St. George's Care Ltd

St George's Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 9 August 2018. The inspection was unannounced. The service provides accommodation and personal care for up to 29 older people. Twenty-three people were living at the home at the time of our inspection.

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

At our previous inspection on 27 March 2017 the overall rating for the home was 'requires improvement' and we asked the provider to make the necessary improvements. At this inspection, we found there had been insufficient action to improve and found additional areas needing improvement across all the key questions. We identified four breaches in the regulations and therefore the home continues to be 'Requires Improvement' overall. Breaches related to the safe care and treatment people received, safeguarding people from abuse, not submitting statutory notifications related to incidents at the home and failing to ensure there was good governance of the service.

The provider had not taken all reasonable measures to minimise risks to people's health, safety and wellbeing. Systems and processes had not been effective in identifying and driving improvement at the home. Following the inspection visit we met with the provider and they explained how they would make the required improvements.

The registered manager in post at our previous inspection had left and a new manager, who had previously been the deputy manager, had been appointed. They were not registered with us at the time of this inspection. The provider told us of their plans for an application to be made for this person to be registered with us. 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.

During this inspection we found numerous reportable incidents had occurred at the home that had resulted in safeguarding referrals being made to the local authority. These had not been reported to us as required. There were also increasing numbers of accidents and incidents within the home and these had not been analysed and considered to help minimise the risk of them happening again.

People had limited involvement in the ongoing review and planning of their care. Staff told us and people confirmed, consent was sought from people before delivering care. The relevant applications had been made where it was considered people were being deprived of their liberty. However, some of the information around people's capacity was conflicting and the reason for the application was not always clear.

We saw staffing arrangements were not always effective because care staff sometimes completed ancillary duties such as laundry and cleaning. This impacted on the amount of time staff could spend with people as well as the amount of time that could be spent keeping all areas of the home clean.

Some staff had not completed training the provider considered essential to manage people's care safely. Some staff practice was not safe such as techniques used to move and transfer people although we saw further training was planned.

Systems did not consistently demonstrate that people always received care and support in accordance with their needs.

Health and safety checks were completed such as gas, electrical and water to ensure both equipment and the environment was safe for people. However, audit checks of the environment and equipment were not consistently effective as we had identified some potential risks. This included risks related to infection control and the home not being sufficiently secure to keep people safe. Equipment checks had not identified repairs needed to ensure these were completed in a timely manner and equipment people used was safe.

Most people's medicines were managed and administered safely to maintain their health but records in regard to the applications of creams were not always completed to show they had been applied as prescribed.

Systems for the recruitment of staff were not consistently followed to ensure staff were safe to work with people.

People were able to access healthcare professionals to address their healthcare needs when required.

Staff had some understanding of their responsibilities to protect people from harm and were aware of the provider's whistleblowing policies.

People and their family members spoke positively of living at the home and of the staff and said they had no concerns and felt at ease to raise any complaints with staff if they needed to. We saw staff were caring and respectful in their approach.

People and their relatives were given the opportunity to comment on the quality of the service through satisfaction questionnaires and meetings. Staff also had regular meetings where they could discuss any concerns or development needs they had.

People had access to some activities but the time staff spent with people was variable with little time spent on activities linked to people's interests, preferences and abilities.

People liked the food available and said they had a choice of meals. Those people who needed support to eat were provided with this as required.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

Risks related to people's care and the environment were not always sufficiently managed to keep people safe. Systems to safeguard people from abuse and potential harm were not effectively followed to keep people safe. Most people's medicines were managed and administered safely, the exception being the management of creams. There were enough staff to meet people's basic care needs but staffing arrangements were not always effective. Systems for the safe recruitment of staff were not consistently followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were asked for their consent before providing care and staff had some understanding of the Mental Capacity Act. Deprivation of Liberty Safeguards applications had been submitted where the provider considered restrictions were placed on people's liberty but it was not always clear why these were required. Training records showed not all staff had completed essential training which impacted on the effectiveness of the service. People enjoyed the food and were supported to eat and drink where appropriate. People had access to healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives were positive about the staff. People were supported by a staff team who were patient and respectful towards them. Some practices at the home were not caring. People's privacy and dignity was not always maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always experience person centred care in

accordance with their needs, preferences and abilities. People's care plans did not always support staff in delivering care in accordance with their needs. Staff knew people well and had some understanding of how to respond to their needs. Complaints were responded to in a timely manner.

Is the service well-led?

