Orchard Care Homes.Com (4) Limited

St Georges Hall and Lodge

Inspection report

Middle St George Hospital Site
Middle St George
Darlington
North Yorkshire
DL2 1TS

Tel: 01325335425

Date of inspection visit:
08 March 2018

Date of publication:
17 April 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place 8 March 2018 and was unannounced. This meant the provider and staff did not know we were coming.

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

We inspected St George's Hall and Lodge in December 2016 and found the provider was not meeting one of Regulations of the Health and Social Care Act 2008 (Regulated Activities) relating to staffing. At this inspection we found the provider had taken action and staff had received regular supervision.

St Georges Hall and Lodge is registered to provide accommodation for up to 83 people. At the time of the inspection the service was providing care to 29 people living with dementia.

The service did not have a registered manager. The acting manager had applied to be the registered manager and was waiting for their fit person's interview with the Care Quality Commission.

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

People and their relatives felt the service was safe. Policies and procedures were in place to keep people safe such as safeguarding and whistleblowing policies. Staff had received training in safeguarding and knew how to report concerns.

Staff recruitment procedures were robust and included Disclosure and Barring Service checks and references. Staffing levels were appropriate to the needs of the people using the service.

Risk assessments were detailed, person-centred, and gave staff clear guidance about how to help keep people safe. People had personal emergency evacuation plans in place in case of an emergency.

Staff were trained in a range of subjects such as health and safety, first aid and fire safety. Staff had also received training to support them to meet the needs of people who used the service, such as dementia training.

Staff received regular supervisions and an annual appraisal which covered their personal development. Staff felt they were well supported by the manager.

People had access to a range of healthcare, such as GPs, occupational therapy and dentistry. Nutritional needs were assessed and people enjoyed a health varied diet.

The premises were well suited to people's needs, with ample dining and lounge space. Bathrooms were designed to incorporate needs of the people living at the home. The corridors and reception area were spacious for people using mobility equipment. Signage was available to support with orientation around the home.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The atmosphere at the home was warm and welcoming with ample communal space. Relatives and friends felt welcome when visiting with staff offering refreshments and the opportunity to eat with their loved one. People were encouraged to make choices in everyday decisions. Staff were described as kind and caring. Staff provided support and care in a dignified manner, ensuring privacy when necessary.

Care plans were in place but these were not always personalised. Reviews of care plans did not always capture whether the plan was meeting the person's needs.

We made a recommendation about the providers approach to care records.

People enjoyed a range of planned activities. The service had positive links with the community.

The provider had a complaints process in place which was accessible to people and relatives. The manager responded to all complaints and concerns.

Staff were extremely positive about the manager. They confirmed they felt supported and were able to raise concerns. We observed the manager was visible in the service and found people interacted with them in an open manner.

The quality assurance process included audits of medicines, care plans, quality surveys and health and safety checks. Where necessary actions were set following audits and these were linked with the development plans for the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff recruitment procedures were robust and included Disclosure and Barring Service checks and references.

The provider used a dependency tools to ensure staffing levels were appropriate to meet the needs of the people using the service.

People were protected from the risk of abuse because staff understood how to identify and report it.

Is the service effective?

Good

The service was effective.

Staff were trained in a range of subjects to meet the needs of the service. Staff received regular supervisions and an annual appraisal which covered their personal development.

People had access to a range of healthcare, such as GPs, district nurses and dieticians.

The premises were well suited to people's needs, with ample dining and lounge space. Signage was available throughout the home to make it easier for people with dementia to orientate themselves around the home.

Is the service caring?

Good

The service was caring.

People and relatives felt staff were caring and kind.

There were positive relationships between people and staff. Staff responded to people in a respectful manner.

Staff supported people to be as independent as possible and encouraged them to maintain skills.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always personalised. Care plans were reviewed, however this did not always capture whether the plan was meeting the person's needs.

The provider had a complaints policy and procedure in place which was accessible to people and relatives.

People were supported with recreational and leisure activities. The provider employed an activity coordinator who planned a range of activities with people; these were displayed on a notice board in each unit.

Is the service well-led?

Good

The service was well led.

The service had no registered manager in place; however, the manager was in the process of being registered with the Commission to manage the carrying on of the regulated activity.

Regular meetings were held with people, relative and staff in order to gain views and opinions and provider information about the service.

The provider had an effective quality assurance process in place. Surveys took place and actions plans were in place to make improvements.

St Georges Hall and Lodge

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 8 March, and was unannounced. This meant the provider did not know we were coming.

