Bupa Care Homes (CFHCare) Limited

St Nicholas Nursing 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

St Nicholas Nursing Home is owned and operated by BUPA, a large national organisation. The home provides nursing and personal care for up to 176 people in six separate units. Three units provide general nursing care; one provides nursing care for people living with dementia. One unit provides personal care to people with dementia and one provides nursing care to people who have a learning disability. The home is set within a residential area and is close to all amenities and public transport.

This was an unannounced inspection which took place over three days on 28, 29 and 30 January 2015. The inspection team consisted of three adult social care inspectors, a pharmacy inspector, a specialist advisor for infection control and an 'expert by experience'. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

We asked people whether they felt safe in the home. We were told, "We are looked after very well – I am moving soon but I have felt very safe here" and "All the staff are

Summary of findings

very good here – if I had a problem I could talk to any one of them.'' One visitor described their relative as appearing to be "settled and safe" since their admission to the home.

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

There have been a number of safeguarding investigations at St Nicholas Nursing Home since our last inspection. The home had assisted the local authority safeguarding team and agreed protocols had been followed in terms of investigating and ensuring any lessons had been learnt and effective action taken. Two of the investigations by social services evidenced failings in care at the home.

At our last inspection in September 2014 we had found the home in breach of regulations relating to staffing. At that time, levels of nursing and care staff, were not sufficient to ensure people received a consistent level of safe care. We told the provider to take action. At this inspection we found that overall staffing had been improved.

Staff we spoke with told us there had, overall, been a marked improvement in the level and consistency of staffing. One staff said, ''Things have improved. Staff numbers have been quite stable recently. This gives us more time to organise care.'' When we looked at the duty rotas for each unit we saw that the providers designated numbers of staff were being met.

We observed there were 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.

The registered manager told us staff recruitment would continue with the aim of further stabilising each house and this would help ensure house managers had necessary time to develop their role and carry out their management duties.

We found on inspection that people were assessed for any risks regarding their health care needs. Risk assessments had been carried out to assess people's risk of developing a pressure sore for example. We saw some assessments for the use of bedrails to help ensure people were safe. We reviewed the care of one person on the house accommodating people with a learning disability. The person displayed some challenging behaviours that staff were closely monitoring. Within the person's care plan we saw a comprehensive action plan to monitor behaviour including the use of distraction techniques. This helped the person to be as independent as possible.

At our last inspection in September 2014 we had found the home in breach of regulations relating to safe administration of medicines. This was because people were not always protected by the medication administration systems in place. We issued a warning notice and told the provider to take action. The provider's action plan told us that systems had been reviewed and improved.

At this inspection we found that overall management of medicines had improved, however, from our findings during the visit and the incidence of medicine errors, we found that overall people were still not fully protected against the risks associated with medicines because the provider's arrangements to manage medicines were not consistently followed.

We have told the provider to take further action.

At our last inspection in September 2014 we had found the home in breach of regulations relating to cleanliness and infection control. This was because people were not protected from the risk of infection because appropriate guidance was not being followed. People were not being cared for in a clean, hygienic environment. We told the provider to take action. At this inspection we found that overall management of infection control had progressed but there were still areas that needed improvement.

On general inspection of units [houses] we found levels of cleanliness to have improved. Toilets and bathrooms had hand wash facilities including liquid soap and paper towels for use. There was better organisation and checking by managers to ensure standards were improving. We found staff had attended training and where more knowledgeable regarding infection control.

Summary of findings

There were still however, some areas of concern and inconsistency. For example, not all staff were seen to be adhering to hand washing routines. Some cleaning was not thorough in the dining areas and some bedrooms. There was a commode pan stored in the sluice still contaminated. This was lifted from the shelf it was stored, which was also very dusty. The clinical room on one house had an old air-conditioning unit that did not work this had been there several months and was cluttering the room; it was also very dusty underneath. Overall we found there had been enough progress but there still needed to be further development of staff roles and on-going vigilance.

We have told the provider to take action

We looked in detail at the care received by 13 of the people living St Nicholas Nursing Home. One person, who lived with dementia, had highly dependent and complex care needs. We saw that they had received input from a range of social and health care professionals who had linked in effectively with the home. One health care professional told us the manager and staff had been very proactive in managing the person's care. Professional support had been documented by the Community Mental health team [CMHT]. There were also some records to show input from the person's GP and dietician.

We reviewed the care of people who were experiencing pain, or had ongoing health conditions that required constant monitoring. We found that referrals had been made to provide appropriate health care input from external professionals when needed.

We looked at the training and support in place for staff. The training manager told us about the induction programme for new staff. New staff we spoke with said they had attended and felt the induction prepared them for their role. The training manager showed us a copy of the staff training matrix which identified and plotted training for staff in 'statutory' subjects such as health and safety, medication, safeguarding, infection control and fire awareness. Staff spoken with said they felt supported by the training provided.

