Norse Care (Services) Limited

St Nicholas House

Inspection report

Littlefields
Dereham
Norfolk
NR19 1BG
Tel: 01362 692581
Website: www.norsecare.co.uk

Date of inspection visit: 6 August 2015
Date of publication: 21/10/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection was unannounced and took place on 06 August 2015.

At the last inspection in October 2014, we asked the provider to make improvements in relation to staffing levels, monitoring the quality of the service and the accuracy of records. The provider sent us an action plan to say that they would be meeting the relevant legal requirements by 28 February 2015. Other improvements were also required in relation to the management of people's medicines, staff knowledge of the requirements of the Mental Capacity Act 2005 (MCA), access to activities that complemented people's hobbies and interests and the completion of staff training. We found that some improvements had been made but that further improvements were required.

St Nicholas House is a service that provides accommodation and care to older people and is registered for up to 39 people. There are two units operating at the service, a residential unit and a dementia care unit. On the day of our inspection, there were 30 people living in the residential unit and five people in the dementia care unit.

Summary of findings

There was a registered manager working at the home who had been registered with us since 5 June 2015. 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 and associated Regulations about how the service is run.

We found that some improvements had been made to how people's medicines were managed, staff knowledge in respect of the MCA 2005 and in the provision of activities that complemented people's hobbies and interests. However, staffing levels were not adequate on the day of the inspection to provide people with safe care or that met their individual preferences, although it is acknowledged that the service had tried to cover the staff absences but had not been successful due to an agency staff member not turning up for their shift.

Actions to mitigate risks to people's safety were not always being taken and the systems in place to monitor the quality of the service and accuracy of some people's care records remained ineffective. Some staffs refresher training was overdue which meant that they may not have up to date knowledge and skills to provide people with safe care.

Staff were seen asking people for their consent before providing them with care. However, the principles of the MCA 2005 had not always been followed when decisions had been made on behalf of people who lacked the capacity to consent to some aspects of their care.

The provider had systems in place to reduce the risk of people experiencing abuse. When concerns were raised, the registered manager had investigated these thoroughly and action had been taken to protect people when necessary. New staff were checked before they started working at the home to make sure that they were safe to do so. The premises where people lived and the equipment they used was well maintained and safe.

Staff knew the people they cared for well and treated them with kindness, compassion, dignity and respect. People had access to plenty of food and drink and saw healthcare professionals for specialist advice when they needed to help them maintain their health.

People and relatives were listened to and their opinions were respected. There was a system in place to fully investigate any complaints or concerns that were received.

The service had an open culture where people and staff could raise concerns without fear of recrimination. People who lived in the home and the staff were encouraged to make suggestions on how to improve the care that was provided and these were acted upon.

The managers and staff at the home acknowledged that there were issues with staffing levels that had impacted on their ability to sometimes provide people with safe care that met their individual needs. However, they demonstrated to us that they were working hard to correct this and were pro-active in trying to improve the quality of life of the people living at St Nicholas House.

There were some of breaches of the Health and Social Care Act 2008 [Regulated Activities] 2014 and you can see what action we told the provider to take at the back of the full version of the report.

We have made a recommendation about following the principles of the Mental Capacity Act 2005 when making best interest decisions on behalf of people.

Summary of findings

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.

Staff had not been deployed effectively on the day of the inspection to reduce the risks to people's safety or to meet their individual needs.

Risks to people's safety had been assessed but actions had not always been taken to effectively mitigate these risks.

Staff knew how to protect people from the risk of abuse and people received their medicines when they needed them.

The premises where people lived and the equipment they used were well maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received refresher training in line with the provider's requirements.

Staff had a good knowledge of how to support people who could not consent to their own treatment. However, the Mental Capacity Act 2005 principles had not always been followed when making decisions in people's best interests.

People received enough food and drink.

People were supported to maintain good health.

Is the service caring?

Good

The service was caring.

The staff were kind and compassionate and listened to people.

People were treated with dignity and respect by the staff.

People and/or their relatives were involved in making decisions about their (or their family members) care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's individual care needs and preferences had been assessed but their care records did not always reflect people's current care needs.