The inspection was carried out by two adult social care inspectors. A specialist advisor who is a Nurse with knowledge and experience of supporting people with dementia within the NHS (National Health Service) and an expert by experience who spoke to people and relatives to gain their opinions and views of the service. An expert by experience is a person who had personal experience of using or caring for someone who used this type of service.

Before the inspection we reviewed other information we held about the service and the provider. This included statutory notifications we had received from the provider. Notifications are changes, event or incidents the provider is legally obliged to send to CQC within required timescales. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We also contacted the local Healthwatch, the local authority commissioners for the service, the local authority safeguarding team and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with eight people who lived at St Georges Hall and Lodge. We spoke with the regional manager, acting manager, one nurse, the administrator, the activity coordinator and 4 care workers. We also spoke with four relatives of people who used the service and one visiting health care professional.

We looked around the home and viewed a range of records about people's care and how the home was managed. These included the care records of five people, 29 medicine administration records (MAR). We reviewed five staff recruitment files, training records, and records in relation to the management of the service.

Good

Is the service safe?

Our findings

People and relatives told us they felt the service was safe. Comments included, "My [relative] is very safe here, she is definitely more settled than any other care home she has been in", "Oh yes, the nurses come straightaway when I press my bell", "My [relative] is extremely safe, [person] loves it here, there is always nurses popping in and out" and "They are always there for my [relative]."

Although the home was clean and tidy we did find some areas which were odorous. One room was extremely odorous which affected the ambiance in the nearby corridor. The room had a new floor fitted but this had not been appropriately sealed which meant the floor could not be thoroughly cleaned. We spoke to the manager who advised they would address this and organise to have the flooring replaced and the gap sealed. Following the inspection we received confirmation from the manager that preparation work had commenced in the room to have a specific type of flooring laid. We observed the ancillary staff around the home cleaning rooms and corridors following a schedule of daily, weekly and deep cleaning.

The kitchen area on the upstairs unit was in need of refurbishment with one drawer missing a front and some of the tiles in need of replacement. We found the provider had purchased a new kitchen which was to be fitted by the maintenance person.

The provider had safe recruitment procedures in place which were thorough and included necessary vetting checks before new staff could be employed. For example, Disclosure and Barring Service checks (DBS) and references. These are carried out before potential staff were employed to confirm whether applicants had a criminal record and were barred from working with vulnerable people.

We found the provider had systems and processes in place to keep people safe. Policies and procedures were available to staff for safeguarding and whistleblowing. Staff we spoke with had an understanding of what abuse was, how to act if they suspected or observed any inappropriate practices. Staff told us they had received training in safeguarding and felt the manager would act on any concerns they raised. We found the manager kept a log of all safeguarding alerts. We discussed how lessons learnt from safeguarding were shared with staff to reduce the risk of further incidents. The manager told us, "We have flash meetings everyday as well as team meetings and staff supervision. I would make sure everyone was told about any changes we need to make." We found records to demonstrate this.

Staff were assessed as to their understanding of safeguarding procedures. The staff member overseeing the assessment was given guidance notes to ensure the correct procedure was being followed. These gave the internal process to be followed and also stated, 'If you feel something is not being investigated you can contact CQC directly.' Staff were also given an internal confidential whistleblowing number so they could report any whistleblowing concerns.

We received mixed comments when we asked about staffing levels in the home. Comments in included, "No, I never think there is enough staff. If someone is doing 1 – 1 supervision and goes for her break, then another carer has to cover", "Yes, I think there are enough staff, they are always there for my [relative]" and "Oh yes,

nurses come straight way". We spoke to the manager about staffing levels. They told us, "We do our best not to be short. We have an extra staff member on duty for 1 – 1 care, they are not part of the numbers."

The provider used a dependency tool to ascertain the level of staff needed on each unit in the home. We reviewed the rota and found these were in line with the needs of the service. We saw staff were visible in the communal areas and sat with people in the lounge. Call bells were answered in a timely manner.

We found risks to people were assessed and control measures were in place for staff to support people in their daily lives safely. For example, moving and handling and skin integrity. These were reviewed on a regular basis or whenever there was a change in need.

Environmental risks were assessed to ensure safe working practices for staff, for example, to prevent slips, trips and falls and kitchen safety. These were reviewed on a regular basis and were accessible for staff support and guidance.