We were told about plans to develop staff education in dementia awareness. There was training to develop 'person centred coaches' who would lead in dementia care. Currently there were two staff trained. The home had also identified clinical leads in infection control and there were identified 'dignity' champions. We found that these developments were very new and needed to be embedded; for example training in dementia care. The home had identified areas for improvement in best practice for dementia care but these had yet to be fully introduced.

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. This is legislation to protect and empower people who may not be able to make their own decisions. People living at St Nicholas' varied in their capacity to make decisions regarding their care. We saw examples where people had been supported and included to make key decisions regarding their care. Where people had lacked capacity to make decisions we saw that decisions had been made in their 'best interest'. We saw this followed good practice in line with the MCA Code of Practice.

We also discussed some of the decisions regarding the right to refuse specific medical treatment in case of a cardiac arrest ['do not resuscitate' (DNR) procedures]. These did not always include clear evidence of a mental capacity assessment for people lacking the capacity to make a decision. In some cases we could not see whether the person's family had been consulted as part of the best interest decision. We discussed how some DNR decisions could be better evidenced and recorded.

We found the home supported people who were on a deprivation of liberty authorisation [DoLS]. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests.

We observed the dinner time meal on some of the houses and saw that meals were served appropriately and the portion size was also appropriate. We saw that people who needed support to eat had sufficient staff time allocated and that staff took time to talk to and socialise with people. There were staff on hand for people who required support with meals. Some menus were not clearly displayed. We discussed this with the manager who said they would look at improving the way the menus were displayed especially on the dementia care houses.

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

Summary of findings

and kindness. One relative described staff as, "friendly and helpful.'' They also said when their relative was being moved using a hoist, "Staff talk to [person] before they lift [them] and talk [person] through it."

We observed staff in the communal areas of all the houses we visited. Staff interactions towards people were respectful and pleasant. During these interactions, staff appeared to listen carefully to and made efforts to communicate with people effectively.

We asked whether privacy was respected. One relative commented, "I have seen staff knocking on doors before going into a person`s room - they are very thoughtful." This was not always consistent. We found an example where privacy when using the toilet [for people living with dementia] had been infringed. On one unit we found a lack of effective locks on toilet/bathroom doors for people to use. One toilet had no lock on at all. This was seen to compromise people's privacy during our inspection.

We told the provider to take action.

We saw different levels of staff social interaction on different houses. If there was a high ratio of very dependent people in terms of personal care [for example the dementia nursing house] this time was reduced. The home employed 'hobby therapists' who were responsible for initiating some activities within the home and we saw some interactions at various times which were positive and helped people to have a greater sense of wellbeing.

We saw references in care files to individual ways that people communicated and made their needs known. We also saw examples were people had been included in the care planning so they could play an active role in their care although this was not consistent and generally centred around specific assessments or 'best interest' decisions. People and relatives told us they were not included in any of the reviews of care planning and we saw no evidence in care files. People and relatives told us, 'Staff will always tell us if we need to know anything, such as a fall.''

We looked at the care record files for 13 people who lived at the home. We found, some examples were staff had not updated care plans and records as care needs had changed. One example was a person who had returned from hospital three days previously with new care needs. The risk of not updating major changes to peoples care plans is that new staff might be unaware of their changed care needs and there is an increased risk that specific areas of care might not be effectively monitored and reviewed.

We found examples where care planning had not been individualised with people's individual communication needs; for example, a person who had experienced a stroke and a person who had a learning disability. We saw there had been no assessment of the use of any communication aids such as written communication sheets or pictures.

We told the provider to take action

We looked at the daily social activities that people engaged in. We asked people who lived at the home how they spent their day. We found variations between houses as to the level of daily activities for people. People's comments varied but included, "There is nothing else to do" (but watch television), "Nothing goes on", "There is not much entertainment." We saw a good level of activity on a dementia care unit where people were engaged and active. This was not duplicated however in other houses that varied in their level of personalised activities.

A complaints procedure was in place and most people, including relatives, we spoke with were aware of this procedure. We spoke with the registered manager who showed us how complaints were recorded and responded to. We saw recent examples of complaints that had been investigated and a response made.

At our last inspection in September 2014 we had found the home in breach of regulations relating to assessing and monitoring the quality of service provision. This was because management did not always protect against unsafe care and treatment by identifying, assessing and monitoring through effective operating systems. We told the provider to take action.

Unlike our previous inspection the registered manager had now got two clinical services managers [CSM] in post to support the daily management systems in the home. The company had also provided another manager to work alongside the registered manager to provide any extra support needed. We spoke with these managers as well as other senior managers for BUPA. Managers felt they had openly acknowledged previous failings in the home and had developed action plans to improve standards and meet requirements.

Summary of findings

The registered manager explained the organisation's system of audits from 'house' level to senior management level and how the results of audits were monitored and fed through to higher managers in the company. Any areas for improvement could be picked up and an action plan devised to help ensure continual improvements. The area manager and quality assurance manager conducted some audits with the registered manager.