People had access to activities that were of interest to them.

People felt able to complain if they needed to and there was a system in place to investigate and deal with complaints.

Summary of findings

Is the service well-led?

The service was not always well-led.

The quality of the service was not monitored effectively to reduce the risk of people receiving unsafe or inappropriate care.

There was an open culture where people and staff could raise concerns without fear of recrimination. Staff felt supported and knew their roles and responsibilities.

People and staff were involved in developing the service and the managers and staff were pro-active in looking for ways to improve the well-being of the people who lived there.

Requires Improvement

St Nicholas House

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 inspection took place on 06 August 2015 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, the provider completed 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 reviewed other information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us and additional information we had requested from the local authority safeguarding and quality assurance teams and the fire safety service.

On the day we visited the service, we spoke with eleven people living at St Nicholas, two visitors, five care staff, the cook, two domestic staff, the deputy manager and the registered manager. We observed how care and support was provided to people. To do this, 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.

The records we looked at included six people's care plans and other records relating to their care, three staff recruitment files, staff training records and staffing rotas. We also looked at maintenance records in respect of the premises and equipment and records relating to how the provider monitored the quality of the service.

After the visit, we requested further information from the registered manager. This was in relation to staff training, how the provider monitored the quality of the service, incidents that had been referred to the local authority safeguarding team and the number of falls people who lived at the service had experienced in June and July 2015. This information was received promptly.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in October 2014, we found that there were not always enough staff available to provide safe care to people who lived at St Nicholas House and to meet their individual needs. This meant that there had been a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider told us that they would meet this regulation by 28 February 2015.

The required staffing levels as determined by the provider were two staff for up to six people within the dementia unit and four staff to care for 30 people within the residential unit with an extra member of staff working for four hours on a late shift or as was required. However, on the day of the inspection, an agency staff member had not turned up on the residential unit and they had been unable to cover the shortage on the dementia unit. The registered manager confirmed that this was unusual but did happen on occasions. This meant that the service was running with two members of staff less than it should have been for a period of the morning. We checked 12 random days of staff duty rotas over the last month and saw that on two occasions, the required staffing levels had not been met.

Whilst it is acknowledged that the service did all they could on the day of the inspection to provide the required levels of staffing, we observed that this shortfall had an impact on people's safety and the ability of staff to meet people's individual needs. For example, we saw that one person was left unattended within the lounge area of the dementia unit for 20 minutes although they had been assessed as being at high risk of falls. A staff member told us that this person should be monitored more regularly due to this risk. This person was also left unattended for some periods during lunchtime whilst eating their meal. This was in contravention of the instructions within their care record which stated they should have a staff member monitoring them whilst eating as they were at a high risk of choking. We told the registered manager about this who referred the matter to the local authority safeguarding team.

On the residential unit, one person who had been assessed as being at a high risk of falls, was observed for five minutes in a communal lounge trying to continually get up out of their chair. They were distressed and asking for help, saying they wanted to be assisted into a wheelchair to go back to their room. The wheelchair was in the middle of the room out of reach of this person and they were trying to stand up to reach it. There were no staff present within the lounge so an inspector encouraged the person to sit down and press the call bell that was around their neck to gain staff member's attention. The lack of staff within the communal area meant that there was a risk to this person's safety.

One person on the dementia unit had not been assisted to get washed and dressed until 10.50am when their preferred time to get up was between 8am and 9am. The staff member told us that this was because they had not had time to assist this person earlier. This person had also received their breakfast later than they preferred. Another person who had been in bed for two days due to illness told us, "I'd like to get out of bed but I cannot as my leg won't work properly." We spoke to a staff member about this. They told us that they could not assist them as they needed two staff members and that no other staff member was available.

We saw that one person was eating their breakfast on the residential unit at 10.46am. When asked, the person was not able to tell us if it was their preference to eat their breakfast at this time. A staff member told us that the person preferred to get up at 9.30am but that they had not had time to assist them when they had woken up.

