Afra Siyab

St Georges Residential Care Home

Inspection report

30 St Georges Road
Mitcham
Surrey
CR4 1EB

Tel: 02086875896

Date of inspection visit:
24 November 2016
29 November 2016

Date of publication:
24 February 2017

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 24 and 29 November 2016 and was unannounced. At our last comprehensive inspection on 23 October 2015 we found the provider was in breach of the legal requirement about safe care and treatment in relation to medicines management. We carried out a follow up inspection on 3 March 2016 and found that although the provider had taken action to address the shortfalls they had not made sufficient improvements to meet the requirements of this regulation.

St Georges Residential Care Home provides accommodation and personal care for up to three adults with learning disabilities. At the time of our inspection there were three people using the service. The manager of the service was also the owner and sole provider and so did not need to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service.

Medicines were still not managed safely. People did not always receive their medicines in line with instructions from the doctor or pharmacist. Medicines were not always signed for at the time when they were administered, increasing the risk of errors. There were not clear records to show how much medicine should be in stock and staff were unable to account for some missing tablets. Some unsafe practices were being followed, such as splitting tablets in half with a kitchen knife and storing them in unsealed packaging. The provider's audits and quality monitoring systems were not sufficiently robust to identify or rectify these problems and medicines audits had not been completed for the last two months. The provider was in breach of the regulations relating to safe care and treatment, notification of incidents and good governance. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Staff sometimes did not refer to people in an age-appropriate manner, use their preferred names or keep them informed about what they were doing. However, at other times staff treated people with respect, were sensitive to their emotional needs and knew how to communicate with them effectively so they had the information they needed to make choices about their care. Staff promoted people's independence by giving them opportunities to do as much for themselves as possible.

The home environment was safe because the provider had measures in place to store chemicals safely, maintain fire safety and otherwise ensure the safety of the environment. People had individual risk assessments and risk management plans that were tailored to their needs. There were arrangements in place to safeguard people from harm and abuse. There were enough staff to keep people safe.

People were able to choose from a variety of nutritious, high quality home-cooked food that met their nutritional and cultural needs. People enjoyed the food supplied by the service and staff provided the support people needed to eat their meals and drink enough fluids. Staff monitored people's weight and food intake to ensure they maintained a healthy body weight. People received the support they needed to maintain their health and attend healthcare appointments.

The manager and staff understood their requirements under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that people are only deprived of their liberty when this is necessary to keep them safe and in a way that ensures their rights are upheld. The provider ensured the relevant processes were in place and appropriate people were involved in any decisions about people's care that were made when they did not have the mental capacity to make the decisions for themselves.

Staff were provided with enough training and support to enable them to carry out their roles effectively. The provider was able to access guidance on good practice to inform their work at the service.

Staff knew people well and were familiar with their likes, dislikes, preferences and needs. People had comprehensive care plans that instructed staff what support they needed with personal care, completing tasks, maintaining their health and other aspects of their care. Care planning took into consideration people's preferences, routines and cultural and religious needs. People received support to maintain contact with families and loved ones and to access their local community. There were not many structured activities available but the provider was looking into this.

The provider spent time at the home and monitored the quality of the service through observation, speaking with people and by using a range of checklists. Although these had not identified the problems we found in relation to medicines management, they were effective in assuring other aspects of the safety and quality of the service.

People benefitted from a small and well-established team of staff, because this meant they were familiar with how the service operated. People, relatives and staff gave us positive feedback about the manager. There were appropriate cover arrangements in place in case the manager was absent.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The provider continued to be in breach of the regulation about safe care and treatment because staff did not always follow safe practice in relation to the handling, recording, storage and administration of medicines.

The provider assessed and managed risks to people's safety. There were procedures in place to safeguard people from harm and abuse.

There were enough staff to care for people safely.

Is the service effective?

Good

The service was effective.

Staff received the training and support they required to carry out their roles effectively.

Staff understood the principles of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) and their responsibilities in relation to these.

People received a variety of suitable and nourishing food and staff ensured their healthcare needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring. Sometimes, staff did not speak to or about people in a respectful manner, although they did at other times.