Overall we found the management systems in the home were 'tighter' and had assisted in the progress the home had made. There was still a need to evidence on-going consistency however.

Some issues we identified on inspection had not been identified by the homes own audits. We discussed some findings where certain auditing processes had not been 'joined up'. In other words they had not provided effective feedback in good time so that improvement could be actioned. One example was the audit by the specialist dementia nurse into the dementia care environment on two of the houses, which had been undertaken some time ago but not fed back to the respective areas. Another was the annual resident and relative feedback survey. We saw the results of a survey dated January 2014 but this contained the results of a survey carried out in October 2013. The information about people's feedback was poorly presented and was not user friendly for people reading it. The registered manager could not locate any actions that had been taken regarding any of the feedback. The registered manager said they would look at making this system better presented and timelier.

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 safe.

At this inspection we found that overall management of medicines had improved, however, from our findings during the visit and the incidence of medicine errors, we found that overall people were still not fully protected against the risks associated with medicines because the provider's arrangements to manage medicines were not consistently followed.

Care was organised so any risks were assessed and plans put in place to maximise peoples independence whilst help ensure people's safety.

Staff understood what abuse meant and knew the correct procedure to follow if they thought someone was being abused.

There were enough staff on duty at all times to help ensure people were cared for in a safe manner. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Although standards for the safe monitoring and control of infection control had improved there were still key areas of inconsistency.

Is the service effective?

Good

The service was effective.

People living at the home had been assessed as having capacity to make decisions regarding their care. We saw the registered manager and staff understood and were following the principals of the Mental Capacity Act (2005) and knew how to apply these if needed.

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

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

Is the service caring?

Requires Improvement

There were areas that could be improved.

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

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

We found a lack of privacy in one area as there was a lack of effective locks on toilet doors in one area we visited.

Summary of findings

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. We found that people living in the home and/or their relatives could be more included in on-going reviews of their care plans.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some areas of planned care could be more personalised; these included the way people communicated.

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

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

Is the service well-led?

Requires Improvement

The service was not always well led.

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

We found the manager and staff to be open and caring and they spoke about people as individuals. There were systems in place to get feedback from people so that the service could be developed with respect to their needs and wishes but these needed developing to provide feedback more effectively.

The home had made improvements since our last inspection. There were areas of care management that still needed to be improved and these had not always been identified by existing audits and systems in the home. The management team acknowledged that further improvements were needed.

St Nicholas Nursing Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place over three days on 28, 29 and 30 January 2015. The inspection team consisted of three adult social care inspectors, a pharmacy inspector, a specialist advisor for infection control 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 not able to review a Provider Information Return (PIR) before 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 had not requested this prior to the inspection. We reviewed other information we held about the home.

During the visit we visited all six of the units [houses] that make up St Nicholas Nursing Home. These included two 'houses' 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 26 of the people who lived at the home. We spoke with 11 visiting 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 care/support staff and the registered manager. We also spoke with other senior managers in the organisation including the area manager, the quality assurance manager and the training manager.

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

When we spoke with people living at St Nicholas Nursing Home they told us they were settled and felt safe. Their comments included: "We are looked after very well – I am moving soon but I have felt very safe here'' and "All the staff are very good here – if I had a problem I could talk to any one of them.'' One visitor described their relative as appearing to be "settled and safe" since their admission to the home. Other relatives said, "The staff on here are really dedicated – if anyone needs anything one of them is straight there" and "I come in about three times a week but when I go home I know she is well looked after and kept safe." There was universal agreement that people felt confidence in the ability of the staff to support them and felt 'well-looked after'.

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

Staff we spoke with had a good understanding of the importance of maintaining people's safety and reporting any concerns, including alleged abuse, to the manager of the home. One staff said, "The most important part of my job is to care for people as best I can and keep them happy and safe." Another staff member told us, "The manager on this unit is great and if you had any issues or concerns you could just knock on her door and talk to her."

There had been 15 safeguarding incidents that had occurred since the last inspection. These are incidents or examples of care were people may be at risk of abuse and neglect and require investigation. Four of these were incidents involving medication errors. These had been picked up by the home's own audits [checks] and notified appropriately. Two involved the management of minor incidents were people with challenging behaviour were being supported and were also managed appropriately. A complaint of poor care, including poor attention to personal care, assisting people to mobilise and poor skin care, was investigated by Sefton Social Services who concluded that: 'Care staff were providing an appropriate level of care'.

The home had assisted the local authority safeguarding team and agreed protocols had been followed in terms of investigating and ensuring any lessons had been learnt and effective action had been taken. This approach helped ensure people were kept safe and their rights upheld. We saw that the local contact numbers for the Local Authority safeguarding team were available along with the home's safeguarding policy.