Requires Improvement 

The service was not consistently well-led.

Processes and systems to check the quality and safety of the service were not sufficient or effective in identifying and acting upon areas which required improvement. This resulted in some unsafe practice, some of which, impacted on people's care. Statutory notifications following incidents at the home were not sent to us as required. People and staff were positive in their comments of the management of the home.

St George's 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 was planned to check 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.

The inspection took place on 9 August 2018 and was unannounced. The inspection was undertaken by three inspectors, one of whose primary role was to speak with people and visitors about their experiences of the home.

As part of planning the inspection, we reviewed information we held about the service. We looked at information received from the local authority commissioners and the statutory notifications the manager had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. These can include unexpected deaths and injuries that occurred when people received care. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority.

We also looked at other information we had received from members of the public and reviewed information we had received from a 'whistleblower' who had raised concerns about the home.

We considered the information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make. We used some of this information to plan which areas we were going to focus on during our inspection visit.

During our inspection visit we spoke with six people and two relatives about their experiences of the home. We spoke with the manager, a compliance manager, four care staff and the cook. Some people who lived at the home were not able to tell us in detail, about how they were cared for so we observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

We reviewed two people's care plans and daily records in detail and looked at other care records related to

people's care to see how care and treatment was planned and delivered. We looked at records related to staff recruitment, staff training and complaints. We reviewed the provider's quality monitoring processes and outcomes to see what actions were taken and planned to improve the quality of the service.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection we rated this key question as 'requires improvement' because systems to safeguard people and protect them from harm were not sufficient. Improvements were required in managing risks related to people's health and in the management of people's prescribed creams. During this inspection we found these areas continued to need improvement. We also identified additional risks and this key question continues therefore to be rated 'requires improvement'.

Systems in place to manage risks were not always effective. Although people's needs had been assessed to identify risks associated with their care, risk assessments did not consistently reflect the support people needed to reduce and minimise these risks. For example, one person had a care plan with instructions for staff on how to manage the behaviour if they became anxious. This stated, "Can become agitated, offer reassurance to encourage them to calm down." However, there was no detail to further support staff such as to what specific action would calm them down. There was no information regarding the triggers to their behaviour for staff to know what signs to look for that the person was becoming anxious. There was no information about distraction techniques known to be effective for this person. The manager knew what the triggers to the person's behaviours were, but had not taken the necessary action to ensure these were recorded and followed by staff. We saw the person had left the home unobserved on more than one occasion when they had become anxious. There was a busy road outside of the home and records stated the person was not safe unsupervised outside of the home. We found insufficient action had been taken to manage this risk to keep the person safe. We made a safeguarding referral to the local authority to make them aware of the risks to the person's safety. The manager said they would add more detail to the person's risk assessment. Following our inspection visit the provider confirmed plans were in place for this person to move to more suitable alternative accommodation where their specific care and support needs could be met.

Care plan records showed one person had a catheter and staff were instructed to "change the catheter every seven days". We established from speaking with staff this was the catheter bag and not the catheter itself. Staff confirmed they had changed the person's catheter bag. However, there were no records to demonstrate the bag was being changed to this frequency to minimise the risk of infection.

Improvements were required in how people were supported to mobilise safely. Not all staff had undertaken training in supporting people to mobilise, which resulted in unsafe staff practice. Equipment used to support people to mobilise was not all in good repair. For example, one staff member held a person under their arm when assisting them to transfer from a wheelchair to a lounge chair. This staff member had not completed practical moving and handling people training. We observed two staff assisting another person using a wheelchair unsafely. One of the person's feet was dragging on the floor, because only one foot rest was in use. The person stated, "My foot is hurting" and we had to intervene to stop this practice continuing, because staff had not identified the risk to the person. One of the staff members stated that one of the foot rests did not work properly, but they had continued to use the wheelchair.

The manager and staff did not have a shared understanding of how best to mitigate people's individual

risks. We saw all the fully functional wheelchairs were in use, as people were seated in them at dining tables. The manager informed the staff member they should have hoisted one of those people from the wheelchair onto a dining chair, to free up a wheelchair to use to take the person to the toilet, and then hoist the person whose wheelchair they had borrowed back again into their wheelchair. A staff member told us people were sat in wheelchairs at the table, because some of the dining chairs didn't have arms and they didn't consider them safe or suitable for some people. Whilst staff had recognised it was not safe for people to sit in the chairs without arms, the manager's proposed solution may have caused an unnecessary risk to another person, by moving them twice with a hoist, and would have been an inconvenience to the person. There was not enough mobility equipment, in good repair, to ensure risks to people's safety were minimised. We discussed this with the provider at a meeting following the inspection and they agreed to provide more dining chairs with arms.