Staff knew people well and were familiar with their individual communication styles. They gave people the information they needed to make choices about their care.

Staff worked to promote people's dignity and independence.

Is the service responsive?

Good

The service was responsive.

People's care was planned and delivered in such a way as to meet their physical, social, cultural and religious needs.

The provider responded to concerns people and their relatives raised and there was an appropriate complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well-led. The provider did not have sufficiently robust quality assurance systems to identify and improve shortfalls we found in relation to medicines management. The provider did not notify us of incidents they are required by law to tell us about.

However, they did have robust systems to ensure the quality and safety of other aspects of the service.

The manager maintained a good relationship with people, staff and relatives.

St Georges Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 24 and 29 November 2016 and was unannounced. It was carried out by one inspector.

Before the inspection we reviewed the information we held about the service, including previous inspection reports and action plans the provider had sent to us.

During the inspection, we spoke with one person who used the service, two relatives of people who used the service, one member of staff and the registered provider, who was also the home manager. We looked at three people's care plans and other records including medicines records and the provider's audits.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection on 23 October 2015 we found the provider was in breach of the regulation in relation to medicines management. There were no robust arrangements in place to keep track of medicines stocks and ensure people received their medicines as prescribed. We carried out a follow-up inspection on 3 March 2016 and found this issue had been partially addressed by the provider introducing medicines audits and checking stock levels weekly. However, medicines were still not handled safely because staff were dispensing medicines into unlabelled boxes and this meant they could not always be sure people were receiving the right dose of medicines at the right time, as prescribed. The provider wrote to us with their action plan and told us on 15 April 2016 that they had successfully arranged for the pharmacist to dispense medicines in blister packs to minimise this risk.

At this inspection, we confirmed that the provider had made the improvements they told us they would make. Most medicines were dispensed in pharmacy blister packs to reduce the risk of medicines errors. We saw evidence that they were carrying out weekly medicines audits from April 2016, although according to records these had stopped in September 2016 and the provider was not able to explain why.

However, staff were still not adhering to safe practice in the handling, administration and recording of medicines. Staff did not always sign to indicate they had administered medicines immediately after doing so and on one occasion a medicine had been signed for before it was administered. This meant there was a risk that people would receive double doses or not receive their medicines as it was not always clear whether they had taken them. Staff told us they had given a person one tablet in the evening because they had forgotten to give it to them in the morning. However, they had not contacted the person's doctor or pharmacist for advice despite the pharmacy label stating that the tablet needed to be taken in the morning. This meant people were at risk of not receiving their medicines safely because staff did not follow the pharmacist's instructions or seek advice to confirm whether this was safe.

We also found that there were no records of medicines stock balances. Staff did not record the dates when boxes of tablets or capsules were opened and so it was not always possible to confirm how many doses they should contain. This meant the provider could not accurately check whether stock records were correct and that people received their medicines as prescribed.

We found two more tablets than expected had been removed from one box between the two days of our inspection and staff were unable to account for them. They told us they did not record if tablets were discarded or accidentally crushed. This meant that medicines could not all be accounted for and there was therefore a risk of them being mishandled or of medicines errors going unnoticed.

Staff told us the dosage included a half tablet and they had to cut the tablets with a kitchen knife. This was not safe practice because there was a risk that food could be contaminated if small particles landed on food preparation surfaces, that tablets could be damaged or lost and that the person could receive incorrect doses because it was not possible to ensure the tablets were accurately split in half using this method. In addition, because the unused halves were returned to the opened blister pack to be used the following day,

there was a risk that they could fall out of the packet or become damaged by moisture in the air or by handling. We discussed this with the manager, who said they would ask the pharmacist to dispense the half tablets separately in future.

The evidence above demonstrated that the provider continued to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us they believed the service was safe. One relative said, "[My relative] is in a safe place and is happy." At our last comprehensive inspection in October 2015 we found that the home environment was safe, the provider assessed and managed people's individual risks appropriately, staff recruitment procedures were robust and there were arrangements in place to protect people from avoidable harm and abuse. At this inspection, we did not look at all of these areas in depth but we checked and confirmed that the provider's arrangements and procedures were still in place.