We were concerned however, that two of the investigations into poor care at St Nicholas Nursing Home in November and December 2014 found evidence of failings in the standard of care received by two people at the time. In one case the family and safeguarding team felt that a person had been neglected in certain aspects of care and had been moved out of the home and found other accommodation. In the other case, the safeguarding investigation revealed failings in the care for a person who had pressure sores. The investigation concluded that safe care had not been carried out and there were failings in monitoring of the person concerned and failings in the recording of care.

We asked about staffing at the home. At our last inspection in September 2014 we had found the home in breach of regulations relating to staffing. At that time, levels of nursing and care staff, were not sufficient to ensure people received a consistent level of safe care. We issued a warning notice and told the provider to take action. The provider sent us a series of action plans to tell us how the home was progressing and the most recent action plan dated 16 January 2015 maintained staffing was now satisfactory. At this inspection we found that overall staffing had been improved.

The action plan from the provider told us that there had been staff recruitment since October 2014 including nursing and care staff. it was acknowledged that recruitment needed to continue but the registered manager told us that on a daily basis each 'house' was now covered by sufficient staff. We were told that four out of the six houses had a 'house manager'.

We visited all of the houses on our inspection. We found staffing was now more stable on each house. Staff we spoke with told us there had, overall, been a marked improvement in the level and consistency of staffing. One staff said, ''Things have improved. Staff numbers have been quite stable recently. This gives us more time to organise

Requires Improvement

Is the service safe?

care.'' another staff member told us, ''We used to have agency [staff] on days all the time, but not now.'' A nurse said, ''I was able to do the medicines this morning in good time when previously it had been a struggle.''

We observed there were enough staff to carry out care in a timely manner. We saw staff were attentive to people's needs; no one appeared to be in distress through lack of attention. For example, we observed people living with dementia were attended to quickly when they became agitated or wanted assistance. When we looked at the duty rotas for each unit we saw that the provider's designated numbers of staff were being met.

We spoke with some staff who felt the incidence of staff having to move to other houses to covered unplanned staff deficits was still an issue and some staff felt demoralised if this happened too much. More particularly we found that house managers were not being afforded the 'supernumerary' time allocated by the provider to carry out management and administration duties. Sometimes this involved following up on important audits of care such as actions from medication audits and care files and care documents. We found examples where actioned had been late in following up as house managers told us they 'did not have enough time'. In one example a medication audit completed by a senior manager had specified actions to improve medication safety. A time to complete the actions had been set on the audit but this had not been followed up by the house manager until a week later. In another example a house manager had come into work on their day off as they had not had the time to catch up on paper work. Another audit by a senior manager had been completed on a care plan which had been found to be in need of review. The 'action' date set on the audit had been missed by over two weeks.

We discussed this with the registered manager. We were told that staff recruitment would continue with the aim of further stabilising each house and this would help ensure house managers had necessary time to carry out their management duties.

Overall we found the warning notice issued following our inspection in September 2014 had been met.

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

We found during our inspection that people were assessed for any risks regarding their health care needs. For example, risk assessments had been carried out to assess people's risk of developing a pressure sore and risk assessments for the use of bedrails to help ensure people were safe. Dietary needs and nutritional requirements had also been recorded and assessed routinely using an appropriate assessment tool and weight charts were seen and had been completed appropriately on a monthly basis. We reviewed the care of one person on the house accommodating people with a learning disability. The person displayed some challenging behaviours that staff were closely monitoring. Within the person's care plan we saw a comprehensive action plan to monitor behaviour including the use of distraction techniques. This helped the person to be as independent as possible.

At our last inspection in September 2014 we found the home in breach of regulations relating to safe administration of medicines. This was because people were not always protected by the medication administration systems in place. We issued a warning notice and told the provider to take action. The provider's action plan told us that systems had been reviewed and improved. At this inspection we found that overall management of medicines had improved; however, from our findings during the visit and the incidence of medicine errors, we found that overall people were still not fully protected against the risks associated with medicines. This was because the provider's arrangements to manage medicines were not consistently followed.

We were accompanied by a pharmacist inspector on this visit. We looked at a sample of medicines records and stocks for nine people who lived on two different units of the home, as well as other records and documents relating to the management of medicines. The medicines storage areas were clean and tidy and medicines were kept securely in locked trolleys and cabinets.

Medication Administration Records (MARs) were clear and accurate. We checked a sample of medicines against the corresponding records and these showed that medicines had generally been given correctly.

Requires Improvement

Is the service safe?

We found that the system in place for ordering of one person's medicines was not in accordance with the provider's policies and procedures. This meant that it was difficult for staff to know whether prescriptions had been ordered and written and as a result, adequate stocks of this person's medicines were not always available. Having good stock control helps to reduce the risk of people missing their medicines as well as reducing the amount of medicines stored and potentially wasted.

This remains a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations

2010.

