Mr Frederick Bilsland

St George's Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

This unannounced inspection took place on 21 November 2016. We last inspected St Georges Residential Care Home in March 2015. At the inspection in March 2015 we found the service was not meeting all the regulations that we assessed and we asked the provider to take action to make improvements. This was in relation to medicine management, providing consistently appropriate and person centred treatment, restrictions on a person's liberty and effectively monitoring the quality of service provision.

We issued four requirement notices and asked the registered provider to tell us how they were going to make the improvements required. At this inspection on 21 November 2016, we found that the registered provider and registered manager had made the changes and improvements needed to meet the requirement notices from the previous inspection

St George's Residential Home provides accommodation and personal care for up to 41 older people. The home is in an older property, close to local amenities in the town of Millom and has been adapted and extended for its current use. The bedrooms in the home vary in size and layout. There is a garden to the rear of the home for people living there and this is private and has accessible outdoor seating. There is parking available at the front of the home for staff and visitors. There were 28 people living at the home at the time of our inspection.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service was run. We noted that there was a clear structure and lines of responsibility being promoted by the registered manager and deputy. A member of care staff told us, "It's a very open and friendly place to work".

People living in the home told us that they felt safe living there and relatives we spoke with told us they were satisfied and "more than happy" with the care being provided. Some people who were living with dementia could not tell us their views but those people who could told us they felt "safe" and "secure" living there. We were told by one person who lived there, "I am happy here".

People confirmed they had a choice of meals and drinks and they told us the food was "good" and that they enjoyed their meals. People were involved in discussions and feedback about food at their 'residents' meetings.

We saw that the people who lived there were being well cared for and were relaxed and comfortable in the home and with the staff that were supporting them. The atmosphere was informal and inclusive and people told us that they would be comfortable raising any complaints or concerns with the registered manager. Everyone we spoke with praised the staff that supported them and the friendliness of the staff and management.

People told us that care staff were available to help them when they needed assistance and that staff respected their privacy. People living at St Georges told us they were able to see their friends and families as they wanted and go out into the community with support. There were no restrictions on when people could visit them in their home. People were able to follow their own interests, practice their religious beliefs and see their friends and families as they wanted. People commented positively on the range of activities available to them in the home and the social events arranged for them.

The registered manager had a system to calculate dependency and staffing needs which they reviewed at three monthly intervals. We could see that the home was being adequately staffed to meet people's needs during the day. We have made a recommendation that the registered manager reviewed their dependency tool to consider the layout of the home and sought guidance on current best practice on risk assessing safe staffing levels at night.

The service had safe systems for the recruitment of staff to make sure the staff taken on were suited to working there. We saw that care staff had received induction training and training for their roles and development and had regular supervision and annual appraisal. Staff said they were well supported by the management team. There was an on call system for staff to access management support at night.

Staff had received training in safeguarding adults. Staff we spoke with knew the appropriate action to take if they believed someone was at risk of abuse. People knew how they could complain about the service they received and information on this was displayed in the home. People we spoke with were confident that action would be taken in response to any concerns they raised.

The service had followed the requirements of the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards. This helped to protect the rights of people who were not able to make important decisions themselves. We looked at people's records and saw that the registered manager had applied to relevant supervisory authorities for deprivation of liberty authorisations for people.

During this inspection, we looked at the way medicines were managed and handled in the home. We found that medicines were being administered safely and records were being kept of the medicines in the home.

The service worked with local GPs, district nurses and health care professionals and external agencies to provide appropriate care to meet people's different physical, psychological and emotional needs.

We looked at care plans and saw there were risk assessments in place and control measures to help minimise them. We looked at the risk assessments in place regarding how people would be moved in the event of fire or other emergency. These had been kept under review. We noted that risk assessments were not being formally carried out to assess the risks of choking for people. The registered manager knew this needed to be formalised and was addressing it as part of their care planning review. We made a recommendation that in their review of risk assessments the registered manager considers current guidance and best practice on assessing the specific risks of people choking.

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 safe.

Appropriate arrangements were in place to help ensure the proper and safe management of medicines within the home.

The registered manager had a system to calculate dependency and staffing needs and this required review to give greater consideration to staffing at night.

There were thorough staff recruitment processes in operation. Staff we spoke with in the home knew how to recognise possible abusive situations and how this should be reported.

