HC-One Limited

St George's Park

Inspection report

School Street
St George's
Telford
TF2 9LL
Tel: 01952 616300
Website: www.hc-one.co.uk

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

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, and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

At the last inspection on 3 April 2013 we found that there were no breaches in the legal requirements in the areas we looked at.

St George's Park was divided into two separate units. One unit provided nursing care and the other unit provided support for residential (non nursing) and people who lived with a dementia type illness. The service provided accommodation for up to 71 older people. The home offers dementia, nursing, residential, respite and end of life care. The home offers a range of communal facilities and each bedroom has an en suite toilet and shower. On the day of the inspection there were 60 people living at the home.

Summary of findings

There was no registered manager in post. A registered manager is a person who has been registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The provider had appointed a manager, they had applied to be registered with the Care Quality Commission.

We observed that staff had no time to sit with people who lived at the home. Staff time was spent focused on task only. This meant staff did not spend time sitting and talking to people. During the time of our inspection we observed there were not always sufficient numbers of staff to meet people's needs. For example we saw that one person who required two hourly turns had a gap of not being turned for four hours and fifteen minutes. Staff we spoke with told us staffing levels were not always sufficient in the day. We observed the lunchtime meal which was not a positive experience for all people who lived at the home. This was because staff were rushed on Rydal unit.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

We saw that people did not get the support they required at lunch time to ensure they ate their lunch and received sufficient fluids. We also saw that people that required their fluids monitoring did not have this done consistently. This could mean that they were at risk of becoming dehydrated. These issues were a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Staff we spoke with and observations we made throughout the day demonstrated that staff were knowledgeable about individuals and how they preferred their care needs to be met. Staff training was up to date in mandatory topics such as safeguarding vulnerable adults and moving and handling.

We saw staff treat people with respect and their dignity was maintained.

The manager had introduced audits which assessed the quality of the service. For example care plan audits. This meant the manager monitored the effectiveness of care plans on a regular basis and told us action would be taken if anything arose out of an audit.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Staff on Rydal unit were not able to meet people's needs in a timely way. Staff were task focused and had no time to spend with people.

Staff we spoke with were knowledgeable about who to, and how to, report any suspected or potential abuse. Staff's knowledge about the Mental Capacity Act 2005 and its application was appropriate to their role.

Staff we spoke with were able to give examples of what it meant to deprive someone of their liberty. At the time of our inspection there was no one on a Deprivation of Liberty Safeguard (DoLS) and we did not see anyone have their liberty, rights or choices restricted in any way.

Inadequate

Is the service effective?
The service was not effective.

Staff received appropriate training and support to carry out their roles which ensured people received their assessed care and support in an appropriate way.

We saw people were given choices about what they wanted to eat at lunchtime. However, the mealtime was not a pleasurable experience for everyone and support was not provided appropriately.

People's healthcare was monitored which ensured that any changes were discussed and referrals made where appropriate to health care professionals for additional support where required.

Requires Improvement

Is the service caring?
The service was not caring.

During our inspection we observed staff being professional. They treated people with kindness and their dignity was maintained.

Staff knew the people they cared for well and were knowledgeable about people's needs including personal care needs.

Relative's feedback about care was mixed. One relative told us they could visit at any time. This meant the service was flexible and imposed no restrictions.

Requires Improvement

Is the service responsive?
The service was not responsive.

Requires Improvement

Summary of findings

People's needs were assessed before they moved into the home. Care plans were regularly updated to show people's changing needs. There was no evidence that care plans or reviews involved the person using the service or their representative.

There was little social activity for people who used the service on the day of our visit.

People were encouraged to maintain contact with family and friends and we saw visitors throughout our inspection.

People we spoke with were aware of the complaints procedure.

The service sought the opinions of people by means of questionnaires, meetings and individual reviews.

We were assured by the manager that the information from questionnaires and resident/relative meetings would be used to improve the quality of service.

Is the service well-led?

Requires Improvement

The service was not well led.

A new manager was in post and demonstrated improvements made since their appointment. Feedback we received about leadership at the home was good although staff reported morale was low due to changes, lack of permanent staff, the high use of agency staff and a recent large scale safeguarding investigation that took place in March 2014.

The manager had a clear insight of the areas that required improvement at the service and was focused on working with staff to achieve these. This meant they were able to set the vision and values required to improve the quality of the service people should receive.

Procedures were being developed to monitor and improve the quality of the service. This meant that quality was seen as being important and would be used to drive continuous improvement.

St George's Park

Detailed findings

Background to this inspection

This was an unannounced inspection carried out by two inspectors, a specialist advisor who had a nursing background and an expert by experience who had personal experience of nursing and residential care for older people.