The environment was clean and free from clutter, malodours and visible hazards. Hazardous substances such as cleaning chemicals were kept in a secure place to protect people from associated risks. Windows were fitted with restrictors to prevent people falling from height. Staff were able to describe fire evacuation procedures and firefighting equipment was available and regularly serviced.

We saw evidence that the provider had assessed people's individual risks and plans were in place to manage these. The plans clearly described measures designed to reduce risks, such as use of an epilepsy monitor at night for one person to reduce risks associated with seizures. Risk management plans had been reviewed since our last inspection to make sure they remained up to date. These were personalised and instructed staff how to care for people in a way that kept them safe.

The home had policies and procedures in place to safeguard people from harm and abuse. Staff knew the signs of abuse and how they might appear differently for different people, particularly for those who did not communicate verbally.

There were enough staff to keep people safe. At the times when we visited there were two people at home with one member of staff, who told us they worked daytime and sleep-in shifts and there was always one member of staff with people. The manager told us they were able to provide additional hands-on support when needed, for example to cover staff sickness or if one person wanted to go out and others did not. The provider had not recruited any new staff since our last inspection and did not plan to do so in the foreseeable future so we did not look at recruitment procedures on this occasion.

Good

Is the service effective?

Our findings

A relative told us, "I am happy with the food served there. They know [my relative] is vegetarian and likes [specific foods]." Another relative said, "The food is good. [My relative] really enjoys it." One person told us they had enjoyed their lunch. We observed staff supporting another person to eat, who appeared to be enjoying their food.

Staff were familiar with people's dietary needs and preferences. For example, some people were vegetarian or did not eat certain foods for religious reasons. People were able to choose from a variety of home-made meals from their culture of origin, although British food was also available. We saw staff providing people with support appropriate to their level of ability during mealtimes, such as preparing food on their behalf or giving them physical assistance to eat. Where people became distracted and left the table during mealtimes, staff prompted them to finish their meals to make sure they had enough to eat. We saw staff offering people snacks and drinks at regular intervals.

Staff were able to describe how they supported people to maintain a healthy body weight. For example, one person had recently been underweight so staff supported them to eat more snacks on the advice of their doctor. By the time of our inspection the person had achieved a healthy weight and records confirmed this. We noted that for other people there was no information on what a healthy weight range would be for them, for example details about their height and body mass index (BMI). The manager told us they would add this information so that staff would be able to check whether people's current weight fell within a healthy range. Staff checked people's weight on a regular basis and kept records to enable them to identify easily any concerning changes in people's weight.

Relatives told us staff kept in touch with them about their family members' health issues or appointments. People had health action plans (HAP). A HAP is a document developed for people with learning disabilities to tell staff and healthcare professionals what support they need to stay healthy. We saw evidence that people received support in line with their HAP to access healthcare services and health checks including GP visits, breast screening, eye checks and specialist clinics relevant to people's health conditions. One person had not seen a dentist for some time and a relative expressed concern about this, but staff confirmed that an appointment had been booked for the person.

People received support from staff who received appropriate training and support to enable them to carry out their roles effectively. We saw evidence that staff had undertaken a wide variety of training courses, including specialist training relevant to the health conditions of people currently using the service. The manager was a registered nurse and told us they were able to access relevant guidance about good practice in social care through regular nursing updates. Although the manager worked closely with staff on a day-to-day basis, we saw evidence that they also had regular formal supervision to provide staff with an opportunity to discuss their work and set targets.

As part of this inspection, we checked whether the provider was meeting the requirements of the Mental Capacity Act (MCA). The 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. Staff knew what they needed to do if a decision needed to be made on behalf of a person who lacked capacity. They knew that they could not make these decisions on people's behalf and should report to the manager in the first instance. Records showed that the provider undertook assessments of mental capacity when appropriate. They also considered what decisions each person was likely to be able to make on their own and who should be involved in helping them make decisions or making decisions on their behalf where necessary.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had used a screening tool to determine whether people were at risk of being deprived of their liberty. At the time of our inspection, only one person had been assessed as requiring a DoLS authorisation and we saw documentary evidence that this was in place.