At our last inspection in September 2014 we had found the home in breach of regulations relating to cleanliness and infection control. This was because people were not protected from the risk of infection because appropriate guidance was not being followed. People were not being cared for in a clean, hygienic environment. We issued a warning notice and told the provider to take action. The provider's action plan told us that systems had been reviewed and improved.

At this inspection we found that overall management of infection control had progressed but there were still areas that needed improvement. People were still not fully protected against the risk of infection. This was because the provider's arrangements to manage infection were not consistently followed.

We looked in detail at standards of infection control in two of the houses and looked more generally at the other houses at St Nicholas'. House managers told us that each house had an infection prevention and control champion (IPC) who would be trained in basics of IPC. One overall person would be in charge of Infection prevention although this person had not yet been appointed [we were told on day three of the inspection this had now been agreed]. A plan was seen that would be used for implementing a programme called 'Call to action'. The training was aimed at taking staff back to basics for infection prevention and would be disseminated to all units. Liverpool Community Health [LCH] infection prevention had been in the home to do several updates on infection prevention which were documented.

We spoke with LCH prior to the inspection. They told us there had been two infectious outbreaks in the home in November and December 2014. LCH reported some improvement in management of infection control but more was needed.

When we inspected we found areas that had been improved. For example, hand hygiene audits were now being completed by house managers; polices seen were up-to-date and were being and were disseminated to house managers on the inspection; temperatures in the bed pan washer were recorded and seen to be correct for a thermal wash; night staff cleaning rota charts had been updated and nursing equipment and bedrooms were being checked and cleaned by the night staff.

Monthly IPC audits were completed and actioned and the next one was due in February 2015;

New taps had been installed so staff could carry out effective hand washing; personal protective clothing was in wall mounted dispensers and readily available; people were seen to be provided with support to wash their hands prior to meals with wipes and again after meals [although this was not universal]; Table cloths had been changed and residents had clean protective aprons on (those that needed them) ready for their meals. Staff used protective aprons to serve meals which were identified by correct colour.

We also saw that slings used in hoists to move people who lacked mobility were now issued for each patient appropriately and laundered regularly or if contaminated. We saw that all commode pans in people's bedrooms were clean dry and free from body fluids. Enteral feeding equipment for people was clean and free from stains. All equipment was disposed of after use correctly and current equipment was in date.

On general inspection of units we found levels of cleanliness to be improved. Toilets and bathrooms had hand wash facilities including liquid soap and paper towels for use.

All of these improvements were noted from our previous inspection and helped ensure people were protected for the risk of infection.

There were still some areas of concern and inconsistency however. For example not all staff were seen to be adhering to hand washing routines. Some cleaning was not

Requires Improvement

Is the service safe?

thorough. For example on both houses visited there was food debris under dining room tables which was left after meals [cleaned when we pointed it out]. There was also food debris in some bedrooms observed during the inspection and it was unclear how long this would remain as there was only one domestic staff for each of the houses. There was a commode pan stored in the sluice still contaminated with faeces. This was lifted from the shelf it was stored, which was also very dusty [this was later cleaned when we pointed it out]. The clinical room on one house had an old air-conditioning unit that did not work this had been there several months and was cluttering the room; it was also very dusty underneath. This was, again, pointed out and we were advised it would be removed.

Overall we found there had been enough progress to meet the warning notice but there still needed to be further developments of staff roles and on-going vigilance.

Following the inspection we had further feedback from LCH. There had been an infectious outbreak on one unit the week following our inspection. The outbreak had been generally well managed but there was lack of clarity around the movement of staff from the infected house to other areas. Staff had not been clear about this area of the home's policy which potentially could put other areas at risk of cross infection.

This remains a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010.

Good

Is the service effective?

Our findings

We looked in detail at the care received by some of the people living St Nicholas Nursing Home. One person, who lived with dementia, had highly dependent and complex care needs. We saw that they had received input from a ranged of social and health care professionals who had linked in effectively with the home. One professional told us the manager and staff had been very proactive in managing the person's care. Professional support had been documented by the Community Mental health team [CMHT]. There were also some records to show input from the person's GP and dietician.

We spoke with a visiting health care professional who told us staff worked well to support this person. In particular the professional had been impressed by the staff who had worked well with the person's family. There had been some challenging behaviours which staff understood and overall provided good support.

We reviewed the care of 15 people; some of whom were experiencing pain, or had ongoing health conditions that required constant monitoring. We found referrals had been made to provide appropriate health care professionals when needed.

There was evidence that residents were able to access their GP. One person told us about having been referred by their GP for an X-ray at the hospital, which had been carried out. When we checked we saw that appropriate follow-up action on this person's condition was being taken. A relative told us the GP had recently visited to take some blood for a routine check of their relative's condition. People we spoke with on the inspection told us that staff had the knowledge and skills to support them.

We looked at the training and support in place for staff. The training manager told us about the induction programme for new staff. This was covered over an initial four to five day programme covering subjects such as; role of the care worker, equality and diversity, dementia awareness, medicines, and health and safety issues. New staff we spoke with said they had attended and felt the induction prepared them for their role. Extra training was included for nursing staff and senior carers if needed.

