accessibility of care records had all been addressed and improvements made.

As part of our feedback to the home manager and regional manager, we discussed the on-going development of the service. Both managers felt there was now a solid base for continued improvement but also realised that currently 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.

The service had a 'new' home manager in post who had started at St Nicholas' in December 2016 and was applying of registration with us [The Commission]. We spent time talking to the (home) manager and asked them to tell how to define the culture of the home and the main aims and objectives. The home manager told us some key aims for the home which included further embedding management systems in the home. This would be achieved 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 manager also talked about the need to learn the lessons of why improvements had been made so they could be sustained in the future. The manager also agreed the need to ensure a good skill mix in the home management team; for example the need to appoint a clinical service

manager [CSM] who would complement the background clinical skills of the existing CSM.

Staff spoken with said there had be a change in the culture of home since the new manager and service recovery team had been working together. Staff understood the need for the home to improve but felt the recent management support was overall more positive.

The registered manager showed us the homes Statement of Purpose [SOP]. This was clear around the culture and values of the home. These included, 'involvement of service users' at all levels and this had been evidenced on the inspection as improving over the past year. The 'quality model' highlighted in the document included the 'resident' at the centre.

Staff we spoke with were all very positive regarding the future direction of the home. They 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 had not received any whistle-blower concerns since the last inspection.

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

The home manager continued the use of a clinical indicator board in their office. This provided an anonymised over view of people's clinical care and dependencies based on the audits and staff's professional judgement. The home 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 service continued to collect the views of people using the service and their relatives. In December 2016 people who lived at the service were given the opportunity to complete satisfaction surveys in the home. We saw the results of this were 42 people had returned surveys. The overall feedback was positive. The survey results report listed 'our strengths' which included, 'happiness and contentment' [of people living in the home], people being 'treated with dignity and respect', and the home being 'safe and secure'.

This survey had been followed up with a meeting of relatives and people living at the home on 31 January 2017; we saw the notes of this and the meeting had been well attended. The meeting notes covered the current situation the home and further evidenced an 'open' attitude by managers.

Through their day to day management the home manager and clinical services manager (CSM) undertook a morning 'walk round' on the units to meet with the staff, visiting health professionals and people living at the home. This we observed during our inspection and confirmed through staff discussions. The home manager told us this was important as daily feedback form staff and people living on the units helped form an understanding of the current needs.

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

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