St George's (Wigan) Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This unannounced focused Inspection was undertaken on 03 January 2017. After our comprehensive inspection of St Georges (Wigan) Limited on 14 and 15 September 2016 the provider wrote to us to say what they would do to meet legal requirements in relation to three breaches of Regulations concerning the risks associated with unsafe or unsuitable management of medicines; maintaining securely accurate complete and contemporaneous records in respect of each person using the service; effectively assessing, monitoring and improving the quality and safety of the services provided.

We undertook a focused inspection to check that improvements had been implemented by the service in order to meet legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Georges (Wigan) Limited on our website at www.cqc.org.uk.

St George's Nursing Home provides nursing and residential care and support for up to 62 people. At the time of the inspection there were 48 people using the service. The home is a grade 2 listed building in spacious grounds and close to a wide range of community resources. There is a dedicated floor for people living with dementia. St George's provides care for people in a variety of single and shared rooms.

At the last inspection on 14 and 15 September 2016 we had concerns regarding the safe management of medicines and this was a breach of Regulation 12 (2)(f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this focussed inspection on 03 January 2017 we found the service was meeting the requirements of this regulation.

We found that the provider had followed the action plan they had written to meet shortfalls previously identified regarding the safe management of medicines and the service was now meeting the requirements of this regulation.

The medication was stored securely in line with the necessary standards. Temperature monitoring of the medication fridge was in place and carried out daily and the fridge was operating within the required limits

The controlled drugs (CD) cabinet was secure and there was evidence of daily CD balance checks undertaken.

We observed evidence of regular balance checks which identified if people's medication needed re-ordering as well as weekly audits designed to identify if medication administration (MAR) charts had been completed appropriately.

The clinical manager showed us the monthly medication audits from November and December 2016 and explained that another audit was due to be completed later that week.

We saw a missing entry on 30 December 2016 for one person's evening dose of medication. We checked the stock balance of this medicine to ascertain if it had been given and found that the medicines had been administered but not signed for.

We checked the care plan and MAR chart for another person who was receiving medication covertly. The appropriate documentation was in place with written authorisation from the person's doctor and evidence of discussing this decision with the person's family

At the last inspection on 14 and 15 September 2016 we had concerns regarding the quality of care planning and recording and this was a breach of Regulation 17(2)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this focussed inspection on 3 January 2017 we found the service was still not meeting the requirements of this regulation.

We looked at both the electronic system and paper copy records for one person. With both systems in place care documentation was difficult to follow. Paper copy records were missing or did not correspond to risk assessments. Care plans existed for pressure care, diet, hypertension, falls and medication. Evidence indicated that regular review by the community dietician was on-going.

Reviews of risk assessments and care plans on both the electronic system and paper copy records did not always mirror each other in either content or reviews.

There was no evidence of a care plan centred on communication for one person which would be expected as the person had communication difficulties as a result of their condition.

These issues meant there was a continuing breach of Regulation 17(2)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because the service had failed to maintain securely and accurate, complete and contemporaneous record in respect of each person using the service. You can see what action we told the provider to take at the back of the full version of this report.

During our last inspection on 14 and 15 September 2016 we found audits had not been effective in identifying and rectifying some of the issues we found during the inspection. This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this focussed inspection on 3 January 2017 we found that although improvements had been made, further improvements were needed to meet the requirements of this regulation.

Audits were carried out by different managers and these covered care files, falls and weights, medicines, wound care, complaints, fire safety, bed rails, infection control and the kitchen.

We found that five care files had been audited in December 2016 and complaints had last been audited in November 2016. Medicines, wound care plans and meal times had also last been audited in December 2016. The last kitchen audit was completed in January 2017 and a 'walk-around' of the premises was last done in July 2016. Accidents and incidents had been audited on four occasions in 2016.

An audit of infection control standards had been completed in September 2016 and this covered beds, trolleys, dressings, wheelchairs, handling aids, corridors, cleaning equipment and cleaning stocks. There had also been separate audits of public areas including store cupboards, the laundry, corridors, lounges, the dining room, meals, nurse call-bells, bathrooms and toilets

An audit of 14 bedrooms had been carried out on September 2016, however we could not find any evidence of the remaining bedrooms being audited.

A formal environmental assessment tool had also been completed, which identified if the overall environment was dementia friendly.

Because audits had not been effective in identifying and rectifying some of the issues we found during the inspection this meant there was a continuing breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service had failed to effectively assess, monitor and improve the quality and safety of the services provided. You can see what action we told the provider to take at the back of the full version of this report.

The clinical manager told us the new electronic care planning system had an audit functionality and when it was fully operational, audits would be logged into this system which we were told would provide a much more detailed analysis of the information inputted.

We found there was still no registered manager at the home. 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. A person had recently taken up post as manager and was in the process of registering with CQC at the time of the inspection.

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

We found that action had been taken and the provider had appropriate arrangements in place to manage medicines safely.

This meant that the provider was now meeting legal requirements.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some care file electronic records did not correspond with paper based records.