Improvements were required to ensure there were enough staff to meet people's individual needs and to maintain a clean and safe environment. The manager told us there were usually four care staff on duty during the day and two care staff at night. People told us they felt there were enough staff to support them. However, we found staffing arrangements were not always effective as sometimes the full complement of staff was not on duty and care staff completed additional non-caring duties such as laundry, catering and cleaning. This meant care staff were not always available to support people when needed because they were completing other duties. The time allocated to ancillary duties was not sufficiently effective as during our walk around the home, we identified numerous areas that were in need to cleaning, which meant infection control may not be effective placing people at risk of developing an infection.

Improvements were required in maintaining a clean environment to minimise the risks of infection or ill-health. We saw a washbasin was dusty and dirty; a pillow on a bed with brown stains; a bedframe was dirty and under the bed was dusty; an air cooler and cupboards in the dining room were in need of cleaning. We identified unpleasant odours around the home, including in people's bedrooms. The manager told us there was a person employed to clean six days each week and care staff cleaned at weekends. Staff told us they could not support people or complete cleaning effectively when covering these duties. One staff member told us, "We have to prioritise and residents take priority so other things (laundry and cleaning) have to wait." Another told us, "We do work short, like last week. There were three care staff, no laundry or cleaner. The day was hectic. We lost a carer to make sure some basic cleaning was done. It has an impact on people because we are rushing around."

Improvements were required in how people's prescribed medicines were managed. Most people's medicines were managed and administered safely to maintain their health, but we identified some gaps in the recording of creams, which meant there was no record to demonstrate they were applied as prescribed. For example, one person had been prescribed a cream to be applied twice a day, but records showed it had only been applied once a day for five days from the beginning of the medicine cycle. Another person had a cream prescribed as "use as directed" by the prescriber. There were no specific directions for staff to follow, but the times to administer this had been recorded once in the morning and once in the afternoon. Records showed this cream had only been applied twice on three days in the previous nine days. We found a number of creams in people's rooms and in a bathroom without prescribing labels to show who they belonged to and how they should be used.

Staff did not manage medicines safely and securely at all times. When a staff member administered medicines, they placed the blister packs (medicines stored in individual sealed pockets) on the desk in the lounge. The staff member removed one person's medicines pack and walked out of the lounge leaving the rest of the medicines unsecured and unattended. This was a risk because the home supported people living with dementia who were at risk of ingesting medicines that we left unsupervised. We alerted the manager to

this and they stayed with the medicines until the care staff member returned.

A staff member told us that staff who administered medicines had completed medicine training. However, the staff training records available, were not up-to-date to demonstrate only trained staff administered medicines. We asked the manager to send up an updated training matrix to confirm people's medicines were managed and administered by trained and competent staff. At the time of writing this report, this had not been forwarded to us.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

Improvements were required in the provider's policy and procedures for safeguarding people from the risk of abuse. The manager told us they did not keep a central record of their safeguarding referrals. The provider was not able to assess the number of concerns that had arisen or assure themselves these had been effectively managed. There was a risk the provider's safeguarding policy and procedure were not up to date as it was not dated. The safeguarding guidance available to staff was the local authority 'Safeguarding adults' procedure dated 2007, which is seven years prior to the year that the Health and Social Care Act 2014 became law and when changes were made to the various relevant agencies' responsibilities. Records showed a member of the management team had investigated a serious incident without involving the necessary external agencies, suggesting the policy and procedure for safeguarding people was not sufficiently understood by the management team.

Improvements were required in identifying the causes of accidents and incidents. Records showed that some people had unexplained bruising. There were no records to demonstrate the incidents had always been investigated to establish the cause of the bruising. There had been no effective analysis of accidents and incidents so that any action required to reduce the risk of this happening again was taken.

There was no assurance that staff had completed the necessary safeguarding training or that any training completed was up-to-date. The provider did not provide us with training information requested at our inspection visit and did not forward this to us at the time this report was written.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

The provider had systems in place to ensure the safe recruitment of staff but records to demonstrate the required pre-employment checks were incomplete. For example, the provider could not demonstrate a Disclosure and Barring Service (DBS) check had been completed for one staff member before they started working at the service. The DBS is a national agency that keeps records of criminal convictions. A member of the management team told us they were confident this had been obtained but were not able to locate it during our visit.