Another person asked us for assistance as we walked past their room. They were concerned that they had not received their lunch and told us that they were very hungry and felt that the staff had forgotten them. We went to alert a member of staff and saw that they were in the process of taking this person their lunch at 1.45pm. They told us that the lunches were being given late due to a lack of staff. We also observed that one person had to ask a member of staff three times for a drink of water. The staff member acknowledged them each time but was busy helping other people so there was a delay in this person receiving their drink.

We received mixed views from people who lived at the home about the availability of staff to assist them with their care. Three of the five people we spoke with about staffing levels told us felt there were enough staff. One person told us, "They [the staff] give me prompt attention." Another person said, "There are enough staff when I need them." However, two people told us that they did not feel there were enough staff to help them when they needed support. One person said they felt they were well looked after but

Requires Improvement

Is the service safe?

added, "You are always waiting, waiting" [for staff to assist them]. A relative told us, "I have noticed a shortage of staff, particularly at weekends. Lunchtimes seem to be a bit extended because of this." We heard another person tell a member of domestic staff, "You have no staff here do you?"

All of the staff we spoke with who told us that they felt they did not feel there were enough staff to provide care to people to meet their individual needs. Staff said that although they tried to make sure that people received the care they needed, people often had to wait for assistance. For example, we were told that staff struggled to get people up in the morning at their preferred times and to provide them with food and drink at time when people wanted it. Staff added that they felt rushed and could not spend time talking to people, particularly those who were being cared for in their rooms.

The registered manager told us they had recognised there was an issue with staffing levels when they had started working at the home. This was due to a number of staff leaving which was exacerbated by a number of staff being away from work unwell. The registered manager had worked hard to recruit new staff to fill these vacancies and confirmed that all vacancies had now been filled, with four staff starting their induction training the day after our inspection. They had also arranged for other staff who worked in the home, such as domestic staff, to receive training in moving or helping people to eat, so that they could help out if necessary.

The registered manager confirmed to us after the visit that the provider had given them some extra hours for another team leader to work to assist with the current staffing issues. The staff we spoke with told us that although they were sometimes working understaffed, they were confident that things would improve. We will check at our next inspection that improvements have been made within this area and whether the required staffing levels have been met consistently.

Risks to people's safety had been identified. These included risks in relation to falls, not eating, assisting people to move, developing pressure ulcers and swallowing. We saw that in some cases actions had been taken to mitigate these risks. These included having sensors in place to alert staff when people got out of bed and people's beds being low to the floor reducing the risk of people injuring themselves from a fall. However, actions had not been taken to reduce the risk to people's safety in all cases and there was not always clear information available for staff to guide them on how to reduce the risk.

For example, one person was recorded as having had four falls in the last three weeks. The risk assessment had not been reviewed to make sure that the current actions staff should take to reduce the risk were appropriate. We observed the same person becoming upset and distressed during the afternoon of our inspection but no action had been identified such as how to calm the person or what triggered their distress, to help staff reduce the risk to the person's safety. Staff had also not been deployed appropriately on the day of the inspection to make sure that risks to people's safety were being mitigated.

This meant that there had been a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our previous inspection in October 2014, we found that people's medicines were not always managed safely and that improvements were required. At this inspection we found that the required improvements had been made.

People's medicines were stored safely and records indicated that people received their medicines when they needed them. The temperature of the room and a fridge where the medicines were stored was monitored to make sure that they were safe to give to people. Staff had clear instructions on when to give people 'as and when' required medicines such as paracetamol and staff recorded what times these were given to make sure that there was a safe gap between doses.

Regular audits of people's medicines were conducted to make sure that the home had sufficient quantities of medicines to give to people when they needed them and that people received them correctly. We saw that people who received medicines such as Warfarin, had their blood checked regularly to make sure that the dose was sufficient for their needs and that staff adjusted the dose as instructed by the GP.

All of the people we spoke with told us they felt safe. One person said, "Yes I feel safe here." Another said, "I have no concerns for my safety."

All of the staff we spoke with on the day of the inspection knew how to protect people from the risk of abuse and told

Requires Improvement

Is the service safe?

us they had received training on the subject. They understood the different types of abuse that could occur and how to report any concerns. We saw that any safeguarding issues at the home had been reported to the relevant authorities and had been thoroughly investigated by the registered manager where appropriate. We were therefore satisfied that steps had been taken to protect people against the risk of abuse.