The training manager showed us a copy of the staff training matrix which identified and plotted training for staff in 'statutory' subjects such as health and safety, medication, safeguarding, infection control and fire awareness.

We asked senior managers about any developments regarding specialist leads for the home. We met with a nurse, employed by the company, specialising in care for people living with dementia [Admiral Nurse]. We were told about plans to develop staff education in dementia awareness. There was training to develop 'person centred coaches' who would lead in dementia care. Currently there were two staff trained. The home had also identified clinical leads in infection control and there were identified 'dignity' champions although both of these roles were fairly new.

From speaking with staff on the units we found that these developments were very new and needed to be embedded. For example staff on both houses for people living with dementia had had minimal training in dementia care. One manager identified some staff who had undertaken training but this had been 'a number of years ago'. The specialist admiral nurse had identified areas for improvements in best practice for dementia care but these had yet to be fully introduced.

The manager told us that some staff had a qualification in care such as NVQ [National Vocational Qualification] or Diploma and this was confirmed by records we saw where 42% of staff had a qualification. Other staff were being signed up to start this training. Staff spoken with said they felt supported by the training provided.

Some staff told us they had regular support sessions with their line managers such as supervision sessions and staff meetings. We found these were not consistent on all houses however. Some house managers said that lack of effective time for their management role meant that 'staff supervisions were behind'. Likewise, we found support systems such as staff meetings [at house level] were also not yet consistent. We spoke with house managers and some felt their role needed more support in terms of assured supernumerary time to ensure staff were supported more regularly. We spoke with the registered manager who told us there were plans to ensure this happened. We were told that the development of the house manager role was a key target; there was no specific date for this to be achieved however.

Good

Is the service effective?

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. This is legislation to protect and empower people who may not be able to make their own decisions. People living at St Nicholas' varied in their capacity to make decisions regarding their care. We saw examples where people had been supported and included to make key decisions regarding their care. Where people had lacked capacity to make decisions we saw that decisions had been made in their 'best interest'. We saw this followed good practice in line with the MCA Code of Practice.

We also discussed some of the decisions regarding the right to refuse specific medical treatment in case of a cardiac arrest ['do not resuscitate' (DNR) procedures]. Some of the DNR records for people who lacked capacity to decide for themselves had had a 'best interest' decision made. In two of the three examples we looked at on one unit [house] the decision did not include clear evidence of a mental capacity assessment. In these examples we could not see whether the person's family had been consulted as part of the best interest decision. We discussed with the house manager how some DNR decisions could be better evidenced and recorded.

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

We discussed with staff and the people living at the home how meals were organised. We recorded mixed opinions but generally people told us the meals were good and well presented. One person said, "You get plenty of food and a nice choice as well – I always enjoy it." Another person said, "I like the food, you get a choice. There's enough to eat."

We observed the dinner time meal on some of the houses and saw that meals were served appropriately and the portion size was also appropriate. We saw that people who needed support to eat had sufficient staff time allocated and that staff took time to talk to and socialise with people. There were staff on hand for people who required support with. Most houses [not all] had a designated 'hostess' who provided extra support with meals. People were served individually with their meals being brought to them on a tray. Nobody was rushed. We saw staff asking people if they wanted an alternative to what was being offered.

Some menus were displayed either on the tables or on the walls near dining areas in the individual houses. However we noted that the print was very small. There were no pictures to illustrate the dishes for those people who couldn't read the print or who may not understand. We discussed this with the registered manager who said they would look improving the way the menus were displayed especially on the dementia care houses.

Requires Improvement

Is the service caring?

Our findings

We observed the interactions between staff and people living at the home. We saw there was a rapport and understanding.

People we spoke with and their relatives said that they (or their relatives) were being treated with respect, dignity and kindness. One relative described staff as, "friendly and helpful.'' They also said when their relative was being moved using a hoist, "Staff talk to him before they lift him and talk him through it."

Relatives told us that they could visit at any time. Visiting at meal-times was discouraged, on the grounds that it could be disruptive and staff where trying to keep meal times 'protected'. Relatives said they didn't mind this rule and didn't feel that they were actually being prevented from coming in at this time.

We observed staff in the communal areas of all the houses we visited. Staff interactions towards people were respectful and pleasant. During these interactions, staff appeared to listen carefully to and made efforts to communicate with people effectively. Several people presented with challenging behaviour in terms of verbally negative or abusive comments, and staff handled these situations with good-humour and managed to diffuse potential conflict appropriately.

We saw staff displaying patience and tact. Over lunch one person who was living with dementia was refusing to eat any of the food on offer. The member of staff, whilst encouraging, and offering alternative items of food, did not press the person into eating, respecting their choice not to eat, as they were adamant in their refusal. Staff were careful to monitor the person and to offer food again later.