There were not always enough suitably skilled and experienced staff on duty to meet people's needs safely. The duty rota was not accurate as it showed the cleaner was on duty when they were not and the duty rota did not reflect how staff's time was allocated to people's needs and ancillary tasks. At lunchtime a person who needed assistance to eat was left waiting for support as staff were called to assist another person needing their support. We reported our concerns about staffing arrangements to management staff so they could be addressed.

Despite our concerns and the provider's failure to manage risks and ensure there were suitable staffing

arrangements. People who lived at St George's home told us they felt safe living there because staff were there to support them. One person told us, "I feel very safe here." A relative told us, "I know [person] is safe. I have no concerns or problems about that." People said staff were available when they needed them. One told us, "Oh yes, staff are there when you need them." Another said, "You may have to wait a minute or two if they are busy but they come. It's fine."

Staff told us they understood their responsibilities to report any concerns such as potential abuse to the manager and stated they felt people were safe at the home. One staff member told us, "They are safe because the staff care about safety. We have a coded door and we are alert to looking for any risks."

We saw that people had up-to-date personal evacuation plans which were kept in an accessible location near the entrance of the home so that staff and the emergency services would have access to these if needed.

Requires Improvement

Is the service effective?

Our findings

During our previous inspections we had rated this key question as "good". At this inspection we found improvements were needed and rated this key question as 'requires improvement'.

Improvements were required in staff training, and in keeping records of staff training. Staff training had not been completed in a timely manner or consistently for all staff. Records showed staff training had not been kept up-to-date to ensure staff could support people safely.

People told us they felt staff had the skills and knowledge to care for them effectively. One person told us, "Oh, they are very good at what they do." Another said, "Wonderful (staff), you couldn't get better. They do all sorts of training."

Improvements were required in checking staff's completion and understanding of their training. Staff gave mixed responses when we asked if they had completed the necessary training to support them in their role. Staff told us that most of their training was computer based. One staff member said they did not like this because they could not ask questions. Some said they had completed all the training the provider considered essential and others said they had not. One staff member told us, "I just turned up and started working." Another described their induction as "very good" and stated they had spent two weeks working alongside an experienced member of staff. This was to help them support people safely and effectively. Another staff member could not recall doing moving and handling people training but said it had been planned for the following week.

Improvements were required in checking staff's competence after training to support them to improve their practice. Records showed that training for new staff was based on the Care Certificate. Staff's training certificates showed the modules staff had completed, but the certificates also stated it was the manager's responsibility for checking competencies by gathering supporting evidence through observations and assessment. Staff who had completed these modules confirmed their practice had not been observed or had their competency assessed. The provider agreed to send us an updated staff training matrix so that it was clear what training staff had completed and what training was planned.

Staff told us they had attended regular supervision meetings (individual meetings) with their manager so they could discuss any concerns they had or discuss their training and development needs. One staff member told us, "Supervision is planned. We meet up to talk about things like training. You can say what you need help with." This helped staff to feel supported in their role however, it was not evident supervision meetings had been fully effective as staff were found to have training needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best

interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

People told us that staff sought their consent before providing care and we saw this happened. One person told us, "They ask me what I need them to do." Another told us, "I have a shower or a bath. They ask me if I'm ready. The girls ask what I want. They ask me what I would like to wear and help me put it on." This demonstrated staff understood the need to seek people's consent prior to delivering care.

Whilst staff demonstrated they had some understanding of MCA, they could not recall doing training in the MCA whilst working at St George's. One staff member understood people who lacked capacity would need to be supported to make decisions. They told us, "It's about their rights and if they can make decisions. Some people have variable capacity. They can make some decisions but not others. When this happens, decisions can be made in their best interest."

Improvements were required in the manager and staff's understanding of the purpose of DoLS. A mental capacity risk assessment for one person showed they did not have capacity to consent to their care and treatment and a DoLS application for authorisation to restrict the person's liberty had been submitted to the local authority. However, staff told us the person had consented to their placement at the home and understood why they were at the home, which suggested they were able to consent to this decision. Staff did not know why the application had been made.

We saw a mental capacity assessment for a second person which showed they had capacity to make their own decisions, but a DoLS application had been made which stated they did not. This meant there was conflicting information. The manager was not clear about the reason for the application. We saw DoLS applications had been made in December 2017 but these had not been followed up to check if they had been authorised.

