St George's (Liverpool) Limited

St George's Care Homes

Inspection report

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Tel: 01516306754

Date of inspection visit:
25 November 2021
30 November 2021

Date of publication:
21 December 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
St Georges is a 'care home' providing accommodation, nursing and personal care for up to 60 older people; some of whom lived with dementia. At the time of the inspection 35 people were living at the home.

People's experience of using this service and what we found
People were not fully protected from the spread of infection. COVID-19 testing taking place at the home was not always carried out in line with government guidance. These matters were addressed at the inspection. Risks were not always fully assessed, monitored and reviewed. Risks such as falls and malnutrition were not always monitored and recorded appropriately. Some key information in people's care records about the management of risk were not accurate with daily notes missing key information.

People told us they were pleased with the care they received and said they felt safe living at the home. One person said, "This is the best placed I have been in terms of care homes. Everyone is attentive and looks after me well." People living at the home were relaxed and happy with staff. Staff spent time chatting with people and supporting them when they became distressed.

People were protected from abuse because staff understood what was meant by abuse and the correct procedures to follow if they had any concerns about people's safety. People received their medicines as prescribed and staff had clear information about how people liked to be supported with their medicines. Staff were knowledgeable about people's health needs and the provider had sought support from other health professionals as appropriate to support people's needs.

Staffing levels were appropriate and matched the dependency tool being used to match the needs of people at the home. A high volume of agency staff were used. The provider assured us they were continuously working to recruit more permanent staff. Staff received training and support to enable them to effectively meet the needs of the people they supported.

Rating at last inspection
The last rating for this service was good (published 20 October 2020).

Why we inspected
We carried out an unannounced focused inspection of this service on 25 November 2021 following a number of concerns relating to staffing numbers and intelligence gathered through various sources and our system. This report only covers our findings in relation to the key questions of safe and well-led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Our report is only based on the findings in those areas at this inspection. The ratings from the previous comprehensive inspection for the caring, effective and responsive key questions were not looked at during this visit. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used to calculate the overall rating at this inspection.

The overall rating for the service has deteriorated to 'requires improvement'. This is based on the findings at this inspection. We found evidence that the provider still needs to make improvements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St George Care Homes on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

At this inspection we have identified breaches in relation to safe care. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

St George's Care Homes

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors, and one Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
St Georges Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and local Healthwatch. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took

this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who lived in the home about their experience of the care provided. We spoke with six members of staff employed including the registered manager, one nurse and four care staff. We also spoke with eight people's relatives.

We completed checks of the premises and observed how staff cared for and supported people in communal areas. We reviewed a range of records that included five people's care and medication records. We looked at two staff files and agency profiles in relation to recruitment and staff supervision. We also looked at a variety of records relating to the management of the service, including audits, policies and procedures, and accidents records.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at audit and governance data, as well as infection prevention and control policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe. There was an increased risk that people could be harmed.

Preventing and controlling infection

- People were not always protected by robust systems for the testing of COVID-19
- Records showed the provider did not have oversight of compliance for COVID-19 testing taking place at the home in line with government guidance.

We found no evidence that people had been harmed however, the provider had failed to take reasonable steps to mitigate risks regarding infection prevention and control. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection and confirmed that a new system was in place for recording and monitoring COVID-19 testing in the home.

- The home was clean and tidy with beds made, clean bedrooms and communal areas.
- We were assured the provider was admitting people safely to the home. There had been reduced admissions during the pandemic.
- We were assured the provider's infection prevention and control policy was up to date.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people were not always fully assessed, monitored and regularly reviewed in line with their risk management plans.
- Risk assessments were not always fully completed and reviewed. Care monitoring records for some people had not been completed to show they had received the care and support they needed to minimise the risk of harm.
- There were gaps in fluid monitoring for people who were identified at high risk of malnutrition, and there were empty logs for fluid intake for the records we checked. We were assured by the provider they would take the appropriate action and make the changes required.
- Care records did not contain information that was person centred. This included a life story, likes or dislikes. We could not be assured that staff coming onto shift would know the person they were caring for.
- Effective fire safety arrangements were not always in place. We saw the fire doors on the first floor could not be opened readily if there were an emergency and people had to evacuate. On the ground floor two fire doors could be accessed and opened by people living at the home and were not risk assessed.
- Falls experienced by people were not always assessed appropriately for risk. For example, we saw that when one person required support with transfers this was not reflected in their risk assessment.

We found no evidence that people had been harmed however, the provider had failed to take reasonable steps to ensure that risks to people were always fully assessed and monitored. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were in place to review incident forms and make sure follow up action such as reporting to CQC was completed .

Staffing and recruitment
● During the inspection there was an appropriate number of staff on duty with a large percentage of agency staff being used by the home. People told us they see a lot of changes to staff. One person said, "I see a lot of agency and they are very good like the permanent staff, but we see a lot of changes."
● Staff personnel files contained the appropriate information needed to ensure 'fit and proper persons' were employed. We saw that in one staff file the provider had not requested a reference from previous employer. We advised the provider about this and were assured the provider would take appropriate actions and make the changes required.

Using medicines safely
● People's medicines were safely managed.
● Medication management procedures were in place and medicines were routinely ordered, safely stored, administered and disposed of in accordance with current guidance.
● People had medication risk assessments in place and staff were familiar with individual medication administration procedures.
● Staff received regular medication training and competency checks. Routine medication audits were completed.

Systems and processes to safeguard people from the risk of abuse
● Procedures were in place to protect people from the risk of abuse.
● Staff understood what to do if they had safeguarding concerns. This included how to 'whistle blow' to external bodies such as the CQC and local authorities.
● Staff had received safeguarding training and were aware of the signs of abuse. Staff we spoke with knew where to report their concerns. They were all confident appropriate action would be taken.
● Safeguarding incidents were appropriately reported to the local authority and CQC.
● Accident and incidents were recorded, and staff completed the relevant documentation and follow up actions were completed.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the service management and leadership was not always consistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider understood the importance of their role but did not always effectively manage risk and comply with regulatory requirements. The provider completed a range of audits, but we were not assured that appropriate actions had been taken when required.
- We found instances where records had not been accurately maintained. For example, some records associated with peoples' care had missing entries and inaccurate daily notes. This had not impacted on people's care and the provider assured us the process of moving from paper system to computer system was still under way and care records would be updated accordingly.
- Governance and quality assurance procedures and processes were not always effective. They failed to identify issues we found in relation to risk management and IPC practices.
- The provider did not always involve people in their care planning and people's voice was missing from discussions about what someone's care should look like.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- Staff we spoke with knew people well and could tell us what was important in people's care. We observed kind and caring interactions between people and staff.
- There was not always information in peoples' care plans about how they preferred to be supported.
- Quality surveys were shared with people and their relatives. People and relatives were encouraged to share their thoughts, views and suggestions about the provision of care provided. Relatives told us they felt comfortable making suggestions and raising concerns with the provider.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider understood and worked in accordance with their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they receive.
- Concerns, incidents and accidents were consistently reviewed. The provider was open and transparent and willing to learn and improve people's care.

Working in partnership with others

● Partnership work was not well embedded, although the provider did engage with relatives and staff they did not always involve the people who lived at the home in decisions regarding their care provided.

● Effective connections with healthcare professionals such as Local GP's and falls team supported people to receive holistic care.

● Joint working with external health and social care professionals meant people had coordinated care. Referrals to external healthcare professionals had been made to help ensure people received safe and appropriate support.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to take reasonable steps to mitigate risks regarding infection prevention and control. The provider had failed to take reasonable steps to ensure that risks to people were always fully assessed and monitored.