The required checks had been made on staff before they started working at the home to make sure that they were safe to work with the people who lived there and we saw that every person had access to a call bell if they needed to alert staffs attention if they needed assistance. People were also checked during the night regularly to make sure that they were safe.

The premises and equipment were well maintained. Fire exits within the building were clear, accessible and well sign-posted. The staff we spoke with knew what action to take in the event of a fire. Equipment that was used to assist people to move had recently been serviced to make sure that it was safe to use.

Requires Improvement

Is the service effective?

Our findings

During our last inspection in October 2014, we found that some staff had not received training in important subjects such as the Mental Capacity Act 2005 and that some staff training was overdue. This meant that improvements were required within these areas. At this inspection, although the staff that we spoke with told us they felt they had received enough training we again found that some staff training was overdue. This meant that all staff may not have had up to date skills and knowledge to provide people with effective care.

Six staff had not received refresher training in moving and handling. Two of them had not been re-trained since 2013. The registered manager told us that this should have been refreshed each year. The majority of staff had not received refresher training in food hygiene. The registered manager told us they were waiting for a workbook from the provider to issue to staff. Infection control training had not been received by a number of staff and eleven other staff had not had their skills refreshed within this area. The registered manager told us they did speak to staff in team meetings about how to control infection as the provider was not planning to role out this training until October 2015 with the introduction of the new Care Certificate.

We were advised by the deputy manager that some people on the residential unit were living with dementia. However, not all of the staff on this unit had received training in this subject although we were advised that some staff were dementia coaches who would provide staff with support regarding the subject. Also some staff had received training in other areas of care such as how to give people insulin and to check people's blood sugar levels to help them meet their individual needs. A district nurse confirmed they had provided this training and that staff were only able to do this once they had been assessed as competent to do so.

The registered manager had recognised that some staff were overdue training and required training in other subjects to enable them to provide care to meet people's individual needs. Outside agencies such as Boots were to provide medication training to staff in September 2015 and further training for the staff in stoma care in August 2015 and pressure care in September 2015 had been arranged. Further improvements are however required with regards to the completion of staff training and the updating of their skills.

Before staff started working on their own, they completed induction training which consisted of working closely with a more experienced member of staff. They were only allowed to work on their own once they had been assessed as being competent to do so by the managers.

At our last inspection in October 2014, we found that the staff on the residential unit did not have a good understanding of how to support people who lacked capacity to consent to their treatment in line with the principles of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). This law was passed to protect people's rights where they lack capacity to make their own decisions. During this inspection, we saw that staff had received training in this subject and staff we spoke with demonstrated that they now understood how they should support people to make decisions about their care where they lacked the capacity to do so. This included showing people what types of clothes they could wear or pictures of food that they could choose for their meal.

We saw that in some cases, people's capacity to make important decisions about their care had been assessed but this had not always happened. For example, people living within the dementia unit had been assessed as not being able to consent to a keypad being on the main door, preventing them from leaving the unit independently. A decision had been made on their behalf by the home to have this keypad in place in their best interests to keep them safe. However, where people had sensors by their beds in their rooms to protect them from falls, this had not been assessed to see whether this was in the person's best interests. This was not following the principles of the MCA 2005. The registered manager agreed to take immediate action to address this issue.

The registered manager had assessed that some people living at the home required a DoLS authorisation. Applications had been made to the local authority and the registered manager was waiting for them to assess these people to make sure they were not being deprived of their liberty unlawfully.

The people we spoke with told us they enjoyed the food. One person said, "The food is good." Another person said, "The food is wonderful." We observed that most people within the communal areas and in their rooms had access to a drink of their choice. The people we spoke with said

Requires Improvement

Is the service effective?

that they had plenty to drink during the day to help them keep hydrated. We saw that hot drinks and snacks were also offered throughout the day. People who were unable to eat and drink themselves received assistance with this.