Improvements were required in the environment to meet the needs of the people living at the home. The environment placed unnecessary restrictions on people because there was insufficient signage for rooms, toilets and bathrooms to help people independently find their way around the home. Some people lived with sight problems and some people lived with dementia, but there were no reminiscence areas or sensory items people could see, touch and talk about. Signage on some of the doors was misleading. For example, one toilet had a sign stating it was a bathroom but there was no bath in it. Two rooms had signs that stated 'toilet' but had baths in them.

People's needs were assessed before they moved to the home to make sure their needs could be met. Staff had handover meetings each day where they could discuss changes in people's care needs and any referrals needed to health professionals such as the GP or district nurse, so that any concerns were swiftly acted upon.

People told us they had sufficient to eat and drink and were provided with a choice of meals each day. One person told us, "The food is wonderful and there is plenty of it." We saw another person clap their hands in delight when staff reminded them bread and butter pudding was the dessert at lunch time. A relative told us, "They cook eggs and chips if [name] wants them. It's their favourite. They will make anything they want."

We saw the lunchtime experience was positive for some people but less positive for others. People were seated at tables, including some in wheelchairs. These people were not asked if they wanted to remain in

their wheelchairs or sit in on a dining chair. A staff member told us this was because there were not enough suitable chairs, with arms, for people to use. Those people who required assistance to eat from staff were seated together and were served their meals last, after staff had served meals to everyone else. However, one person said, "I don't mind waiting." We saw staff supported the people who needed assistance to eat at a pace suitable to them so that they did not feel rushed.

We saw one person chose to eat their meal in an armchair away from the dining area demonstrating their choice to stay there had been respected. The person told us they liked their meal and we saw they were provided with their 'favourite' condiment, red sauce.

No food menus were available for people and a handwritten menu on a notice board was not accessible to all people. Staff told us they had asked people what they wanted to eat verbally and they had made a choice. We asked if picture cards or visual choices were provided for visually impaired people or people who lived with dementia. A staff member told us, "There are cards but no one uses them", suggesting the use of these was not always considered to assist people in making choices.

The cook was aware there were some people who required a fortified or soft diet. They knew how to fortify foods, such as adding butter, double cream and cheese to food such as mashed potato, to increase the calorie content. However, one person's food records did not always show their meals had been fortified as required. The cook explained they had made a dessert of bread and butter pudding on the day of our inspection, using sweetener rather than with sugar, so people who were diabetic could have a portion.

The teatime options of the day of our visit were sandwiches or cheese on toast. The cook said, "Because not many people like cheese on toast I am putting on some jacket potatoes with beans." This demonstrated they took people's likes and dislikes into account.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection, we found people were happy living at the home and their privacy and dignity was maintained and we rated this key question 'Good'. However, we found at this inspection there were some practices that were not caring and people's privacy and dignity was not always respected. This key question is therefore rated requires improvement.

People were positive in their comments and said staff treated them well. One person told us, "The staff are marvellous. They can't do enough for you. They are my friends." Another told us, "They have a chat as they pass you by. They are friendly." Relatives were also positive about the staff. One told us, "The carers are the best thing here. They are happy, friendly and caring."

Staff spoke with one another in a respectful way and were helpful towards each other in completing their care duties and supporting people. Care staff knew about most people's needs and told us they used the information in care plans to support people in ways they preferred. The manager had assessed people's needs before they came to the home so people were involved in decisions and planning for their care.

One staff member told us caring meant, "It's everything about the person. Learning about what's important to them, making time and showing a real interest. Talking and making them smile and laugh." Another staff member said they developed relationships with people by talking to them and they recognised some people had different methods of communication. For example, they told us, "You get to know them and their facial expressions if they don't like something. A person had a stroke and lost their speech but if they want something they point to places."

We saw staff were kind in their approach towards people, for example, a staff member held a person's hand and sang to them. The person responded well to this by smiling. We saw staff addressed people by their preferred names and explained what was happening when providing care and support. One staff member sat with another person and looked at a book of interest to the person with them, which generated lot of discussion. It was clear the person enjoyed this one-to-one time.

However, there were some practices that we observed that were not caring. For example, at lunchtime staff did not serve one table at time so everyone could eat together. This meant some people had to sit and watch others eat whilst others finished their meals before others had begun to eat. A staff member told us, "It's just the way we do things." We established this was because they served all those that had chosen one particular meal first and then served the second option afterwards. Staff's decision to serve lunch in this way was convenient for staff, but was not person centred. We discussed this practice with the provider when we met and he and the manager agreed to review this to one table at a time.

