Caring Homes Healthcare Group Limited

St Georges Care Home

Inspection report

Kenn Road
Bristol
Avon
BS5 7PD

Tel: 01179541234
Website: www.caringhomes.org

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19 September 2018

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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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

St Georges 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. St Georges care home provides accommodation with nursing and personal care for up to 68 people. At the time of our inspection 44 people were living in the home.

At the last inspection on 25 and 26 October 2017 the service was rated Requires Improvement. We found repeated breaches of the regulation relating to accuracy of records and quality assurance systems. We issued a requirement action. Following the inspection, the provider sent us an action plan telling us how they would make the required improvements.

We carried out a comprehensive inspection on 18 and 19 September 2018. At this inspection, we found significant improvements had been made and the legal requirements had been met.
The service has improved to Good.

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

Sufficient numbers of staff were deployed at the time of our visit. Staff performance was monitored. Staff received supervision and training to ensure they could meet people's needs.

Medicines management shortfalls were promptly acted upon and actions taken to make improvements.

Staff demonstrated a good understanding of safeguarding and whistle-blowing and knew how to report concerns.

People were helped to exercise support and control over their lives. People were supported to consent to care and make decisions. The principles of the Mental Capacity Act (MCA) 2005 had been followed.

Risk assessments and risk management plans were in place. Personal and nursing care was delivered in line with assessed needs and accurate monitoring records were maintained.

Incidents and accidents were recorded and showed that actions were taken to minimise the risk of recurrence.

People's dietary requirements and preferences were recorded and people were provided with choices at mealtimes.

Staff were kind and caring. People were being treated with dignity and respect and people's privacy was maintained.

A range of activities were offered and provided people with entertainment in communal areas and in their rooms.

Systems were in place for monitoring quality and safety. Where improvements were needed the provider acted to address identified shortfalls.

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 has improved to Good.

Improvements had been made to the management of medicines. Where shortfalls were identified the provider took prompt action.

People were protected from abuse because staff had received training and knew how to identify and act on concerns.

Risk assessments were completed and risk management plans were in place to minimise identified risks.

Staff were safely recruited. Recruitment procedures were in place and appropriate checks were completed before staff started in post.

Improvements had been made and staffing levels and deployment of staff were sufficient to meet the needs of people living in the home.

Accidents and incidents were reported and actions taken to reduce recurrences.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service has improved to Good.

Care delivery and care records were personalised and responsive to people's current needs.

Activities were provided to people in communal areas and in their rooms.

A complaints procedure was in place and this was easily

accessible.

Is the service well-led?

Good

The service has improved to Good.

The registered manager had made significant improvements and staff received consistent guidance, direction and support. Staff felt able to openly express their views and concerns

Systems were in place to assess, monitor and mitigate risks to people.

Systems had been strengthened to make sure identified shortfalls were promptly identified and acted upon.

A registered manager was in post. People spoke positively about the leadership in the home. They said they could provide feedback and express their views.

The registered manager recognised their responsibilities regarding notifications required by the Commission.

St Georges 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.

We undertook a comprehensive inspection of St Georges on 18 and 19 September 2018. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two inspectors, an assistant inspector and an expert by experience on 18 September 2018 and two inspectors and an expert by experience on 19 September 2018. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we looked at the information we had received about the home. We looked at the notifications we had received. Notifications are information about important events that the provider is required to tell us about by law. We also used information the provider sent to us in their Provider Information Return (PIR). This is information we require providers to send to us at least once each year, that gives key information about the service, what they do well, and improvements they plan to make.

During our visit we spoke with 13 people who lived at the home and 5 visitors. We spent time with people in their bedrooms and in communal areas. We observed how people were being cared for and supported.

We spoke with the provider's operations director, regional manager, registered manager and 15 staff that included registered nurses, care staff, maintenance, housekeeping, laundry, activity and catering staff. We received written feedback from two healthcare professionals. We have included the feedback and comments received in the main body of this report.