The majority of people told us that they had a choice of meals and said that an alternative would be made for them if they didn't like the food that was being served on that day. However, two people who had their breakfast later in the day told us they had wanted to have porridge. We spoke to the catering staff about this who told us that porridge was only available until 10.30am after which it would be thrown away. The people were given an alternative but this had not been their favoured meal and therefore, their choice of food had not been provided. We fed this back to the registered manager who agreed to speak to the kitchen staff.

People who required a specialist diet received this and people who were at risk of choking when they drank had their fluids thickened as recommended by a healthcare professional. The cook told us that the communication about people's dietary requirements from the staff was good so they could make sure that people got the correct foods to meet their needs.

In the main, staff supported people to maintain their health and referrals were made to healthcare professionals quickly when people needed attention. One person told us, "Yes I saw the doctor recently when I needed to." Staff confirmed that the GP visited regularly when required. Visits were also made by other healthcare professionals such as the continence advisor, district nurse, chiropodist, dentist, occupational therapist and optician to provide people with assistance with their healthcare needs.

We recommend that the service considers current guidance in relation to assessing people's consent in line with the principles of the MCA 2005 so make sure that people's rights are protected.

Good

Is the service caring?

Our findings

The people we spoke with told us that the staff were kind and caring. One person said, “The carers are very friendly.” Another person told us, “The staff are always polite and courteous.” A further person said, “Wonderful care, I couldn’t be happier.” A person visiting the service told us, “The staff are kind and supportive” and a visiting healthcare professional commented that they always saw staff being helpful and that they felt there was a good atmosphere within the home.

During our observations, we saw and heard staff speaking to people in a polite and courteous manner. All staff were seen to be friendly and approachable including the domestic and catering staff as well as the care staff. One member of the domestic team was observed providing a person with a cup of tea. They helped the person to sit up and asked them how they liked their tea. Two other members of staff were seen talking to a person who had become upset. They spoke to the person in a quiet and gentle manner, kneeling down so they could make good eye contact with them. They listened to the person and gave them time to explain why they were upset. This comforted the person and the staff only left them when they were sure that the person was settled.

A cat lived at the home and we saw people making a fuss of it and it spending time with people in their rooms. One person told us how much they liked stroking the cat and that it kept them company in their room. We observed that people who were in their rooms were well supported with pillows and that staff made sure they were comfortable when they visited them.

Staff were knowledgeable about the people they cared for. This included their likes and dislikes and preferences such as what time they liked to get out of bed in the morning, their interests and their life history. Staff told us that this helped them develop a good rapport with people and that knowing their history enabled them to have conversations with people that were meaningful to them.

People we spoke with said that they were treated with dignity and respect. One person said, “The staff are very respectful.” Throughout the day we observed staff respecting people’s decisions. For example, one person was asked by a member of staff if they would like to move to another area or if they preferred the room they were in. People were also asked where they would like to eat and if they were ready to eat.

The people who lived at the home and visiting relatives we spoke with told us they were listened to and that they felt involved in their own or their family member’s care. One relative told us they were often asked by the staff if they were happy with the care that had been given to their family member. They added that staff always updated them on the care provided to their family member which was important to them.

We saw that regular meetings were held with the people who lived at the service in a group session for feedback on the care they received and that any recommendations raised by people were acted on. For example, people had suggested that it would be nice to have different types of bottles of juice on the dining room tables for people to help themselves to and this was implemented. Regular reviews of people’s care also took place with the individual person and their relative if required.

Requires Improvement

Is the service responsive?

Our findings

People's preferences and choices had been assessed by the provider but these were not always being met on the day of the inspection. Some people did not receive assistance to get up in the morning when they wanted to or have their main meal at a time that suited them. Other people did not receive the breakfast of their choice or had to ask several times for a drink before it was received.

We observed that for the majority of the inspection, staff did not have time to talk with people or spend quality time with them. They often appeared rushed and could only talk to people when they were performing a task such as assisting them with personal care. One staff member told us that they should have offered people a bath or shave on that day but that they had been unable to do this due to lack of time. Whilst it is acknowledged that the service had tried to obtain cover for staff absences but had not been successful in doing so on the day of the inspection, this shortage of staff impacted on the ability of staff to meet people's preferences.