Before our inspection we reviewed the information we held about the service, including information we had asked the provider to send to us prior to our inspection, called the provider information return. This helped us to decide what areas to focus on during our inspection. We contacted the Local Authority Quality Monitoring team. They told us about a safeguarding adult investigation in relation to pressure area care that had taken place in March 2014. People had not been supported appropriately when they developed a pressure area. We looked at how this had been managed since the investigation had been concluded.

During our inspection we spoke with nine people who used the service, three relatives and 18 staff – a combination from the care team, catering staff, the manager, quality assurance manager and clinical lead nurse. Not all the people we met were able to speak with us about the care they received and their experience of living in the home. Therefore we observed how staff interacted and supported people and looked at some records including staff training records and audits.

During our inspection we observed how staff interacted with people who used the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at seven people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the home. These included audits and minutes of meetings

Inadequate

Is the service safe?

Our findings

During the time of our inspection we observed there were not always sufficient numbers of staff to meet people's needs. For example we saw that one person who required two hourly repositioning had a gap of not being turned for four hours and fifteen minutes. Staff we spoke with told us staffing levels were not always sufficient in the day. Staff told us, "We have to turn call bells off and tell people we will return because we are dealing with someone else". This meant people did not receive their care in a timely manner when they needed it. One relative told us, "Care could be better". Another relative told us, "Today is a hot day, I have just come in and found [relative] slumped over the side of the bed. It is boiling hot in here. I've drawn the curtains and put the fan on. Staff know if [relative] gets too hot they will have a seizure". We observed some people were still in bed not having had their personal care at mid-day. One relative told us, "There are a lot of agency staff that work here". This meant that people did not receive consistency in their care from staff who knew them well.

We observed lunch being served in the ground floor unit, Rydal. Some people were seated at the table at 12.50pm and did not get served their lunch until 2pm. We heard some people calling out for food because they had sat and waited for so long for their lunch. This was because there was not enough staff to serve lunch and assist people who required support. Staff did not remain in the dining room after they had served eight people their lunch and did not return to the area for approximately 15 minutes when they served dessert. This was because we saw staff were busy serving meals out to other people and assisted people that required help.

These issues were a breach of Regulation 22 of the Health and Social Care Act 20018 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of this report.

We saw systems were in place which ensured any concerns about a person's safety were identified and reported. All of the staff we spoke with were aware of how to recognise poor practice and how they would report it. Staff we spoke with and training records we saw confirmed that staff had undertaken safeguarding, understanding the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training. All of the staff we spoke with demonstrated they understood the principles of the Act. The Care Quality Commission had received notifications staff had made to the local safeguarding authority, who take the lead in all safeguarding of adult investigations. Notifications are required to be sent to us by law. They inform us of any significant events that occur at the home. This demonstrated the staff understood how to identify and report potential abuse.

We discussed the use of agency staff with the manager. They told us the home was short of permanent staff and recruitment of more staff was in progress. In the meantime the home had to be covered and therefore using agency staff regularly was the only option. They agreed this was not the preferred option but assured us they were taking active steps to recruit permanent staff.

One person who was able to speak with us told us they felt safe but did not like seeing lots of different staff due to staff leaving and agency staff providing cover. They told us it unsettled them. One relative we spoke with told us, "I think [relative] is safe here". One person told us, "It's all changed and gone to pot since all these agency staff are here. They don't know the place".

Mental capacity assessments had been completed for people who lived at the home. This and staff's understanding of the Mental Capacity Act 2005 meant that people were supported with the person's agreement and consent.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the DoLs and to report on what we find. At the time of our inspection the manager told us that there was no one who had their liberty, rights or choices restricted in any way.

Care plans were well structured and comprehensive. They provided good information for staff to be able to deliver safe and effective care. We looked at wound care management plans and found these to be detailed. Photographic evidence had been taken so that the service could monitor progress or deterioration with a wound.

We looked at the systems the provider had in place to manage risks. We particularly looked at how pressure area risks were managed. We saw that staff followed national clinical guidance in relation to management of pressure areas. We spoke to the lead nurse who had responsibility for wound care. We saw there was an assessment process in place which identified any areas of concern. Appropriate

Inadequate

Is the service safe?

aids such as pressure relieving mattresses and cushions were put in place. Waterlow scores were maintained. The waterlow score gives an estimated risk for the development of a pressure sore and we saw this was reviewed regularly.

Requires Improvement

Is the service effective?

Our findings

Some people complained the lunch was cold but staff did not respond to this. We saw a member of staff seated assisting a person to eat, they did not pay attention to what they were doing as they were also trying to assist two other people at the dining table. We also saw a staff member assisting someone to eat in their bedroom, they left the person to go to the dining room to get a dessert. Whilst they were in the dining room they stood by someone and assisted them with a couple of spoons of their dinner and promptly left and returned to the person who they were assisting in their bedroom. We observed lunch time was not a pleasant experience for people because there were not enough staff to assist. Some people who were sitting in a lounge had no mobility. They were unable to reach their drink that had been left on a nearby table. It was some time before staff attended to them.