We observed medicines being given to people. We checked how equipment, such as pressure relieving equipment and hoists, was being used in the home.

We looked at six people's care records in detail and checked other care records for specific information. We attended a daily heads of department meeting, looked at medicine records, staff recruitment files, staff training records, quality assurance audits and action plans, records of meetings with staff and people who used the service, survey results, complaints records and other records relating to the monitoring and management of the care home.

Good

Is the service safe?

Our findings

At the last inspection in October 2017 we rated this key question as Requires Improvement. This was because improvements were needed in medicines management and staffing levels and deployment of staff. At this inspection improvements had been made in these two areas, and this key question is now rated as Good.

People who used the service and relatives told us they felt safe in the home. Comments included "Yes I feel safe. They move me around and I've never had a problem. I trust the people here," "I feel safe in the home as there is always someone passing the room and they do pop in from time to time," and, "My sister is very happy living here. The staff know her limitations and I feel she is safe. I don't worry when I leave."

Medicines were managed safely. We observed medicines being given to people. The registered nurses showed an awareness of people's needs and preferences. People were asked if they were ready to take their medicines and they received the support needed. One person told us, "They put my medication in my hand and stay while I take it." Another person said, "My medicines are given in a safe way and around the same times. They will wait until I've taken them. I am happy with how it's done."

Medicine Administration Record sheets (MARs) provided details of the person, a photograph, details of allergies and how the person liked to take their medicines. For example, for one person it was written, 'Likes tablets from a spoon, one at a time.' The registered nurses signed the MARs to confirm they had given people their medicines. People who needed medicines to be given at specific times, such as '30 minutes before breakfast' received them at the right time.

For people prescribed topical creams and lotions for application to their skin, there were clear directions for care staff about when and where to apply them. Topical MARs had been completed in full to confirm that staff applied creams and lotions as prescribed.

For people who were prescribed medicines to be taken as required (PRN), for example, for pain relief, protocols were in place. They provided guidance for staff about when people may need these medications. Three of the protocols did not provide comprehensive guidance for staff. One was to support a person with distress, anxiety and hallucinations. The records did not describe what support the person may need before medicines were given. For a person who did not have English as their first language, the protocol did not fully describe how the person expressed their pain. For another person, the records instructed staff to give a prescribed medicine if the person had a "prolonged fit." For each of these people, staff were fully aware of the circumstances in which the medicines would be needed and detailed records were completed before we finished our inspection.

When people needed to have their medicines crushed and given in food or drinks, GP and pharmacist advice had been sought and this was recorded. One person self-administered their medicines. Their ability to do this safely had been assessed. One of the medicines was not always stored safely. We brought this to the attention of the registered nurse at the time.

A monthly medicines audit was completed by senior staff, and where shortfalls were identified, actions were taken. For example, a recent audit had identified gaps in recording, and confirmed actions required to address the shortfall. At our inspection we found actions had been taken and there were no gaps in recording in the records we checked.

Staff had received safeguarding training and understood their responsibilities for keeping people safe from the risk of abuse. They could give examples of signs and types of abuse and what they would do to protect people, including how to report any concerns. The care home had a whistle-blowing policy which provided guidance for staff on how to report concerns in the workplace. Staff told us they would report immediately to the registered manager if they were concerned or suspected a person was being abused. A member of staff commented, "I would go to the manager. There is also a safeguarding contact number to ring."

Risk assessments were in place and these were reviewed monthly. These included risks associated with skin condition, falls, moving and handling, nutrition and dehydration. Where risks had been identified actions were planned, along with provision of equipment such as bed rails and pressure relieving mattresses. For example, for people who used pressure relieving equipment, this was used correctly. Where people also needed support to change position regularly, this was fully recorded.