We found the management of medicines within the home was safe. We observed people had their medicines when they needed them and in a safe manner. Staff had received training in the safe handling of medicines and had regular checks to ensure they remained competent to administer medicines. We saw medicine administration records (MARs) were completed correctly. We saw where hand written instructions were recorded; these were signed by two members of staff. Where people were prescribed transdermal patches we found individual records to indicate where the patch had been applied. Transdermal patches contain medicine and are applied to the skin and need to be applied to different areas of the body to prevent skin reactions.

A range of health and safety checks were completed to ensure the environment and the equipment used to support people was safe. For example, electrical installation checks, gas safety certificates and hoist checks. Fire alarms, emergency lighting and fire extinguishers were checked regularly. Staff and people took part in fire training on a regular basis.

People had personal emergency evaluation plans (PEEPs) in place in case of emergencies. A contingency plan was available to staff in case of an emergency to ensure the continuity of the service. Staff had out of hour's access to on call support from senior managers when necessary. Staff ensured visitors signed in and out of the home.

Good

Is the service effective?

Our findings

We previously visited the home in December 2016 and found the home to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing. Staff had not received regular supervision and appraisal.

Systems were in place to ensure staff supervision and appraisal were planned and completed. We saw records to demonstrate staff received an appraisal and had supervision on a regular basis. Staff also told us they received supervision on a regular basis but could also speak to the manager about any concerns. One staff member told us, "I have regular supervision; I also speak to the manager on a daily basis". Other staff comments included; "I have just had one, if we have any issues we can discuss them" and "Yes, every couple of months I think."

We saw that at appraisal staff performance was graded in areas such as; being caring, promoting and respecting individuals' rights, building relationships and team work. This meant that appraisals were useful tools to develop staff skills and meet the overall aims of the service.

Staff training was carefully monitored to ensure that all staff had the right level of training for their roles. Staff told us they felt supported and that they received regular training. Comments included, "We do lots of training, I have completed Level 5 and would like to progress" and "My training is up to date, [manager] is good like that, we are more together as a team."

People and relatives felt staff had the skills and knowledge to support them or their loved ones. Comments included, "Yes, I think the staff have very good skills to do their job" and "The staff know what they are doing, I am very grateful to them".

Care records demonstrated how the person's physical, mental and social needs were assessed on admission to the home and then on a regular basis. Care records contained information which took into account current legislation and national guidance when planning outcomes. For example, nutritional guidance from the NHS regarding Focus on Undernutrition had been used in developing eating and drinking care plans with an outcome of providing a nutritionally safe diet and National Institute of Clinical Excellence (NICE) Management of medicines for older people used in developing plans to support people with their medicines.
Care plans identified people's specific dietary needs. A rolling set menu was provided, however staff told us the cook was able to prepare other choices for people if they did not want or like what was on the menu. A pictorial menu was available for people with communication needs.

The cook had completed training in nutrition and food preparation. They told us that they completed audits to ensure the quality of the food and the dining experience and said, "It's about the whole process, the presentation of the food and staff's manner. It's all has to be right." They told us that fresh, home cooked food was prepared that met the needs of all the people who used the service. We saw how dietary information was shared between staff and the kitchen so that all staff knew people's needs and preferences.

Staff confirmed that they knew what people liked and were able eat and drink. We saw that snacks and drinks offered were appropriate to meet the needs and preferences of people who used the service. Records showed that people's diets were monitored and dieticians were involved for advice and guidance when required.

People were offered a healthy varied diet. We observed people having lunch in the dining room. Tables were set with cutlery, crockery and condiments. Menus were displayed on the dining room walls with the alternative menu choice on each table. People were offered soup with a sandwich or a mini buffet followed by lemon sponge. We observed people were offered the alternative if they did not want the set menu. People living with dementia can get up and leave the table before finishing their meal. We saw when this happened staff were supportive and encouraging. People were given finger foods to eat on the go to support their intake.

The Mental Capacity Act 2005 (MCA) providers a legal framework for making particular decisions on behalf of people who 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Where people lacked capacity to make decisions MCA assessments and best interest decision meeting records were available. The manager kept a record of all DoLS applications made along with copies of authorisations. Staff clearly understood the importance of empowering people to make as many of their own decisions and choices as possible. These included explaining options to people and anticipating needs for some people by observing facial expressions and body language. We observed staff supporting people to make decisions regarding meal choices and attending activities.

Care records confirmed people had access to external health professionals when required. Records detailing visits from district nurses, community matrons, speech and language therapy and GP's. People also accessed the dentist, chiropody and opticians. We spoke with a visiting health care professional who told us the staff made appropriate referrals for support. They told us, "I come in regularly and when required, there are no problems. I came in regarding a person's legs, the staff gave a good history. I am confident they'll [staff] do as I advise."