Is the service effective?

Good

The service was effective.

There was a programme of staff training in place that was being kept under review.

People were having their individual needs and preferences assessed to promote their best interests in line with legislation.

People reported the food was good. They said they had a choice of food at mealtimes and had a choice of nutritious meals, drinks and snacks.

Is the service caring?

Good

This service was caring.

People told us that they were well cared for and happy living in the home.

We saw that people were treated with respect and kindness and their independence, privacy and dignity were being protected and promoted.

We saw that staff engaged positively with people. This supported people's wellbeing.

Is the service responsive?

Good

The service was responsive.

We saw that people made their own choices about their daily lives in the home. There were organised activities for people if they wanted to take part.

Support was provided to help people maintain their relationships with friends and relatives.

Information was displayed on how to make a complaint within the home. There was a system in place to receive and handle any complaints raised.

Is the service well-led?

Good

The service was well led.

People who lived in the home were asked for their views on how they wanted their home to be run and their comments and suggestions were listened to by the management.

Quality audits were being used to monitor care planning, medication management and to assess the overall quality and safety of the service provided.

Staff told us they felt supported and listened to by the registered manager.

St George's 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 unannounced inspection took place on 21 November 2016. An Adult Social Care (ASC) Inspector carried out the inspection.

We spent time speaking with and observing people who lived in the home within the communal areas of the home and spoke with people in private. We were able to see some people's bedrooms, bathrooms and the communal bathrooms.

Some people living at the home could not easily give us their views and opinions about their care and support. We used the Short Observational Framework for Inspection (SOFI) to help our observations in the home. SOFI is a specific way of observing care to help us better understand the experiences of people who could not easily talk with us. It is a useful tool to help assess the quality of interactions between people who use a service and the staff who supported them.

During the inspection we spoke with 12 people who lived in the home, three relatives, four of the care staff, a visiting health care professional, the senior care worker and the registered manager.

We looked at care plans for six people living in the home, their medication records and care plans relating to the use of their medicines. We observed medicines being handled and discussed medicines management with the staff involved in this. We checked the medicines and records for six people and spoke with members of care staff with responsibility for medicines.

We looked at records relating to the maintenance and management of the service and records of checks or 'audits' being done to assess and monitor the quality of the service provision. We also looked at the staff rotas for the previous month and staff recruitment and training records.

Before our inspection we reviewed the information we held about the service. We spoke with commissioners of the service. We looked at the information we held about notifications sent to us about incidents affecting the service and people living there. We looked at the information we held on safeguarding referrals, concerns raised with us and applications the registered manager had made under Deprivation of Liberty Safeguards (DoLS).

Before the inspection, the provider completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

Requires Improvement

Is the service safe?

Our findings

People we spoke with who lived at St George's made positive comments about their life in the home. We were told, "The staff are all very friendly" and "It's lovely here, smashing place to be". Another person told us, "I feel I am safe here and I am cared about, everyone has been very kind".

A relative told us, "We can go home and relax because we know [relative] is being so well looked after and that they will be safe and sound". Another relative told us, "I visit every other day and I can tell you that on the whole the staff here are really very good and pay attention to what you say and tell me how [relative] has been doing".

At the inspection of this service in March 2015 we had found that there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people using the service could not be sure appropriate care and treatment would be provided following an accident. During this inspection we looked at the accident and incident records and found that clear reporting systems were in place to report these and these systems were being used. We noted that the approach taken by staff to managing risk was consistent and that appropriate treatment was being provided to people following accidents.

At our inspection in March 2015, we found that the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because appropriate arrangements were not in place to ensure the proper and safe management of medicines within the home.

At this inspection we found that medicines were being safely administered and records were being kept of the quantity of medicines kept in the home and those disposed of. We saw that there were appropriate arrangements in place in relation to the recording of medicines administration and the records had been correctly signed when medicines were given out. Medicines that are controlled drugs (medicines subject to tighter controls because they are liable to misuse) were stored and recorded in the right way. We checked a sample of three controlled drugs on each floor of the home and found that stock balances were correct.

We saw there were clear protocols for giving 'as required' medicines and when these medicines had been given, it had been clearly recorded. This helped to make sure that people received the medicines they needed appropriately. We found that regular audits and stock checks were being done and administration procedures were being monitored. We saw that medicines requiring refrigeration were stored within the recommended temperature ranges.