Improvements were required to support people maintain their privacy and dignity. People told us that staff were respectful towards them and maintained their privacy and dignity when delivering personal care. Comments included, "Girls [staff] cover me up and things like that" and "The staff knock my door." However, we saw staff weighed a person in the communal lounge, which compromised their privacy and dignity.

When we asked a staff member about this, they confirmed this was standard practice. They told us, "Yes, ever since I came here we normally weigh people in the lounge. I never really thought about privacy. It would be more private in their bedroom." The manager told us they would do this in future.

We saw the toilet nearest to the communal lounge had no lock on the door, this meant people could not lock the door to maintain their privacy. A staff member told us there had never been a lock on the door as long as they had worked there. They accepted that it did not offer people privacy.
When we looked at the garden area, we noticed a fence panel was missing out of the garden fence near the entrance to the kitchen. This meant there was no privacy for people to sit in the garden area. The cook told us, "I think it's being sorted."

One person told us they would like a key to their bedroom for privacy and security. We discussed this with the manager and they told us arrangements were being made for this.

Requires Improvement

Is the service responsive?

Our findings

During our previous two inspections, we found improvements were needed in responding to people's individual needs. During this inspection, we found improvements were still needed. The rating therefore continues to be 'Requires Improvement'.

People had opportunities to participate in some activities but improvements were required in staff's response to people's individual needs to socialise. We had found this to be the case at our previous inspection. One person told us, "I would like to go to the pub. I spend my time reading the newspaper. There is not much else to do." However, other people told us they did not want to do any activities and were satisfied with the activities provided. Comments included, "I like to listen to music and the music is often playing" and "I don't really want to do any activities. I am happy sitting here." Relatives told us there were activities provided but their family member chose not to join in. We saw during our visit staff played skittles with people in the communal lounge. The activity lasted for around 15 minutes and involved two people. We saw one person playing chess and were told this had been specifically arranged for them with a person from the local community who came in specifically to spend time with them.

An 'activity planner' on display showed activities took place each day between 2 and 3pm and 3.30 to 4.30pm each day. This included exercise classes led by an external provider, quizzes, playing cards and trips to the local shops. Records showed some of these activities took place on some days, but not every day. Staff acknowledged that the provision of activities was something that could be improved, because they had limited time to spend with people to sit and chat and to do activities. One commented, "I like the idea of doing more activities. If we could just take people out to the park in their wheelchairs it would be lovely." They explained this was not possible as there would not be enough staff left in the home to look after people. The manager told us they were looking into having an activities co-ordinator, who could support people with their preferred activities.

People told us they were able to maintain relationships with people important to them such as their relatives and we saw relatives were made to feel welcome at the home. One relative told us, "I think the staff are wonderful. They do a great job. They always make me feel very welcome and look after [name] very well."

People's care plans contained information about their needs, with instructions to staff on how to meet them, but they were not always accurate and staff were not guided to be responsive to their individual needs. For example, one person who was living with dementia had a mental capacity assessment that stated they did not display "aggressive behaviour. However incident records showed this was not accurate. The person's care plan records stated it was important for the person to have money in their pockets and the reasons why this was important were stated. However, through discussions with the manager we identified this did not happen, which was a trigger to them becoming anxious and displaying behaviours that challenged others.

Staff told us they knew about changes in people's needs because they were informed during a handover

meeting at the start of each shift. Staff said the handover was also recorded on a 'handover shift sheet' and stated there was a section where staff could add important information they had identified during their shift. Handover records we saw contained information about people's basic needs.

Care plans contained some personalised information about people to support staff in providing individualised, person centred care. For example, in one care plan there was a document titled, 'a little bit about me', which detailed the times the person liked to get up in the morning and what time they liked to go to bed. This stated the person's preferred drink options and that they liked to drink through a straw. We saw the person drank through a straw throughout our inspection visit, which demonstrated their preferences were known and responded to by staff.

People could not recall being involved in the development of or a formal review of their care plans, but felt they could approach staff to discuss anything if they needed to. One person told us, "One of the girls [staff] asks me if everything is ok. I must say everything is good." A relative told us, "I haven't been to a formal meeting, but I can discuss things at any time if I need to. I have no concerns." A staff member confirmed they did not sit with people to complete a review of their care but they did make any necessary changes to care plans when required.