During our inspection in October 2014, we received mixed views from people about how staff supported them to follow their interests and hobbies. We therefore noted that improvements within this area were required. During this inspection, we found that improvements had been made.

Most people told us that they were able to participate in activities that reflected their hobbies and interests. One person told us how they enjoyed gardening and that they were supported to continue with this hobby by the staff. Another person said they had plenty to keep them entertained including dominoes, bingo and outside entertainers. A further person told us how trips were organised for people. They added that they were going to attend the Sandringham flower show in August which they were looking forward to and that they got taken into Norwich on occasions to go shopping. We observed some people taking part in activities such as playing dominoes or skittles during the inspection.

A full assessment of people's individual needs had taken place with the person and/or their family member. Plans of care were in place to guide staff on how to provide people with the care they required although some of these contained inaccurate or unclear information. For example, one person's care record stated that they required a frame to help them walk. However, the staff were using a wheelchair when assisting the person to move which was not noted within their care record. Another person was being assisted to move by using a stand aide but again, this was not reflected within their care record. We were also advised that two people were approaching the end of their life and that therefore, the amount they ate and drank was not required to be monitored but this information was not clear within their care record and staff were still recording their food and drink intake. Although the staff we spoke with on the day of the inspection were knowledgeable about people's current needs, the fact that the service regularly used agency staff meant that it was important for care records to contain accurate and up to date information to reduce the risk of people receiving unsafe or inappropriate care.

One relative we spoke with told us that the staff responded well to the changing needs of their family member. They said that when they came back from hospital that a new bed and chair had been ordered for them. The staff told us that changes in people's needs were communicated to them well. A visiting healthcare professional also told us that the staff responded quickly to people's changing needs and contacted them so that they could assess and advise what treatment people needed to receive. They advised that the staff always acted on their recommendations.

People and visiting relatives told us they did not have any complaints but that if they did, they would feel confident to raise the issue with staff. We saw that there was a system in place to deal with complaints although, none had been received so far this year. We were therefore satisfied that people's complaints would be responded to appropriately if they were raised.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in October 2014, we found that the provider was not monitoring the quality of the service effectively to make sure that people received good quality safe care and that some records relating to their care were inaccurate. This meant that there had been a breach of Regulations 10 and 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider told us that they would meet this regulation by 28 February 2015. At this inspection, we found that the required improvements had not been made.

The provider had not ensured that the actions they had said would be taken in response to our last inspection findings in October 2014, had been implemented. It was recorded within the action plan they sent us after that inspection, that enhanced auditing had been put in place to make sure that all care records were accurate and that staff training had either been updated or plans were in place for this to be completed. We were also told that staffing levels would be kept under regular review by utilising a dependency assessment tool so that staffing levels could be based on people's individual needs. We found that these actions had not been implemented effectively.

The registered manager told us that the provider had conducted some audits since our inspection in October 2014. We viewed these audits and saw that they did not address all the issues we found during that inspection and we again found similar issues during this inspection.

For example, the completion of staff training was again found to be not monitored effectively and therefore, some training was overdue. We also found that four of the six care records we looked at relating to people's care held some inaccurate information that did not reflect some of their current care needs. Although the staff we spoke with knew about these changed needs, there was not an effective system in place to make sure that the care records were updated to reflect these changes. Therefore there was a risk that these people could receive incorrect care. The accuracy of these records was of particular importance as the home was regularly using agency staff who may not have been familiar with people's individual needs.

Although it is acknowledged that the service had tried to obtain cover for staff absences but had not been successful in doing so on the day of the inspection, the remaining staff had not been deployed appropriately to reduce the risk to people's safety and to meet their individual preferences. No dependency tool was being used to assess whether there were enough staff to meet people's individual needs as was advised would be completed in the provider's action plan following our last inspection. There was a lack of monitoring to make sure that the care people had been provided with was appropriate to mitigate risks to their safety.

Therefore we have concluded that the systems the provider had in place to monitor how the service was ensuring they met the shortfalls found at our last inspection and how to keep people safe through the mitigation of risk and accurate records were not effective.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The registered manager advised us they had recently implemented a number of audits to help them improve the quality of the service that was being provided. This included audits of the accuracy of care records, risk assessments, nutrition, the premises, infection control and medicine management. As these audits had only recently started, we were unable to evidence whether they were effective.