We looked at the staff rotas for the previous six weeks and observed staff deployment during the inspection. A person living at the home told us, "They're [staff] all very friendly and always show willing". During the day of the inspection the registered manager was on duty, a senior carer, four care workers working the full day and one working the busy morning period. In the afternoon three staff were on duty with an extra staff member for the later evening period when people would be having their evening meal. At night and weekends the service operated an 'on call' system should staff need advice or support from management.

The registered manager had a system to calculate dependency and staffing needs that they reviewed at three monthly intervals. We could see that the home was being adequately staffed to meet people's needs during the day we inspected. At night the rotas showed there were two care staff on duty. The home's current occupancy was low. Eight people had been assessed as high dependency and at times needed two staff to help them. Evacuation plans in the event of an emergency indicated that more than one staff member may be required should someone need to be moved to another part of the home in an emergency situation.

Staff and the registered manager told us if they needed additional staff to support someone if their condition was deteriorating or for particular behaviours or appointments then staff could be called in. Staff told us that the registered manager and most staff lived locally so if they needed in an emergency they could be called in to assist. We discussed staffing needs with the registered manager and that this arrangement for additional assistance was not formally agreed. We discussed that their current dependency assessment did not take into account the layout of the building when considering staff deployment within it at night. We recommended that the registered manager reviewed their dependency tool to consider the layout of the home and staff deployment in emergencies and sought guidance on current best practice on safe staffing levels at night.

We found that a deputy manager had recently been appointed to support the registered manager and help develop the management structure. This was a developmental role and the deputy was being supported to achieve the appropriate level of skill to undertake a greater management role in time. This indicated a proactive approach to service development.

There was a member of domestic staff on duty during the day of the inspection and they were supporting a new member of domestic staff with their induction. There was a maintenance person working in the home and we saw records of their regular maintenance tasks and safety checks. We found that the home was clean and tidy and being well maintained. We looked around the home and saw that staff had access to personal protective equipment. We saw staff using this equipment appropriately when supporting people and delivering care. The service had procedures and guidelines for staff to work to about managing infection control.

The home had two cooks to cover the week and a kitchen assistant to help them. The cooks now stayed until half past four each day. This change was introduced to make sure a greater variety of hot meals would be available to people for their evening meal. The home also had an activities coordinator who was in the home doing group and individual activities during the day.

Staff had a paid 15 minute handover at shift changes to give them the time to pass on information and update the next shift on changes. This was also to make sure that there were sufficient staff available to attend to people's needs during handover periods.

We saw that safe recruitment procedures were in place to help make sure staff were suitable for their roles. This included making sure that new staff had all the required employment background and police checks and references had been taken up.

Staff told us they had received training in safeguarding adults and the training matrix and staff files confirmed this. Staff we spoke with knew the appropriate action to take if they believed someone was at risk of abuse. The staff we spoke with were confident that the registered manager would follow up any concerns they might raise and take action promptly to make sure people were kept safe. They were also aware of the procedures for reporting bad practice or 'whistle blowing 'within the organisation.

Records indicated that the mobility equipment in the home was being regularly maintained under contract agreements. There were records of safety checks and servicing in the home including the emergency equipment, fire alarm, call bells and electrical systems testing. We could see that repairs and faults had been highlighted and attended to by the maintenance person or contractors. These measures helped to make sure people were cared for in a safe and well maintained environment. We visited the small laundry in the home and found the door unlocked and detergents inside the room. We discussed with the registered manager that the door lock was not working and this was addressed during the inspection to help keep people safe.

We looked at the risk assessments in place concerning fire safety in the home and how people would be moved in the event of a fire or emergency. There was an overall fire risk assessment for the service in place. We saw there were notices within the premises for fire procedures.

Everyone had a risk assessment for nutrition but we saw that risk assessments were not being formally carried out to assess the specific risks of choking for people. The registered manager was aware that this was an area that they needed to risk assess individually and was addressing this and incorporating it in the care planning review. There was one person identified at possible risk, although they had not had any episodes of choking. The registered manager had completed the new risk assessment for this potential risk following our discussion. We recommended that the registered manager's review considered current guidance and best practice on assessing the specific risks of people choking.