Accidents and incidents were recorded and actions taken to reduce future risks of injury. The registered manager told us they also focused on what could be learned from incidents and accidents to reduce recurrence. They had introduced a 'registered nurse accountability daily checklist' for staff to complete at the end of shift. This included comments about accidents and incidents and if there were any concerns, or specific actions needed. This was in addition to the regular analysis of accidents and incidents required as part of the provider's quality monitoring system.

Overall, people told us there were sufficient staff to meet their needs. People spoke about significant 'improvements' and 'more consistency' in staffing levels. Some people also commented that further improvements were needed, especially at weekends. Whilst people told us their call bells may not be so promptly answered at these times, no one expressed concerns their care needs were not being met. There were no planned reductions in staffing levels at weekends, and the occasional reductions arose from last minute staff sickness. The registered manager showed us the dependency level tool used to calculate staffing levels. They also told us in their PIR, 'This is supported by indirect methods such as monitoring the length of time it takes to answer call bells, feedback from staff and manager walk-arounds. So, part of this equation is around nursing judgement, especially when taking into account suitable skill mix on each shift.' Staff told us that staffing levels had increased and comments included, "Staffing is so much better now," and, "Lately, staffing levels have improved and we are not so rushed off our feet. We get to spend more times with residents and can sit down and have a coffee with them." During our inspection, sufficient staff were on duty and people's needs were being met.

Staff were safely recruited. Staff files included application forms, proof of identity and references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS check ensures that people barred from working with certain groups such as vulnerable adults were identified. Additional checks were completed to make sure registered nurses had current registration with their regulatory body, the Nursing and Midwifery Council.

The environment was maintained to ensure it was safe. For example, water temperatures, legionella control, electrical and gas safety, lift maintenance and hoist checks had been completed. Fire safety measures and checks were in place. Personal emergency evacuation plans (PEEPS) were recorded for each person. They provided guidance about how people could be moved in an emergency if evacuation of the building was

required.

The home was clean throughout. We spoke with a member of the housekeeping team who described their role and responsibilities. We observed staff using gloves and aprons when needed which showed good infection control practices.

A redecoration programme, mostly on the first floor had taken place since our last visit. Flooring had also been replaced and lighting had been upgraded. This programme of redecoration showed the provider's commitment to investing and making improvements to the environment.

Good

Is the service effective?

Our findings

People and their relatives told us their needs were met and that staff were trained to meet their needs. Feedback included, "The carers know me and how I like things done," "They always know if I'm having a slow day," and, "The staff are good. They know my Mum's needs and will always support her in making choices for her diet, as she needs a soft diet."

Staff told us they received sufficient training to enable them to carry out their roles. When new staff started in post they completed an induction programme and shadowed colleagues to gain practical experience before they worked unsupervised. Staff told us they were provided with regular update and refresher training for topics such as fire safety, moving and handling, safeguarding, mental capacity act, infection control and food safety.

In addition, where training was needed to meet the specific needs of people living in the home, they told us this was provided. For example, a registered nurse told us they had recently completed syringe driver training. Other staff, including non-care staff told us about the 'My world' dementia training programme they had completed. A member of staff told us, "This is brilliant training and really has made me have a much better understanding." The registered manager reminded staff when specific, additional training was available. We read from the minutes of a recent staff meeting where the registered manager had reminded staff, 'It is important we all have the skills needed to care for our residents effectively. So please can you all ensure you have completed the 'e-cademy' course on care for people who have diabetes.'

The staff we spoke with told us they felt supported with supervisions and appraisals with a member of staff telling us supervisions were, "Useful and they are completed on a regular basis now which is nice." Another member of staff told us they felt, "I can talk frankly, open and honestly and I wouldn't be scared to bring anything forward."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 had been assessed for their capacity to consent to specific aspects of their care. When they lacked capacity to consent, best interest decisions were made and the records showed how decisions had been reached and who had been involved. People told us that staff asked before they provided support. We heard staff asking people, such as, "Is it ok?" and "Are you ready to?" before they provided support on several occasions during our inspection. A member of staff told us, "I always ask people…If they are not in the mood or the frame of mind that is fine. We do what they want so long as they are not in danger. At the end of the day we are here for them and it is their lives and their choice."