We found staff monitored people's health using the early warning score (EWS). EWS is a guide used to determine the degree of illness of a person. It is based on monitoring a person's respiratory rate, oxygen saturation, temperature, blood pressure, pulse/heart rate. The manager told us, "Everyone has had their observations completed so we have a base line". A base line of people's observations is used as a comparison when someone is not well. This supports staff in decision making regarding obtaining support from health care professionals such the GP or district nurse.

The home was in the process of being refurbished with new flooring being laid. We found people's rooms were individualised with lots of personal items in place, such as: photographs, posters and ornaments. Bathrooms were designed to incorporate the personal care needs of the people living at St Georges Hall and Lodge. The corridors and reception area were spacious for people using wheelchairs and mobility equipment.

The manager was keen to develop the environment of the home to make it more dementia friendly. We saw bedroom doors were painted different colours with people's name and a photograph. Handrails were painted a different colour to assist visual impaired people. Corridors were themed to encourage communication such as older film stars. We found some equipment for people living with dementia such as boards on the walls with locks and bolts, these encourage people to stop and handle the locks and bolts giving a tactile experience.

The manager told us that the home has recently received funding to develop the home's gardens to provide more safe and useable outdoor space, including raised flower beds and sensory gardens.

Good

Is the service caring?

Our findings

People and relatives told us the staff were caring and kind. Comments included, "The staff are very caring and very kind", "Staff are brilliant and approachable. They always engage with the family and let us know who [person] is doing", I love each of them, they are my friends" and "Staff are lovely, the senior nurses are very good."

During our inspection, we saw many caring interactions between staff and the people living at the home. Staff had an understanding of people's needs and had developed positive relationships with them. Staff were led by what the person wanted to do where ever possible. People appeared at ease with the staff, looking comfortable and relaxed in their presence. People's privacy and dignity was respected, we saw staff closing doors when supporting people with personal care and ensuring people were supported to eat and drink when appropriate. We saw staff also had a good relationship with relatives and friends who visited the home, staff were open and welcoming offering tea or a coffee.

Staff told us they promoted people's independence and respected their wishes. Staff clearly explained options to people encouraged them to make their own decisions such as whether they wished to join in activities, or to have a drink and snack. Staff supported people to use mobility aids and encouraged people to do things for themselves such as eating and drinking independently. Relatives gave examples of how independence was promoted. Comments included, "There is one thing [person] likes to do and that is to make her bed, nurses are aware and make sure that her bed is left for her to do", "[Person] likes to wear and shirt and tie and tries to do as much as he can for himself, they let him wash and dry himself" and "I am quite independent, I like to dress and shave myself."

Staff were aware of people's communication needs and were observed supporting people verbally, as well as using gestures and body language to communicate and to engage people. When asking a question we saw staff repeated the person's response to make sure they had understood. When approaching people staff addressed them by name and crouched down to eye level so people could see their faces clearly.

Some people who used the service had access to advocacy services. The provider had information relating to advocacy. Advocates help to ensure that people's views and preferences are heard. The manager told us how they spoke with relatives and social workers if any advocacy support was needed.

One staff member told us that the best thing about working in the service was kind attitude of staff. They told us, "There is lots of enthusiasm, staff go above and beyond."

We saw the service had received an number of 'thank you' cards, comments from these included; "Thank you so much for the care and love you have given my [relative]." and another one said that staff were "Fantastic" and had a "Caring and professional manner."

Requires Improvement

Is the service responsive?

Our findings

We looked at care records for five people. We found the care files on the nursing unit were not always personalised. For example, where people were at risk of isolation the action to meet this need was a 15 minute check. There was no guidance for staff in trying an activity or using a planned strategy to engage the person is conversation or interaction to assist with their mental health and well-being. We asked staff how they support people in their rooms. Staff told us they do spend time with people, having a chat. The activity coordinator also spent time with people on a one to one basis.

We found the care files for people living on the residential unit were comprehensive, detailed and personalised. Care plans included what people could do for themselves and what staff needed to support them with to reach their full potential.

Care plans were evaluated regularly, however the evaluation did not always detail how the care plan was or was not meeting the person's needs. We discussed this with the manager who advised care plans would be reviewed in light of our feedback.

We recommend the provider reviews their approach to person centred care planning to acknowledge activity opportunities for people by referring to: National Institute of Clinical Excellence (NICE) guidelines: Mental Well-being of older people in care homes. December 2013.