We looked at care plans and saw there were risk assessments in place and control measures to help minimise them. People's care plans included risk assessments for falls, moving and handling, mobility and nutrition. The district nurse had done assessments of peoples' skin integrity. The registered manager was aware that they needed to undertake further risk assessments in relation to some specific risks to an individual. This was in progress but not yet implemented and included those at risk of choking and recording the checks done on bedrails. One person had bedrails in place. The registered manager provided us with the risk assessment for their use and records of the discussion that had taken place with family and healthcare professionals before the rails were used in their best interests.

Good

Is the service effective?

Our findings

People told us that the staff who supported them knew how they liked to be helped by them and always checked with them how they wanted to be helped. One person living at the home told us, "I am asked what I want to do and they [staff] help me with the things I can't do". We were told that the food provided was "Good" and that they always had a choice of food at mealtimes. One person told us, "The chef's good, always enjoy my food".

A relative told us "I take my hat off to them [staff], it's a hard job. They keep [relative] clean and tidy and their skin is in a good state, they look after the skin religiously and put all the creams on and turn [relative] day and night".

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA).The Mental Capacity Act 2005 (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.

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.

At our inspection in March 2015 we had found that there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because applications had not been made to a supervisory authority where there had been doubt about a person's liberty being restricted.

At this inspection we looked at people's records and saw that the registered manager had applied to relevant supervisory authorities for deprivation of liberty authorisations for people. These authorisations had been requested when it had been necessary to restrict people for their own safety and these were as least restrictive as possible.

We saw that people who had capacity to make decisions about their care and treatment had been supported to do so. We saw that care staff at the home communicated well with the people who lived there and gave people the time they needed to express their wishes. One person had a 'living will' so that their wishes were clear for the future should they be unable to communicate them.

Some people were not able to make some important decisions about their care or lives due to living with dementia. The records in place showed that the principles of the Mental Capacity Act 2005 Code of Practice were being used when assessing a person's ability to make a particular decision. Procedures were in place,

and were being put into practice, for assessing a person's decision making capacity. This helped to make sure that any decisions that needed to be taken on a person's behalf were only made in their best interests. Staff had received training on the MCA and those we spoke with understood the principles of the act.

We noted that the information around who held Power of Attorney for a person was being recorded so staff knew who had this in place. Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or care and welfare needs.

We saw that people's care plans had nutritional risk assessments in place and for specific dietary needs. We saw that people had their weight monitored for changes so action could be taken if needed. Training records indicated staff had been given training on food hygiene.

We joined people at their lunch time meal and carried out an observation in one of the dining rooms. Lunch was a relaxed occasion and staff spoke with and encouraged people as they served or helped them with their meals. We saw that care staff assisted people in an unhurried way and also prompted and encouraged people, where appropriate, with their meals and drinks. We saw there was a choice of food at all mealtimes in the home and people were being asked what they wanted. One person we spoke with at lunch told us "It's sausages today with black pudding and proper chips".

We looked at staff training and development records and spoke with staff about their training and the supervision and support they received. Staff we spoke with told us "Training has been good; we need the updates as things change so much". Newer members of staff told us about doing the care certificate using college and distance learning courses. This is a recognised qualification from the government backed training organisation Skills for Care. It is the new minimum standards that should be covered as part of induction training of new care workers.

There was a programme of staff training in place that was being kept under review. There was a programme of induction training in use for new staff. We could see that training was booked for throughout the year and that improvements had been made to monitoring training provision to reduce the risk of staff missing important training. We could see from records and from speaking with staff that they had undertaken training that the registered provider considered essential for their roles. This included moving and handling, health and safety, safeguarding, medicines management, food hygiene and first aid.

The registered manager told us that infection prevention and control training was overdue for updating. Training on this had been booked and as an interim measure until the full training session the registered manager had talked through the policy with staff on an individual basis.

Training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) had been done by staff but had not been updated recently or provided for all new staff. This was also the case for dementia awareness training. The training matrix indicated that training courses for the following month had been booked for staff to attend. This also included training on end of life care that was booked. Fire training for all staff was being done and also a session on developing care plans and carrying out assessments. This indicated that the registered manager was monitoring the training and had made arrangements for the relevant training to be delivered.