We asked whether privacy was respected. One relative commented, "I have seen staff knocking on doors before going into a person`s room - they are very thoughtful." We spoke with one relative who demonstrated how a person's privacy was preserved by the door locking device on the inside of the bedroom door, which enabled them to lock the door from the inside, thus preventing any other person entering the room, and at the same time, enabling staff to enter from the outside if necessary, by key (so no risk in terms of safety).

Again this was not always consistent. We found an example where privacy when using the toilet [for people living with dementia] had been infringed. On one unit we found a lack of effective locks on toilet/bathroom doors for people to use. One toilet had no lock on at all. This was seen to compromise people's privacy during our inspection. We fed this back to the house manager and registered manager for action to be taken.

This is a breach of Regulation 17(1)a (2)a HSCA 2008 (Regulated Activities) Regulations

2010.

People told us they felt they were listened to and generally staff acted on their views and opinions. One person said; ''They [staff] do listen when you talk to them. There's not always a lot of time to just talk and socialise.'' We saw different levels of staff 'socialisation' on different houses. If there was a high ratio of very dependent people in terms of personal care [for example the dementia nursing house] this time was reduced. The home employed 'hobby therapists' who were responsible for initiating some activities within the home and we saw some interactions at various times which were positive and helped people to have a greater sense of wellbeing.

Throughout the inspection we observed staff supporting people who lived at the home in a timely, dignified and respectful way. Over the three days of the inspection we saw the home as generally busy with lots of daily activity. We saw staff respond in a timely and flexible way so people did not have to wait if they needed support.

The staff we spoke with had a good knowledge of people's needs. The manager and senior staff told us of the value of building consistent relationships and having continuity to the care provided. They felt this had improved with the improvements in staffing generally.

Requires Improvement

Is the service responsive?

Our findings

We asked people who lived at the home how staff involved them in planning their care. People who were able to give an opinion and relatives we spoke with varied in their opinions. They said they felt involved in any key decisions. For example, one relative said they had been consulted about a decision made regarding whether emergency resuscitation should be carried out if needed for their relative.

We found other, documented examples, where this had not been consistent however. Some people said they had been asked when staff carried out various assessments but none of the people we spoke with or their relatives understood, or had seen their care plan. Only some, most notably on the residential dementia house, had documented evidence that people had been spoken with and consulted routinely at reviews of their care plan [or aspects of it]. None of the care records we saw had a care plan which had been signed.

People and relatives told us, 'Staff will always tell us if we need to know anything, such as a fall.'' We saw a sheet in the care records which evidenced when staff communicated with relatives over specific issues.

We looked at the care record files for 13 people who lived at the home. We found that care plans and records overall were individualised to people's preferences and reflected their identified needs. We found, however, some examples were staff had not updated care plans and records as care needs had changed. Also, examples where care planning had not been individualised with respect to people's individual communication needs.

One example was a person who had returned from hospital three days previously. We heard that their care needs had changed considerable; they were on new medication for a newly diagnosed medical condition, had lost weight and needed careful monitoring for dietary intake. We found staff were aware and were monitoring the person but when we looked at the care records they had not been updated. The house manager showed us a 'short term care plan' which could have been used. The risk of not updating major changes to people's care plans is that staff may be unaware of their changed care needs and there is an increased risk that specific areas of care might not be effectively monitored and reviewed.

One person who had experienced a stroke could not communicate verbally although understood their surroundings. We saw there had been no assessment of the use of any communication aids such as written communication sheets or pictures. We found this was also to be the case with a person who had a learning disability.

This is a breach of Regulation 9(1)(b) i & ii of the HSCA 2008 (Regulated Activities) Regulations

2010.

We looked at the daily social activities that people engaged in. We asked people who lived at the home how they spent their day. We found variations between units as to the level of daily activities for people. On the residential dementia house we observed a game of indoor bowls in progress. On speaking to the unit manager, we found out that other residents had been taken to the adjacent unit that afternoon for a musical session. We were informed that other interactive sessions take place on the unit include 'knit and natter' [we saw this later] and baking. The house manager said that some residents/relatives were able to attend a local dementia café. On the dementia nursing unit, the senior activities coordinator [hobby therapist] had been giving hand-care massages to individual people in the lounge and to people in their own room.

We spoke with one relative and a person living at the home who told us about a trip they had made to the theatre and they showed us photographs highlighting the trip. This person told us they were able to participate in gardening during the summer months and that they often helped out with laying the tables etc. They were also going to be helping staff with 'admin'. It was clear that these kind of stimulating activities were contributing to the person's well-being and day-to-day living in the home. It was noticed that the 'hobby therapist' had more input on this house – at least twice a day.

This kind of example was not duplicated however in other houses that varied in their level of personalised activities. People's comments included, "There is nothing else to do" (but watch television), "Nothing goes on", "There is not much entertainment'' and "I haven't seen any activities." A relative said that they had never asked about any activities (for his relative in the home) or seen any, but assumed they happened when they weren't there.