People who lack capacity can only be deprived of their liberty so they can receive care and treatment when

this is in their best interests and legally authorised under the MCA. The procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. The service had submitted DoLS applications for eight people that were waiting to be processed by the local authority. Three people had current authorisations in place. Where conditions had been stated, such as making sure a person was offered specific activities, these were being met.

We received positive feedback about the quality of the food served in the home. People's comments included, "We can have what we want. It's always nice" and, "The food is excellent, always a large portion." A relative told us they ate in the home on a regular basis and said the food was, "Of a very high standard." We observed the meal service, to people in the two dining rooms and in their rooms. The tables in the dining rooms were laid in advance and menus were displayed on each table. People were offered a choice of drinks to have with their meal. In the dining room on the ground floor the catering staff checked that people were happy with their meals. We heard encouraging comments including, "Can you eat a bit more before your pudding." The person smiled and it was clear there was a good rapport between them. The catering staff also walked around the tables asking people if they had enjoyed their meals and if they would like more. We saw other people being supported with meals in their rooms and in the first-floor dining room. People received the support they needed.

When we spoke with catering staff they could tell us about people's individual needs and preferences, likes and dislikes. They told us they spoke with people 'most days' to obtain feedback, so they could adapt meals and make changes if needed. They told us how spoke with people to make sure likes, dislikes, preferences and needs were known. They told us they also attended meetings with people who used the service and with relatives.

Care plans contained nutritional assessments and people's weights were monitored. When people had lost weight, support and advice was sought and people were referred to the GP. A nationally recognised hydration tool had been introduced to assess people's risk of dehydration. When risks were identified plans such as targeting the amounts of daily fluids a person needed and recording of fluid intake were included in the person's care plan. Where monitoring charts were in place, we checked at random, and found they were fully completed.

For some people who did not speak English as a first language, staff were employed by the service who spoke their language. The registered manager told us they ensured staff were available on each shift to communicate. In addition, one person used signs and gestures to communicate their needs. We asked staff what they would do if there were no staff available to speak to the person in their first language, or if a person was unable to communicate verbally. A member of staff told us, "If the resident has the ability to write they will be provided with a whiteboard and if not, pictures. Some residents use sign language to show if they are in pain or need food and the signing is specific to each resident. This is indicated in the care plans but you learn this in daily care and discuss with the nurse in charge."

People's healthcare needs were being met. For example, for people who had swallowing difficulties, they were assessed by the speech and language therapists (SALT) team. Staff followed written guidance and recommendations made by the team. This included support with textured diets, thickened fluids and positioning when eating and drinking. There were choking plans in place which informed staff of the action to take if this happened. We did note in one person's plan that, 'skilled staff' were to support them with eating and drinking due to their 'high risk of aspiration'. It did not state, as we were told by a registered nurse, that 'skilled staff' meant that only registered nurses could and did, provide this support for the person. The registered nurse told us they would amend the care records to accurately reflect the support the

person was being given.

People were supported to access ongoing health care. This included appointments with the optician, dentist, falls specialist, tissue viability nurse and chiropodist and regular visits from the GP, the care home liaison team and the dementia well-being team.

Good

Is the service caring?

Our findings

People were treated with kindness, respect and compassion. They told us they had good relationships with staff and were well looked after. Comments from people and relatives included, "The staff are kind to me," "I think it's lovely here. The staff are so kind. They understand her and even though there are lots of staff, the core ones have stayed the same and the new ones are great," and, "Lovely staff, all of them."

Throughout the two days of our inspection, we observed people being treated in kind and respectful ways. Staff were helpful and friendly and people looked relaxed and comfortable in their presence. They provided reassurance and support to people when needed. A member of staff told us how they always tried to, "Gain trust with residents and get conversations going." We saw several occasions when staff provided gentle touches and words of encouragement to people. This often happened as staff were passing by people in their rooms or in communal areas. Staff called in, even if it was just for a moment to check people were comfortable and ask if they needed anything.