Information about people's faiths was included in their care plans, as well as any support they needed to maintain their traditions. At the time of our visit, those people whose care we reviewed were non-practising of their religion, but where one person had culturally-specific dietary needs, action had been taken to address this. The manager had spoken with a member of the person's family to obtain recipes of meals they enjoyed, so these could be provided at the home.

There had been some consideration given to formulating end of life care plans so that people's wishes could be followed at this time. We saw one person also had a RESPECT form that was at the front of their care plan, so this was visible to staff. This contained personalised information about the person's clinical care in the event of an emergency in which they were unable to make or express choices. The RESPECT form assists health care professionals in responding to an emergency and assists them to make immediate decisions about the person's care and treatment.

The provider's complaints policy and procedure were effective. Information on how to raise a complaint was displayed in people's bedrooms. People knew who to approach if they had a complaint and told us they felt comfortable to raise any concerns they had with staff. One person told us, "I wouldn't sit here, I'd tell someone. They would sort something out. No problem." Another told us, "If I wasn't happy I'd tell the staff." We saw a record of complaints received had been maintained which showed they had been investigated and responded to in a timely manner.

A relative told us, "If I had a complaint I would go to the manager. She is very approachable." They went on to say they had never had a complaint since their family member had been at the home.

Requires Improvement

Is the service well-led?

Our findings

During our previous inspection, we identified improvements were needed in the management and leadership of the service. We had found risks related to people's care were not effectively managed and care provided was not always responsive to people's needs. At this inspection, we found the required improvements had not been made and additional areas requiring improvement were identified. This applied to all the key questions we assessed. We found there were four breaches of the regulations due to the seriousness of some of the concerns we identified. The rating for this key question remains 'Requires improvement'.

The provider's systems and processes to monitor the quality and safety of the service were not effective in ensuring the home was well managed. Audit checks completed by management staff did not ensure risks were identified and acted upon. For example, we found several areas around the home had unpleasant odours, were dirty, and in need of cleaning. We saw a drain outside the kitchen window was blocked with food debris and the water was not draining away. Kitchen staff were not aware of the blockage and therefore, no action had been taken to unblock it. These combined issues presented an infection control risk. The cook told us they would ask the maintenance person to unblock the drain.

There were insufficient processes to analyse and act upon accidents and incidents to ensure any necessary actions to help minimise them were taken and lessons were learnt.

People's medicine charts did not confirm prescribed creams were applied as required to address skin problems. This had been identified as a concern during our previous inspection. The provider could not be assured people's skin care was managed effectively.

The provider had not ensured staff were suitably trained. Training records showed staff had either not completed training or were not up to date with their training, to ensure they supported people safely and appropriately. We raised concerns around staff practice during our inspection, which showed how the lack of staff training was impacting on safe care. For example, some staff used unsafe moving and handling techniques when transferring people, placing themselves and others at risk of harm.

The provider did not have suitable arrangements in place to check staff competencies following any training they completed to ensure training was effective, for example, in dementia care and how staff responded to behaviours that challenged others. Staff did not understand the importance of identifying triggers to people's behaviours so they could help minimise them. This had resulted in a negative impact for one person whose records showed their behaviours had escalated when they had become anxious. The person's records did not provide sufficient guidance to staff on how to manage this behaviour to prevent it escalating.

Processes to check equipment around the home had not been effective. For example, staff told us there were not enough dining chairs with arms to enable people to sit at the table in comfort and safety. This had resulted in people sitting in their wheelchairs at mealtimes. Audit checks had not identified the weighing

scales used to assess people's weight and health did not work effectively due to a broken foot rest. This was only established when we questioned one person's significant weight loss and found this was an inaccurate reading. A staff member had stated they had been supporting the person's foot on the scales resulting in false readings. Audits checks had also failed to identify a wheelchair had a broken footplate and needed repair. Staff were seen to use this wheelchair which meant they did not transfer people safely.

The provider's systems for managing and reducing known risk were not effective. For example, one person had left the home unsupervised on three separate occasions which had placed them at significant risk. Despite this no action had been taken to look into the reasons for why the person had chosen to do this, or secure the garden area, for example by closing the front gates, which the person had used to exit the home. We saw the front gates remained open throughout our visit. We asked a staff member if the gates were ever closed. They replied, "They are broken, they are always open." We asked, "Is that safe?" and they replied, "Well, [Name] got out once, but nothing was done to fix them." This meant opportunities to keep the person safe had been missed and showed us lessons had not been learnt.