Relatives we spoke with told us they were involved in their family members care planning. Comments included, "yes, I was involved with my [person] care plan it was all to do with giving good care and health" and "I filled out a questionnaire for my [family member] which included what he likes to eat, does he like to go out."

We found referrals to various health care professionals such as tissue viability, challenging behaviour team and community matrons. When advice or treatment plans have been developed with health care professionals these were incorporated into the persons care plans. These plans were evaluated and monitored for their effectiveness. We found examples of community psychiatric nurses and GP's working closely with the staff to monitor change in behaviours, to increase or decrease mental health medicines. This meant changes can be made immediately to benefit people's health and well-being. This responsive and proactive method was a positive aspect of the service.

One visiting health care professional told us, "They [staff] are very responsive to patient's needs. Getting the district nurse in appropriately, making sure equipment is in place and used. The carers are very good."

We found people had a document in their care records which detailed their life history, giving a picture of what they enjoyed doing before moving into the home. Activities were displayed on a notice board on each unit and we observed people were encouraged to participate if they wished. People were not pressured to join in showing that staff respected their decision. At the time of the inspection people were have a baking session, everyone around the table appeared to be having a lovely time.

Staff told us they were given time to read care plans when changes took place and were involved in developing plans. Daily records were held in each unit which staff completed on a daily basis. We found records showed what the person had done during the day, any appointments they had attended and any changes in need.

The provider had a complaints policy which outlined how people could make a complaint if they were unhappy with the service. The manager kept records of all complaints and concerns raised along with investigation notes and responses to complainants.

No one at the service required end of life care. The manager advised plans would be discussed with family, health and social care professionals, staff and wherever possible the person to ensure their wishes were captured and planned for in the event of their declining health.

Good

Is the service well-led?

Our findings

At the last inspection we found that the service was not always well-led and there was no registered manager in post. At this inspection the service did not have a registered manager in post. However the manager had applied to become the registered manager and is currently in the process of being registered with the Commission to manage the carrying on of the regulated activity. A deputy manager is also being appointed to support the manager. The manager told us they were committed to staying at the service and told us about a programme of improvements. We saw that these had been documented in a comprehensive action plan. The manager was knowledgeable about the service, staff and people receiving the service.

People and relatives told us the service was well led. Comments included, "She is always about, I see her most days and she always says hello", "The manager is absolutely marvellous. She is proactive and her door is always open, she is very approachable and visible in the home" and "Aw she is lovely."

One visiting health care professional told us, "The manager is responsive, she's always about."

Staff told us they found the manager approachable and supportive. One staff member told us, "I get lots of support and I am going to do my level five qualification which will allow me to move into a more senior role." Another said, "[Manager] is making changes but they are all good, the home is better." Staff told us they had confidence in the manager, one said, "The manager has some good ideas" and that "Things are gradually improving in the home."

We found the manager understood the opportunity to enhance the environment and was active in planning projects and changes to ensure those living at St Georges Hall and Lodge were given every facility to enjoy a fulfilling lifestyle. We saw the refurbishment, furniture upgrades and carpets were being changed. The manager ensured the walls now had a range of dementia friendly art, these were bright and stimulating and provided people with talking points.

The manager was introducing memory boxes for each person which would also give an opportunity for communication and aid in orientation. The home had recently been given a budget for enhancing the outside space. The manager told us of their plans to have raised flower beds, a sensory gardens and more space for people to wander in the garden safely.

The home had links with the community with regular visits from local clergy, family members were welcomed to join in services. Relatives had suggested a bar area would be a good idea, this was underway with the room already being decorated and some bar type memorabilia being ordered. Students from a local college were assisting in painting murals in different areas of the home.

Staff were involved in the running of the service in a variety of ways; including staff meetings, clinical governance meetings, and by using surveys. There was also a confidential e-mail address for staff to raise any concerns and provide any feedback or suggestions. Staff achievements were celebrated and we saw that positive feedback from other agencies had been shared with staff.

We saw that people who used the service were asked for their views during audits and thought the use of resident's survey. We saw that action plans had been developed to address any concerns raised, for examples we saw that new tablecloths and table decorations had been purchased to improve the appearance of the dining rooms. Developments in the organisation were shared via regional newsletters.

The quality assurance system covered all aspects of the service and ensured regular checks were made to ensure the quality of the service. We found that development plans included actions identified in internal and external audits; such as by completed by the Local Authority, infection control audits completed the NHS and fire risk assessments by the Fire and Rescue Service. Development plans gave clear, prioritised actions which were signed off once the evidence was in place to show these had been completed.

The manager ensured notifications were submitted to CQC as part of their regularity requirements.