We saw one person was not offered a dessert. We asked staff why this was. They told us the person could not have the apple crumble because they were on a diabetic diet and believed a diabetic could not have the crumble. They went to the kitchen and returned back with a fruit bowl which was offered to the person. We spoke to the chef, manager and quality assurance manager about this. We were informed that the produce used in the desserts were suitable for diabetics and they did not understand why this had happened.

Lunchtime on the ground floor was disorganised and not a pleasant experience for people. In contrast we also observed lunch being served upstairs. The meals were served in two sessions. This enabled staff to attend to people individually and provided a relaxed meal time experience. We saw one person refused lunch. The staff asked if the person wanted other alternatives but they refused and asked for Weetabix. The person was given Weetabix and ate them. This showed staff respected individual choice.

The home used a malnutrition universal screening tool (MUST) that showed regular observations were made. All records showed referrals to other professionals such as the doctor and speech and language therapist in response to people's needs. Some people had eating and drinking plans in place which consisted of fluid intake and nutrition input records. In one person's fluid intake records for the four days preceding the inspection totals were, 1,010mls, 1,180mls, 520mls and 430mls. We could not be sure from the records whether their intake was inadequate or the recording was inconsistent. There was no daily target to be achieved by the person regarding how much fluid they should have. This meant staff did not know if the person had taken enough fluids or not. There was no care plan in place that directed staff what to do if the person did not achieve their daily target amount. This could mean the person got dehydrated through poor fluid intake. This was brought to the attention of the manager.

We saw that people did not get the support they required at lunch time to eat and drink. We also saw that people who required their fluids monitoring did not have this done consistently. This could mean that they were at risk of becoming dehydrated. These issues were a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All staff received a comprehensive induction programme before they commenced work. One staff member told us, "Training is good". We looked at training records and saw staff had completed courses in a variety of topics. These included, food safety, safeguarding vulnerable adults, manual handling, infection control, health and safety, dignity, understanding the Mental capacity Act and DoLS and person centred care.

Staff we spoke with told us they received regular supervision and an annual appraisal of their work. These are ways of the management team supporting staff to do their work.

We saw people had appropriate access to healthcare professionals when they required it. For example the tissue viability nurse had been called to people if their wound was assessed as a grade two to three pressure wound. At the time of our inspection no one had a pressure ulcer and it was reported to us that improvements in people's wound care management meant that ulcers had been treated with success. One relative told us, "They are on the ball. They can tell if [relative] is restless and agitated, [relative] gets a lot of water infections, they test [relative] water and call the Doctor".

We saw action had been taken in relation to a person who had fallen on more than one occasion. They had been referred to the falls management clinic. This meant that the staff had reviewed the person's situation and sought professional advice for the person involved.

Requires Improvement

Is the service caring?

Our findings

We spoke with nine people who lived at St George's Park that were able to communicate with us. They told us they were treated with kindness and respect. Comments included, "Looking after me they are good here", "They do what I want with regard to going to bed late because of my bad chest and getting up early. It's what suits me. I've told them what I want and they respect that".

Relatives we spoke with gave mixed feedback about the service they told us, "The staff are superb I can't praise them enough. One person told us their relative was treated with dignity and respect. It was apparent through our discussions with families of people living on the ground floor that some families were very involved in their relatives care and care planning process which meant they could tell staff how their relative/friend preferred their care to be delivered because they knew them best. People told us they had told staff when they liked to bath or shower and usually they were supported at their chosen times.

We looked at seven people's care records as part of our pathway tracking process. This process helped us judge if people were getting the care and treatment they needed. We saw that each person was assessed by staff for their risk of injury from falls, from developing pressure sores, malnutrition and dehydration and risks involved when people need to be moved with assistance. Care plans were comprehensive but care staff told us they did not have time to read them. This could mean that staff did not know how to support people fully if they had not familiarised themselves with care plans.

We saw that people could move around the units whenever they wished. We saw staff speak to people as they were passing and staff popped into bedrooms to check people's wellbeing. We saw that people were able to receive visitors whenever they wished. One person told us "There's always someone popping in to see me". We saw information about advocacy services was available to people who lived at the home.

We spoke to staff and found staff knew the people they cared for and were knowledgeable about people's needs including personal care needs. One staff member we spoke with told us the life history of a person who used the service. They had gained this from the person's family because the person was unable to communicate themselves. This meant that they could understand the person's history and important details about them before they moved into the home. Having this information can help care staff when caring for people with dementia related illness. This is because they may display behaviour that is linked to their past.

Staff we spoke with told us of the importance of protecting people's dignity whilst supporting them with personal care. We saw staff treat people with respect and kindness during the inspection. We saw staff knocked before they entered people's rooms. All bedrooms had en suite facilities which meant personal care could be provided in someone's private facilities.