Requires Improvement

Is the service caring?

Our findings

When we asked relatives if they felt the service was caring they told us, "Yes, they are. They are OK. Everything is fine" and, "They respect [my relative] a lot. They listen to her." People told us they were able to make choices, such as how their bedrooms looked. One person showed us their room, which was decorated in a style they liked.

We observed most of the time that staff spoke to people in a caring and respectful manner. However, on some occasions we observed staff referring to the people who used the service, who were adults, as "this boy" and "that girl" in their presence and using language that could be seen as judgemental or infantilising. For example, on one occasion they said, "This boy is a little bit difficult in the mornings." There was a risk that people would not always feel respected and valued as a result.

We also saw that sometimes staff did not offer people choices or explain what they were doing. For example, a member of staff stated that one person was "making too much noise" and pulled on their arms to encourage them to get up from their seat and go into their bedroom. The member of staff did not explain to the person why they were doing this, although they did later tell us that when the person was becoming agitated they found it easier to calm down in their bedroom. We discussed these issues with the manager, who told us they would ensure staff used people's preferred names, told them what was happening and referred to them in a respectful manner. Staff told us they made sure the person who had gone to their room was comfortable and listening to music and we later saw the person in their bedroom appearing relaxed and happy.

At other times, staff made sure people knew what was happening and took time to reassure them if they appeared anxious. We observed staff reminding one person that a family member was due to visit them at the weekend. There was information in people's care plans about how to reassure and comfort them if they were upset. This helped staff to provide people with the emotional support they needed.

Staff knew people well and were familiar with their likes and dislikes, communication styles and interests. They were able to demonstrate how they offered choices to people who were not able to verbalise what they wanted, for example by using objects of reference. They were also able to explain to us what people were trying to communicate. When one person told us one of their soft toys was "crying," the member of staff on duty told us they had learned over time that this meant the person wanted to go out. They then reassured the person that they would be able to go out soon. The provider had also considered people's individual communication needs when planning care, including what they were able to understand as well as how they expressed themselves. This helped staff to give people information they understood and to enable them to make choices about their care.

We saw staff adjusting people's clothing where necessary to preserve their dignity and ensure their comfort. People were dressed in suitable clean clothing and were well-groomed. Staff promoted people's independence. They told us most people were able to bathe and shower independently and they only offered support where people needed it. We saw care plans included how staff should support people to

develop their skills and maintain their independence.

Good

Is the service responsive?

Our findings

One person said they were happy at the home and told us they enjoyed having staff support them to visit the shops. They told us, "They take you out in the car. We buy clothes." A relative said, "We tell [staff] what we want done and they do it. There are no problems." Another relative said, "[The care my relative receives] is right for her. She is so much calmer and gets angry much less since she went to live there."

Staff were able to describe how they met people's specific needs and this corresponded with information in people's care plans. The care plans were person-centred and contained detailed information about what people were able to do for themselves and what support they needed, how they preferred staff to support them and things staff should avoid. For example, one person did not like being in a noisy environment. Care plans included information about personal care, continence support, nutrition and hydration, sleep routines, mobility and other things relevant to people's care. There was also information about people's specific health and sensory needs and how staff should support people to meet them, such as by prompting them to wear glasses or supporting them to eat an appropriate diet to manage diabetes.

People with epilepsy had diaries that staff used to record any seizures they had. This helped identify any triggers, warning signs and patterns in the frequency and timing of people's seizures. There was information about what people's seizures looked like and the action staff should take in response. Seizure management plans were agreed and signed by people's GPs. This helped staff to meet people's needs in this area and keep them safe.