People's equality and diversity was recognised and respected. We heard staff referring to people by their preferred names, using appropriate volume and tone of voice. One person told us, "They always call me by my full name although I hear others being called by names such as, 'darling' and 'lovely'." Where we heard people being called using terms of endearment, people responded positively and it was clearly a positive part of the relationship staff had developed with people. A relative commented, "I know Mum has good banter with the staff."

Staff communicated in ways that were meaningful to people. For example, we saw the gestures used with one person, and another person spoken to in their first language by a member of staff. The member of staff told us they, or one of their colleagues, often acted as an interpreter when external health professionals visited the person.

Staff clearly knew people well and could describe people's personal histories, interests and preferences. These were also recorded in the care plans and included preferences for gender of staff to provide personal care. One person told us, "They asked me when I first arrived if I minded male carers, but it doesn't bother me."

Care staff told us how they made sure people's dignity and privacy was promoted and maintained. They made sure people were fully covered and that others didn't enter rooms when they were supporting people with personal care. Staff also explained how they encouraged people to do as much for themselves as possible. A member of staff said, "I promote independence by asking resident's if they would be able to wash their face or comb their hair, then choose what they would like to wear."

People told us they were asked and felt involved in decisions about their care. Comments from people included, "I have a bath each week, and it's always a female carer because that's what I want." Staff spoke positively and affectionately about the people they provided care for. Comments included, "It is lovely to put a smile on people's faces and lovely to see the resident's happy," and, "I like to know each resident and what

their families are about and get to know them personally. It's nice to have a good rapport with them."

People's rights to a family life were respected. Visitors were made welcome at any time. One relative told us, "If they know we are going out, dad is always ready. The staff will do anything if they are asked, Very obliging."

We read recent compliment cards and letters received in the home. They included the following, 'I would like very much to thank you for all your loving care and kindness you gave to my auntie over the last five and a half years. She was always very happy to be at St Georges and gradually, as her health deteriorated and she became bedbound, we knew she was in kind hands.' We also read feedback recently entered by relatives onto a national website that included, 'My mother has been a resident for two years and in that time, I have found the care and attention to her needs very good…I find it to be a happy home.'

Good

Is the service responsive?

Our findings

At the last inspection in October 2017 we rated this key question as Requires Improvement. This was because care records did not accurately reflected people's current needs and preferences. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities Regulations) 2014. At this inspection sufficient improvements had been made and the legal requirements were being met. The rating for this key question has improved to Good.

People and relatives told us that care was responsive to their individual needs. One person commented their care was, "Right for me." Another person told us how their care needs had changed as they were no longer able to walk. They told us they, "I don't walk now so they got me a wheelchair with no problem."

Before new people moved into the home they were assessed by the registered manager or senior staff to make sure their care needs were known. Care plans were designed to reflect individual needs, choices and preferences. Care was well planned and records were checked and reviewed every month. Relatives told us they were not usually involved in formal reviews of care plans. They told us they were kept up to date and involved when there were changes. We did see in care records that letters had been written to relatives inviting them to care reviews.

People had their care plans reviewed each month as part of the 'Resident of the Day' system. In addition to a care plan review, heads of department visited the person, to check they were satisfied with the service provided, and to ask if any changes were needed. One person referred to this as their, "Just for you days" where they chose to have their nails painted, have a book read to them, or just chat with the activity team.

Most care plans provided specific details of how people's needs were being met. For example, where people needed support with personal care, their preferred frequency for bathing or showering was recorded, and included the toiletries they liked to use. For one person, their records noted they liked to be supported to 'shave each day' and for another person how they liked to be supported 'to put jewellery and make-up on.' In addition, daily handover sheets provided short descriptions of people's needs and were used for staff to provide up to date information about each person.