Observations of staff assisting people with care had also recently started to make sure that the care that was being provided was safe and appropriate. Analysis of incidents and accidents had also commenced from July 2015 so that lessons could be learnt to reduce the risk of the accident or incident reoccurring. The registered manager was in the process of writing an action plan in response of the findings. There was a process in place to analyse any complaints that had been received each month to see if any patterns emerged. As the home had not received any complaints, no action in relation to this had needed to be taken.

People who were able to give us their feedback were in the main happy with the care they received at St Nicholas House. One person told us, "It's a nice place to live." Another person said, "It's very comfortable here." A relative told us, "The care is excellent and the staff are second to none."

Requires Improvement

Is the service well-led?

The manager had an 'open door' policy where people could go and speak to her when they wanted to. We saw that people who lived at the service and relatives went to the office on various occasions to speak to the registered manager. People and the staff told us they were listened to and that they could raise concerns without fear of any recriminations. A survey had been conducted in 2014 to request feedback from people on their care. The comments received were positive and had been analysed. This demonstrated that the service had an open culture in which it welcomed feedback from people and staff to help them improve the quality of the service that was being provided.

The staff told us they felt very supported by the registered and deputy managers and that they understood their individual roles and responsibilities. They said they found their work currently a challenge but that each staff member supported each other and that they pulled together as a team to provide care to the people who lived at the home. They added that this had been recognised by the registered and deputy managers who had acknowledged that they had all worked very hard during a difficult period. This had made them feel valued. We had also observed that the staff worked hard to provide people with the care they needed. However, due to the lack of staff, people did not always receive 'person-centred' care which was based on their own individual preferences. The staff and the registered manager told us that they were confident this would improve once the required staffing levels were in place.

People who lived at the home and the staff were encouraged to help develop the service and it was clear that the new registered manager, deputy manager and the staff were passionate about improving the lives of the people who lived in the home.

Some people had been involved in helping in the recruitment of staff. This had involved them interviewing potential staff and giving their opinion on whether or not they should be employed. People had also been consulted about another project called 'making meal times special'. This was about improving the meal time experience where people had been consulted about the menu and how the meals were to be served. In response to people's feedback, tureens were being used so people could help themselves to the amount of food they wanted rather than it being put on their plate.

The registered and deputy managers were involving people who lived in the home in a project called 'Ladder to the Moon'. The provider had signed up to this project that is run by an outside company with the aim being to create a more innovative and creative thinking culture amongst the staff. This in turn would enable them to provide people living at the home with more meaningful engagement to increase their wellbeing.

The deputy manager told us they and the registered manager had attended a workshop on how to achieve this and that staff would also be attending the same workshop in the future. Following the workshop, the deputy manager had issued questionnaires to the staff, people who lived at the home and their relatives to gain information about what they felt made a happy home and what was important to them. These questionnaires were yet to be returned to the deputy manager but they told us that these would be analysed and action taken in respect of what people had fed back.

Staff had recently been consulted for their ideas on how to improve the service and the care that people received. A suggestion had been made about changing the working patterns of the staff and this was shortly to be trialled. Since the new registered manager had been in post, regular meetings were held with staff to keep them updated with what was happening within the home and they told us that they felt the communication was good.

The registered manager was pro-active in looking at other ways to develop the service to improve the lives of the people who live there. This included working with Age UK and local businesses in the community to set up a dementia café at St Nicholas, where people who lived within the home and in the community who were living with dementia, could meet and socialise. The deputy manager was also considering implementing a 'make a wish on Monday' where people would be able to participate in some form of activity that was important to them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Actions had not always been taken to mitigate risks to people's safety. (Regulation 12, 1 and 2 b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems in place to monitor the quality of the service provided, to mitigate risks to people's safety and welfare or to make sure that the improvements they said would be made following our last inspection had been implemented. Not all care records contained accurate and up to date information. (Regulation 17, 1 and 2 a, b and c).