We asked how managers were planning to improve the level of personalised care in the home. The specialist nurse

Requires Improvement

Is the service responsive?

in dementia care had carried out an audit which had identified improvements needed in personalised care on the dementia care houses in terms of the environment. One house manager told us this had not been fed back so, to date, no action had been taken.

A complaints procedure was in place and most people, including relatives, we spoke with were aware of this procedure. We spoke with the registered manager who showed us how complaints were recorded and responded to. We saw recent examples of complaints that had been investigated and a response made. None of the people we spoke with or their relatives had ever made a complaint but all felt that they could speak to a carer or the house manager if they were worried about anything.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post. We spent time talking to the registered manager and asked them to define the culture of the home and the main aims and objectives. We were shown the Statement of Purpose [SOP] for the home and this made strong reference to 'person centred care' and valuing people's individual rights. Since being appointed as registered manager, there was feeling that standards in the home were more consistent as staffing had become more stable.

At our last inspection in September 2014 we had found the home in breach of regulations relating to assessing and monitoring the quality of service provision. This was because management did not always protect against unsafe care and treatment by identifying, assessing and monitoring through effective operating systems. We issued a warning notice and told the provider to take action. The provider's action plan told us that systems had been reviewed and improved and we checked this out on this inspection.

Unlike our previous inspection the registered manager had now got two clinical services managers [CSM] in post to support the daily management systems in the home. The company had also provided another manager to work alongside the registered manager to provide any extra support needed. We spoke with these managers as well as other senior managers for BUPA. Managers felt they had openly acknowledged previous failings in the home and had developed action plans to improve standards and meet requirements.

Staff spoken with told us that all levels of management were more consistent in their approach and were more 'visible' around the home. Managers had arranged staff meetings to get staff feedback including preferred areas or work.

The registered manager explained the companies system of audits from 'house' level to senior management level and how the results of audits were monitored and fed through to higher managers in the company. Any areas for improvement could be picked up and an action plan devised to help ensure continual improvements. We saw copies of 'service improvement plans' [SIP] which addressed areas of specific concern. These had been primarily areas highlighted from our last inspection. The registered manager said that these audits had previously been in operation but had, previously, not always been carried out effectively or necessary actions clearly identified.

We saw audits conducted by the house managers and CSM's. These concerned clinical issues such as care plan reviews, medicine management, infection control and pressure sore management. We saw a schedule for these being carried out. Health and safety meetings were held with house managers following various audits. We saw notes from a meeting where an accident had been discussed and action taken to reduce the risk of further incidents.

The area manager and quality assurance manager also conducted some audits with the registered manager. We saw a copy of the 'provider review carried out in January, which reviewed medication safety and also referred to information gathered in the 'quality metrics' report. This was a report covering key indicators of care taken from audits carried out. Clinical issues were highlighted. For example, we saw a review of all people who had lost weight had recorded appropriate referrals had been made to dieticians and GP's. This was monitored higher up in the organisation.

Overall we found the management systems in the home were 'tighter' and had assisted in the progress the home had made. We discussed the need to evidence on-going consistency as the history of the home over the past two years had been marked by management inconsistency.

Some improvements were still needed. We discussed some findings where certain auditing processes had not been 'joined up'. In other words they had not provided effective feedback in good time so that improvement could be actioned. One example was the audit by the specialist dementia nurse into the dementia care environment on two of the houses, which had been undertaken some time ago but not fed back effectively to the respective areas.

We identified some areas of care management that needed improvement from our inspection. For example, the lack of input by people living at the home and their families into on-going reviews of care planning; issues around protecting people's privacy as well as inconsistencies in evidencing mental capacity assessment and family input around decisions regarding resuscitation [DNR]. These had not been identified by existing systems of audit.

Requires Improvement

Is the service well-led?

We saw a process was in place to seek the views of people living at the home and their families. We saw the results of a resident and relative survey dated January 2014 but this contained the results of a survey carried out in October 2013. The information about people's feedback was poorly presented and was not user friendly for people reading it. There was no easy read formats available and the survey was not displayed anywhere at 'house' level. The registered manager could not locate any actions that had been taken regarding any of the feedback. This was discussed at our feedback with the home and the registered manager said they would look at making this system better presented and timelier.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **How the regulation was not being met:** People were not protected against the risks associated with medicines because the provider's arrangements to manage medicines were not consistently followed. Regulation 13(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **How the regulation was not being met:** People privacy and dignity was not respected as the provider had not maintained effective locks on toilet/ bathroom doors. Regulation 17(1)a 2(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **How the regulation was not being met:** The provider’s arrangements to manage infection were not consistently followed. Regulation 12(1)(a)(b)(c) 2(a) (c)i

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met:

The planning of care did not always ensure the welfare and safety of people. Changing care needs had not been reflected in the care planning.

Regulation 9(1)(b) i & ii

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.