People's specific health care needs were personalised, recorded in detail and up to date. For a person who had seizures, their care plan provided details of the actions staff may need to take to support the person. For a person with diabetes, their care records stated the symptoms they displayed if they were unwell and needed treatment and provided clear guidance of actions staff needed to take in such circumstances. For people who had wounds, care plans were clear and detailed. They provided accurate assessments of the progress of the wound along with clear instructions for staff to follow.

Where we identified areas that needed strengthening, to make sure the records were fully reflective of people's needs, actions were taken, and the records updated before the end of our inspection. For example, for one person, their records stated they declined care on occasions and could be verbally aggressive to staff. An entry in the records referred to 'see communication with challenging behaviour plan.' There was no

plan in place. However, staff could fully describe the circumstances around the person displaying behaviour that could be challenging to others. They immediately completed a detailed plan that fully reflected the person's care needs.

Staff had discussed end of life plans and recorded what people wanted to happen if they became very ill. Relatives were involved in discussions where appropriate and when DNACPR's had been agreed. This is a way of recording a decision not to resuscitate a person in the event of a sudden cardiac collapse.

Staff told us how they made sure care was personalised to each person's specific needs. A member of staff told us, "Personal care can be intimidating for the residents, so before I do anything I always knock on the door and check it's ok. If they want care later, there's no set time for these things.

A range of activities were provided. Peoples comments included, "Yes I join in, they are fun and it's nice to get together," and, "I am invited to join in but only go if it's a singer." The weekly group programme included bingo, crafts, singing, external entertainers, exercises, films and discussions. The activities coordinator told us about a daily history newsletter they used as themes for discussions, music and quizzes relating to that particular week in history.

Whilst people were given copies of the weekly activities programme and reminded on the day, their right to choose not to attend was respected. One person told us, "I like to stay in my room and have quiet time but they always ask and if they are free they have a chat instead." We checked the records for another person who stayed in bed. Their 'engagement booklet' in their room showed that staff had visited the person each day for a chat. One entry included, 'Had a lovely chat and read to her.'

We watched a game of bingo taking place. People were supported to 'dab' their numbers and call 'house' at the right time. There was laughter, smiles and encouragement throughout the activity, including from people in the lounge who were just watching and not taking part.

We discussed other activities and events that had taken place, or were planned for the near future. An 'around the world' theme continued, as we had noted when we last inspected the service. A country was identified as the chosen location for a period of time. The lounges were decorated with flags, food was provided, activities were organised and staff dressed up in outfits specific to the chosen country. The registered manager told us how successful the 'slow boat to China' had been. For people who participated in the activity for the country, they were given a 'passport' to confirm they had 'visited' and this was displayed in their room. For people unable or who declined to attend, they were given the opportunity to 'chat' about the 'destination' in their room.

The activity coordinator told us how they celebrated events such as the 'royal wedding,' and supported people to visit their local church. They had developed a relationship with the local nursery and the 'tiny tots' visits took place every two weeks.

A complaints procedure was in place that was readily available to people and relatives. It was on display in the reception area in a 'We value your opinion' booklet, and copies were provided to people in their rooms. People told us they would feel comfortable to raise concerns if needed. One person said, "my son would make a complaint if we needed to." We discussed complaints the registered manager had received and responded to. They told us they were introducing a 'You said, we did' where lessons from shortfalls in care, complaints and feedback would be used to make improvements to the service.

Good

Is the service well-led?

Our findings

At the last inspection in October 2017 we rated this key question as Requires Improvement. This was because quality assurance systems were not fully effective and did not always identify shortfalls in care provision. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities Regulations) 2014. At this inspection, we found significant improvements had been made. The legal requirements had been met. The rating for this key question has now improved to Good.