The provider's staffing arrangements were not effective because when cleaning, laundry or catering staff were not on duty, care staff completed ancillary tasks in addition to their caring duties. Staff told us this meant at times they were not available to support people when needed.

The provider could not assure themselves the quality and safety of the service was being maintained because records were not consistently updated. Staff training records, staff duty rotas and the provider's safeguarding policies and procedures were not up-to-date. In some cases, records were not available at all, such as a care plan for a person with a skin wound and a central log of all safeguarding referrals made. Information in staff recruitment records did not demonstrate all checks had been completed. Arrangements to maintain people's confidentiality were not always followed. We found one person's confidential care notes in an empty bedroom.

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

The provider had not complied with their legal responsibilities in regard to their registration with us to report notifiable incidents. Records of incidents that had resulted in a safeguarding referral, showed they had not been reported to us as required. A "Safeguarding Alerts Audit" showed there had been a number of incidents since 10 May 2018 that had been referred to the local authority safeguarding team, but they had not been notified to us. Some of these referrals had been made by the manager of the home and others by external people. We established from the local authority safeguarding team there had also been safeguarding incidents that had occurred in 2017 which the provider had not notified us of.

This was a breach of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

The registered manager who was present at our last inspection had left the home in March 2018 and the deputy manager who had worked at the home for several years, had taken over the role of manager. They were supported by a compliance manager, who we were told was present at the home on most days. The compliance manager worked on behalf of the provider to support the effective running both of the provider's homes. At the time of our inspection visit, there had been no application to register a manager at the home. The provider told us of their intentions to pursue this.

People spoke positively of living at St Georges. Comments included, "I am very happy here. They look after

me well. This is a good place to be" and "I like living here. I have what I need." One person told us they would not want to be anywhere else and told us, "This is the best place. I don't ever want to go anywhere else. This is my home with my friends."

Relatives also spoke positively of the home and how it was managed and felt their family members were looked after well. One told us, "We think [name] is very well looked after. There have been some changes to the management, but things have carried on as normal. The manager is very approachable."

Staff told us they felt supported by the manager. One staff member told us, "[Manager] is approachable. I feel able to talk to her if I need advice." Another told us, "The manager is okay and can be supportive." Staff said they worked well as a team and supported each other. One staff member told us, "We are definitely a good team. Everybody gets on well and we help each other out. We all do what we do for the residents."

Staff told us they attended regular meetings with the manager and felt they could raise any issues or concerns if needed, which helped them to feel listened to and valued. One staff member told us, "You can speak out in meetings. The minutes are displayed on the board so you can read them and check things." Staff told were aware there were policies and procedures available to them to help them understand what was expected of them. They told us they also took guidance from the manager when required.

We saw the provider had sought people's views of the home through quality questionnaires which had been sent to people and their families in May 2018. Nineteen surveys had been completed and all responses showed that were either "very happy" or "happy" with their care. Family members had commented "Staff are friendly" and "We are always made to feel welcome" demonstrating their satisfaction with the home. 'Resident' meetings also took place at the home where people could attend and learn about any plans for the home. The cook told us they asked for people's views about the food at these meetings although the notes we viewed did not include discussions about food.

Staff told us the manager was 'on call' out of normal office hours if they needed advice or guidance. However, one staff member told us, "The seniors are very experienced and know what to do so there are no problems if the manager is not in." They added, "If you need the manager you have a telephone number to call."

Health and safety checks were completed such as gas, electrical and water to ensure both these aspects of the environment were safe for people. We had received a Provider Information Return (PIR) prior to our inspection visit containing information about the service and improvements planned as required.

We saw the notice board at the home did not contain the rating certificate from the previous inspection. We asked the managers about this and they confirmed it was not on display as required. We saw this was put on display during our visit.

Following the inspection visit we met with the provider. They acknowledged our concerns and spoke of the action they had started to take and those planned to address the issues we had identified.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 CQC (Registration) Regulations 2008 – Notification of other incidents The provider had not ensured that notifiable incidents were reported to the CQC as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe Care and Treatment People were not protected from risks associated with their health, safety and welfare because risks were not fully assessed to ensure care and treatment was always provided in a safe way. This included some medicines not being consistently managed safely as prescribed. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA RA Regulations 2014 – Safeguarding service users from abuse and improper treatment People were not protected against the risk of abuse as systems and processes in place to protect people were not always followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to monitor the quality of the service were not effective as they did not result in maintaining the health, safety and welfare of people.