We saw the way staff assisted people to move round the home. They managed the process well and explained to people what they were going to assist with. Staff provided the appropriate reassurance. This meant that staff consulted people about the support they provided and people were reassured by staff who were skilled to provide support.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before they moved into the home. Care plans contained information that was individual to each person taking into account people's needs, choices, likes and dislikes. We saw risk assessments were undertaken and regularly reviewed.

We saw that care plans had been regularly reviewed. One relative we spoke with told us, "I attend care reviews every six months" and I am aware of the care plan but I don't know when it's reviewed".

Care plans we saw confirmed that reviews had been undertaken. However people we spoke with told us they were not involved in any reviews of their care plans.

People on Derwent unit were very dependent on staff for all aspects of their care. Observations we made showed people looked cared for. Care plans we looked at showed that when a person's health or condition had changed, appropriate steps had been taken to make changes to the plan of care. The clinical lead nurse told us an example of this was where a person developed a pressure area, photographs were taken to record the wound to monitor progress. This was done following clinical best practice guidelines. We saw that the home referred people to the tissue viability nurse, again in line with clinical best practice guidelines. We saw wound care plans had been developed as necessary and wound care assessment charts completed to monitor the wound site and progress. We saw wounds had been checked at every dressing change or at least weekly. We saw a system was in place to identify dressing schedules. The wound care regime within the home was well managed.

The activity for the day of our inspection was a visit from the hairdresser and 'pampering' which included hand massage. The hand massage was to be performed by care staff but they did not have time to do this. People were invited to take part in a sing along session that was being held on the afternoon of our inspection. We were told and saw photographs of a recent trip to RAF Cosford. One person enjoyed sitting in the garden during our visit. They told us this was important to them because they enjoyed having a cigarette. We saw an out of date activities list for weeks 1 – 4 June 2014 but no information about what activities were taking place in July. This meant people did not know what activities were available to them for the forthcoming month.

Relatives we spoke with felt confident to raise concerns or complaints with the manager. One person gave us an example of where they had recently complained and told us details of their complaint and how this had been managed to their satisfaction. Another relative told us, "I have not been given any literature about the complaints procedure but I know how to complain".

One relative told us they felt that if they did not visit things would not get done for their relative as they had identified issues when they had visited that should have been picked up by staff. They have had mixed responses to their concerns. They went on to tell us their relative's health needs were met and responded to.

Requires Improvement

Is the service well-led?

Our findings

We met the manager who had been in post since February 2014. They were open with us and told us there had been a number of challenging issues that had to be addressed when they started at the home. This work is still on going but they had a clear vision of where the home needed to be and how this would be achieved.

One staff member we spoke with told us they felt supported by the new manager and said, "I have a good idea of where the manager wants to take the home, I know it will be hard but I look forward to it". Other staff members told us, "I can see changes that are being implemented for the good. I feel supported by the new manager and involved in the changes and improvements.

People told us they thought the new manager was excellent and that they had introduced themselves at a residents meeting. They told us they thought improvements had been made at the home since they had been appointed.

Staff told us morale was low because there had been staff sickness, staff had left and there was a high use of agency staff who did not know the home or people that lived there. They told us, "It takes time to teach agency staff about people's needs". We saw permanent staff taking agency staff around the home to show them how to support people. We were also aware that where there had been unsuitable agency staff the manager had contacted the company and asked them not to return to work at the home.

We spoke with relatives, some of the comments included, "I have been invited to relatives meetings and have received minutes from meetings" and "I have received a questionnaire from here and the local authority. I also receive a newsletter and minutes following a relatives meeting. I try to attend relatives meetings.

We contacted the local authority before we carried out our inspection and they told us the manager had worked in an open, transparent and co-operative way during a recent large scale safeguarding of vulnerable adult investigation. Matters investigated related to incidents before the new manager commenced in post.

We were told the manager held meetings at the start of each shift with heads of each department. These meetings were used to convey important information. The manager took us on a tour of the home and demonstrated a good understanding of people's needs on the tour. We also met the Quality Assurance manager who provided support to the manager. It was evident through discussion that both managers were focussed on improving the quality of care at the home and aware of the need to put systems in place that would support continuous improvement.

We saw that audits had been completed on areas that included care plans, accidents and incidents. Audits ensured the effectiveness of the service was monitored regularly. We did not see any issues that had been identified through the providers audit system.

We saw from the service records there was a system in place to record accidents and incidents. This showed that the manager and staff at the head office monitored accidents and incidents for trends and themes. We saw that people were referred to the falls clinic as a result of this monitoring.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Staff did not support where necessary people that required support to eat and drink sufficient amounts.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purpose of carrying out the regulated activity.**