People and their relatives told us the home was well managed. Feedback included, "Yes he is a good manager, all the staff are happy in their job, so that tells you a lot," and, "Everything seems calmer now and a happy place when you come in, the staff welcome you." They spoke about the registered manager being, 'approachable' 'available' and 'always around.'

Systems were in place which identified shortfalls, a range of audits and monitoring checks were completed by the care home management team. Where shortfalls were identified, actions were taken and rechecked to make sure they had been completed. In addition, the regional management team completed audits. For example, a catering audit had been completed just before our inspection. The catering team told us they were pleased with the results, as they had scored highly. Shortfalls noted were minor, and had been actioned straight away.

We saw other actions had been taken in response to shortfalls the provider identified in their monitoring systems. For example, they recognised and acted on shortfalls in the care planning records. For one person, their pain assessment recording was incomplete, their PEEPS plan was not up to date and their eating and drinking records needed to be improved. Actions were agreed and actions were taken within a week of the shortfalls being identified.

People using the service and relatives were provided with opportunities to feedback at meetings and by completing surveys on paper, or onto the iPads provided in the home. We read the summary report from the resident survey undertaken between May and July 2018. Feedback indicated improvements could be made to make sure staff had sufficient skills and knowledge. We read the meeting minutes from a relatives meeting held in July, where redecoration, staffing and surveys were discussed. The registered manager informed those present that staff recruitment had been successful. New staff had been employed who were 'highly experienced and will improve the depth of experience and knowledge within the team.' This showed how the registered manager monitored the service and made improvements in response to feedback.

Staff spoke positively about the support from the registered manager and proudly about the improvements made since our last inspection. Their feedback included, "Staff morale is improving. There is more team work and staff are on the same page and there is more communication. Everyone is aware of their responsibilities." "It's so much better here now. He (the registered manager) is brilliant. There's not the back-biting there was," "[Registered manager] talks to you one to one and not just like a boss. He's really down to earth" and, "I feel really supported by the management and with the training I get. The manager is very open and accommodating and makes the overseas nurses feel comfortable."

Throughout the inspection, it was clear that teamwork amongst staff had improved significantly. Staff were open and honest with us, they were warm and welcoming, and they told us how much they enjoyed working at St Georges. They told us they now felt valued and appreciated. A member of staff said, "I look to where we were before and where we are now. Our manager is really supportive. He is really appreciative and will bring in chocolates for each floor to say thank you." Another member of staff told us, "I just love working here."

Staff had the opportunity to share their views at staff meetings. At the most recent meeting the registered manager asked staff to read the most recent resident survey and make a commitment to support improvements in response to the feedback collated. They also reminded staff to complete training that was due and reminded staff of the importance of using bed rails correctly and safely. They also asked staff to vote and to encourage people who used the service and relatives to vote for their ''caring star of the month.' This was an initiative introduced to recognise staff for their work and for 'going the extra mile.' Staff were encouraged to contribute to the meetings and suggestions were discussed. At the most recent meeting staff discussed how to consistently improve the completion of fluid charts, and discussed the benefits of moving towards computerised care records.

The registered manager told us their initial challenge, when they started in post was to build a staff team that could work together, with shared values. They told us how they promoted accountability and expected staff to take responsibility for their actions. They told us how they listened and implemented ideas from staff. This included the introduction of the registered nurse daily accountability checklist. This was completed at the end of each shift, and registered nurses were expected to confirm they had checked records were fully completed, for example fluid charts. They also recorded any issues of concern and handed over significant changes. This meant the registered manager was kept up to date with any changes in people's condition, so they could ensure appropriate actions were taken.

The registered manager could told us how they kept up to date with current practice. They told us they received support, direction and guidance from the provider. They had enrolled on a 'Future leaders' course run by a national leadership and management institute. They researched to make sure they provided care in line with nationally recognised best practice. For example, they had recently introduced a nationally recognised hydration assessment tool into the home. In addition the provider had a range of policies and procedures that were regularly updated in line with up to date legislation and best practice.

The registered manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required.