One relative told us, "There were lots of [planned] activities before but they are not very good now," but then added, "I told them and they take [relative] out every day." Another relative said, "[Structured activity] has stopped. I think it's so much better for [relative] to go. It's important to [relative]." We saw evidence that staff supported people to go out into the local community most days for shopping or walks if they did not attend day centres. However, we confirmed that there were not many structured activities. Staff explained that they had been trying to secure college and day centre places for people but there was not much available at this time. We discussed this with the manager, who said funding had been an issue but they were continuing to look into the matter and would carry on doing so until they were able to find suitable placements.

The service was responsive to people's cultural needs. When we arrived at the service we noted that the television people were watching was showing a channel that was appropriate to their cultural background. Staff told us one person attended a community day centre for Asian people. There was information in people's care plans about people's religious beliefs and other cultural needs, including what support they required to meet their needs in these areas. We heard from staff and relatives about the support people received to celebrate religious festivals.

People received the support they needed to stay in touch with their families. One person told us they were looking forward to a family wedding taking place that weekend and said staff were supporting them to get suitable clothing for it. Their relative later told us they were very pleased with the support the person had received to attend the wedding and that the person "felt very happy and said so." Staff told us people's

relatives telephoned the home regularly and spoke with people. Care plans contained information about friends and family members who were important to people. Records showed people saw their families regularly.

Relatives told us they knew how to raise concerns or make complaints if they wished to do so. One relative said, "We tell them if anything goes wrong and they act on it." At the time of our inspection, the service had not received any complaints but there was an appropriate complaints procedure in place to enable people and their relatives to complain if they wanted to.

Requires Improvement

Is the service well-led?

Our findings

The provider carried out a number of checks and audits to monitor the quality of the service and took action where shortfalls were identified. This included a range of health and safety checks such as weekly water safety checks, fridge and freezer temperature checks and fire alarm tests. However, according to records they had stopped carrying out their weekly medicines audits in September 2016 and the provider was not able to explain why. The provider had not identified any of the problems we found with medicines management and had not taken sufficient action to ensure the breach of regulations we found at our last inspection with regard to this was rectified. This showed that the provider's systems for checking and improving the safety and quality of the service were not sufficiently robust.

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

We noted that the provider had not submitted any statutory notifications since our last inspection. Registered providers are required by law to notify us about significant events that take place within services. This includes notifications that must be submitted when an application is made to deprive a person of their liberty, which applied to one person using the service. The manager told us they were not aware of this requirement but said they would take note of this in future. No other events requiring statutory notifications had taken place at the service since our last inspection.

The provider's failure to notify was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The manager and staff had been in post for several years and it was evidence from interactions we observed that they knew people well and that routines and procedures within the service were well established and consistent. Feedback we received from people, staff and relatives about the manager included, "[The manager] is very helpful, creative and sensible," "[The manager] is nice. She makes me tea" and "[Manager] is good. We can't complain." We observed that the manager listened to people and they were involved in day-to-day decision making within the service, such as what activities should take place.

The manager explained that they did not carry out formal audits of some aspects of the service such as the quality of interactions between staff and people, record keeping or care plans, because the service was small and they were present much of the time to observe these things directly. We saw evidence that the provider spent enough time with people and staff to be able to monitor these and identify any areas for improvement through observation. We also saw evidence that the provider regularly checked care records and updated care plans. There was a range of policies and procedures to help ensure safe and consistent practices were adhered to.

Staff told us the manager was very supportive and that they were able to contact them at any time in an emergency. They told us they always had opportunities to discuss their work when needed.

The manager told us about their contingency arrangements and plans for the future of the service, including action they were taking to ensure the service had leadership cover in the event that they were unavailable, such as to cover holidays.

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 The registered person did not inform the Commission without delay of any request they made pursuant to Part 4 of Schedule A1 to the 2005 Act (Deprivation of Liberty Safeguards) for a standard authorisation Regulation 18(1)(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not effectively operate systems to assess, monitor and improve the quality and safety of the service. Regulation 17(1)(2)(a)

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not provide care in a safe way for people by ensuring the proper and safe management of medicines. Regulation 12(1)(2)(g)

The enforcement action we took:

We served a warning notice against the provider.