Good

Is the service caring?

Our findings

We spoke with people living in the home about how they were cared for and how staff supported them to live as they wanted. People commented positively upon the staff supporting them saying they were "cheerful" and "lovely" as well as telling us, "This is a nice homely place" and "A home from home". One person said, "I can say what I think, they listen to me, they look after us well, I think we do alright". A staff member told us "We try to keep it homely and nice for them, it's their home".

A relative commented, "Staff have a good rapport from what I have seen, they are generally attentive and we feel we are welcome and included in [relatives] care". Relatives told us about their experiences of the end of life care provided by the home. One said, "They have been so well cared for they have even perked up" and "Communication has been very good, we are able to talk about how [relative] wants things, the MacMillan nurse has been contacted and they are following up with us. Everyone has been very understanding and deal with any niggles sensitively".

People were able to see their friends and families as they wanted and go out into the community with support. There were no restrictions on when people could visit the home. People were able to follow their own interests, practice their religious beliefs and see their friends and families as they wanted.

Training records indicated that two members of staff were undertaking training on supporting people at the end of life. A district nurse we spoke with who visited the home regularly told us they had no concerns about the care they had observed people receiving. They told us that the district nursing service and GP were involved with end of life care in the home and in supporting and working with the staff in the home to provide good palliative care. Staff told us that they were supported by the district nursing service and a person's GP to provide the right care and treatments at the end of a person's life.

We used the Short Observational Framework for inspection, (SOFI) to observe how people who were living with dementia, and who could not easily express their views, were being supported by staff and how they were spending their time. We saw that people appeared comfortable and relaxed with the staff that were helping them. Staff took the time to speak with people and allow them to express themselves and took up opportunities to talk with them and offer reassurance if needed. During lunch we found there was a high level of interaction between staff and people living there and a lot of good humour and conversation at the tables. A relative was having lunch with a person living there and they were included in the conversations going on.

We saw that the staff took the time to chat with people and relatives in the lounges and took up opportunities to interact and include everyone in activities and conversations We saw staff talking to people in a calm and friendly manner. People confirmed to us that their privacy and dignity were respected and said they were always asked how they wanted to be looked after.

We saw that staff knocked on the doors to private rooms before entering. They also ensured doors to bedrooms and bathrooms were closed when people were being helped or receiving personal care. People

told us that the staff got the doctor when they wanted them and that doctors and district nurses saw them in their bedrooms for medical examination or any discussions.

We spoke with some people in their bedrooms and saw these had been made personal places with people's own belongings, such as photographs and ornaments to help them to feel at home with their familiar and valued things.

Good

Is the service responsive?

Our findings

We sat with some people at lunch who told us about the activities they were planning to attend during the afternoon. They told us they were going to join in the cards and dominoes planned for the afternoon. We spoke with one person who wanted to spend time in their bedroom that day. They told us, "I will probably watch a bit of telly later, I am feeling a bit out of sorts today". A relative who visited regularly told us, "There are quite a few things going on, social events in the evening and they have been doing singing today".

A range of organised activities were available for people living at St Georges and these were led by the home's activity coordinator who worked in the home five days a week. The planned activities were advertised on the notice board for people to see and were on the home's website as well. There was a hairdressing room and a weekly visit from a hairdresser, regular exercise classes and Wi Fi access was available for people if they wanted this. On the day of the inspection we saw activities going on in one of the lounges. We could see that a variety of social events had been planned for over the Christmas period including a meal out and a party.

The home had a newsletter for people living there and their families. This was to help make sure everyone knew what was happening in the home. It had updates on staff training and any new staff people could expect to see around the home.

We saw on the home's notice boards many pictures of social events and celebrations that people living there had taken part in such as the fireworks and hot dog supper on Bonfire Night and the harvest festival. One person told us about going out on a trip to a local castle and owl sanctuary and another about a recent fashion show held in the home. They told us they had liked being able to see different clothes and choose what they wanted for themselves.

Information on people's preferred social, recreational and religious preferences were recorded in their individual care plans along with life stories and background information. Staff we spoke with had a good understanding of people's backgrounds and lives and this helped them to give support and be more aware of things that might cause people to worry or upset them.

The service had procedures in place to allow people to raise a complaint and these were displayed within the home and in the service's statement of purpose. Records were available and demonstrated complaints were investigated and action taken to improve if necessary. We asked people what they would do if they had any worries or complaints. We were told by one person, "I would tell the girls or [manager] when they come round" Another said, "I think my family would sort it out with [manager], they are a decent sort". A relative told us, "If we have any niggles we talk to the staff, they get it done. We find we can be open with them". Another relative told us, "The two way communication has been very good so nothing has ever got to the point where you would make an official complaint".

We could see in people's care plans that there was effective working with health care professionals and support agencies involved in people's care such as local GPs, community nursing teams and social services.

The care plans and records that we looked at showed that people were being seen by appropriate professionals to meet their physical and mental health needs.

A district nurse we spoke with who visited the home regularly told us that the service made appropriate referrals to relevant services and that the district nursing team had a good relationship with the home. They told us that staff listened to advice and acted upon instructions about people's care. They told us they worked with staff on skin care and they felt that staff acted promptly to report to them any changes in people's skin condition and take appropriate action.

Assessments of individual support needs and risks had been undertaken with people and also relevant family members to try to identify people's individual care and support needs. Where they were able to people had signed and agreed their plans. Family members told us they could be included in review meetings to help support their loved one. The care plans we looked at recorded how personal care needs and personal preferences should be met by staff. We saw that care plans had been regularly reviewed and updated to show where people's needs had changed so that staff knew what kind of support people required. For example, changes in a person's behaviours or weight that needed to be followed up with other agencies.

Good

Is the service well-led?

Our findings

People who lived at St Georges said they knew the registered manager of the service and saw them and the senior staff every day to talk with. People told us they felt comfortable talking with them and making comments and with telling care staff what they wanted. We saw during our inspection that the senior care staff and the registered manager were accessible and spent time with the people who lived in the home and engaged with them in a positive and informal way as individuals. A person living there told us, "We all get on here, they're good to me and take note, even the bosses".

At our inspection in March 2015 we found there was a breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the systems being used to assess the quality of the services people received and to protect them had not been effective in identifying, following up and continuously monitoring where improvement had been required.

At this inspection on 21 November 2016 we found that improvements had been made to governance and quality monitoring systems in the home and these were being maintained. We saw that there were systems in place to assess the quality of the services in the home. There were also regular visits from the registered provider who carried out their own checks and monitored the internal audits.

There was a programme to monitor or 'audit' service provision and people's satisfaction in operation. We saw that audits were being done on care plans, training, recruitment, staff supervisions, medication records and stock checks. Looking back at the medications audits that had been done evidenced a continued improvement in the systems in use. Any discrepancies found at these had been followed up with the relevant staff. Monitoring checks were being done on people's weights and body maps to identify any changes that needed to be followed up with other agencies.

Checks were done on supervisions to make sure all staff had received individual supervision and the registered manager had also done observations of practice with staff. This helped to make sure that staff were working to the home's policies and procedures and that they received feedback on their performance from the registered manager. Training was being monitored on a matrix and this helped to make sure the registered manager was able to get any required training booked when it was due.

The home had a registered manager in place as required by their registration with the Care Quality Commission (CQC). All the staff we spoke with told us that they felt they were being well supported by the management in the home and in their work. Staff told us they felt that they could speak with the registered manager or senior care staff at any time. They told us that the registered manager held regular staff meetings and that they had individual supervision and appraisals that allowed them to discuss work issues, any problems and areas for personal development.

We noted that there was a clear structure and lines of responsibility being promoted by the registered manager and newly appointed deputy. A member of care staff told us, "It's a very open and friendly place to work" and another said, "I feel appreciated by the manager and by the residents, we're a good team".

We also looked at the minutes of the 'residents and relatives' meetings and saw that people had discussed a range of issues about what they wanted in their home, such as new staff appointments, activities and menus. A support group, 'The Friends of St Georges' also held their meetings in the home. This group was made up of families, friends and volunteers who, supported by the registered manager, came together to help people living there make the most of their social opportunities and activities.

We looked at the records of accidents and incidents that had occurred in the home. We did this to check if action had been taken promptly to reduce the risk of it happening again. We saw that incidents had been recorded and followed up with appropriate agencies or individuals and, if required, CQC had been notified.