Some care plans had missing information or had not been updated to reflect the current position.

Is the service well-led?

Inadequate

The service was not consistently well-led. There was no registered manager in post.

Audits had been carried out in a number of areas but these did not identify some of the issues we found during the inspection.

The manager was visible within the home, supported the staff group and provided advice and support throughout the inspection.

St George's (Wigan) Limited

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 was 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.

We undertook a focused inspection of St Georges (Wigan) Limited on 03 January 2017. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 14 and 15 September 2016 had been made. We inspected the service against three of the five questions we ask about services: is the service safe; is the service responsive; is the service well-led. This is because the service was not meeting legal requirements in relation to these questions at the previous inspection.

The inspection was undertaken by one adult social care inspector from Care Quality Commission (CQC), a specialist advisor in medicines and a specialist advisor in nursing.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements. We also spoke with the local authority commissioning team.

At the visit we looked at the administration of medicines including medicines administration records for five people, five people's care records, complaints records, accident and incident records and manager's audit records. We spoke with the manager, the clinical manager, the office coordinator and a nurse and looked at the new electronic care management system called Fusion, which was not fully operational at the time of the inspection.

Good

Our findings

During our last inspection on 14 and 15 September 2016 we had concerns regarding the suitable management of people's medicines and this was a breach of Regulation 12(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At that time the Safe domain was rated as Requires Improvement; the only area that required improvement was in relation to medicines management and the service was meeting the requirements of the remaining key lines of enquiry (KLOE) for this domain. This focused inspection only looked at medicines management which the service had improved and is the reason why this rating has now changed to good.

At this focussed inspection on 03 January 2017 we found that the provider had followed the action plan they had written to meet shortfalls previously identified and the service was now meeting the requirements of this regulation.

We inspected the medication stored on both floors of the home. The medication was stored securely in line with the necessary standards. At the time of the inspection the home was one week into a new medication cycle and there was no evidence of over ordering or being overstocked.

Each resident's medication was stored in a separate container that was labelled and on inspection the medication cabinets were in order and not cluttered.

We inspected both the fridge and the controlled drugs (CD) cabinet. Temperature monitoring of the fridge was in place and carried out daily and the fridge was operating within the required limits. The clinical manager told us that staff had received training on how to re-set the fridge and knew what action to take if it went outside the required limits.

The CD cabinet was secure and there was evidence of daily CD balance checks undertaken by two staff members. The cabinet was not now being used to store personal items and only contained medication, and it was not overstocked or cluttered.

We spoke with a staff nurse who was responsible for giving medication on the ground floor. The nurse didn't have any concerns and felt that the implementation of daily 10 point Medicine Administration Record (MAR) checks, weekly stock checks and audits had improved things.

We asked the nurse what she would do if she discovered a medication error had been made and she

correctly stated the process she would follow.

We observed evidence of regular balance checks which identified if people's medication needed re-ordering as well as weekly audits designed to identify if MAR charts had been completed appropriately. The audits had identified that sometimes the MAR charts were not being completed correctly and had also identified that medication was not always signed for. In some but not all instances it was clear what action had been taken to address any problems identified by the audit. We discussed this with the nurse who told us how they had dealt with the issues although this was not always documented.

The clinical manager showed us the monthly medication audits from November and December 2016 and explained that another audit was due to be completed later that week. They explained that as part of their improvement plan the audits would be loaded onto the server and reviewed quarterly to identify any common themes and training needs.

We asked the clinical lead to provide us with information of any recent medication errors that had been highlighted. They showed us information from the start of December 2016 where on two occasions an antibiotic had been given to the wrong resident. There was evidence of a full investigation and a safeguarding incident had been raised. The doctor had been informed and the individuals responsible for the error had been notified and appropriate action taken.

We looked at MAR charts for five people. One person was on an 'as required' (PRN) dose of insulin to be given if their blood glucose measurements were above 16. We found that these measurements were being taken and it was clear that the insulin was being administered correctly according to the blood results.

The MAR charts of two other people were complete and accurate but we saw a missing entry on 30 December 2016 for one person's evening dose of medication. We checked the stock balance of this medicine to ascertain if it had been given and found that the medicines had been administered but not signed for.

We checked the care plan and MAR chart for another person who was receiving medication covertly. The appropriate documentation was in place with written authorisation from the person's doctor and evidence of discussing this decision with the patient's family.

The clinical manager told us that as from 23 January 2017 the home was changing pharmacy providers. At the time of this inspection, the medication was administered from original packs; in future these would be in the form of a Biodose system, which is a monitored dose system. We discussed with the clinical manager what measures were being taken to ensure a smooth transition from one pharmacy provider to another.

The service sent us a plan to show the actions being taken to ensure that medication would be managed safely during the transition period from one pharmacy supplier to another. All nurses had attended update training regarding the new system; medication had arrived in advance of the start of the new cycle to enable time for these to be checked-in and to identify any issues; new medicines trolleys were being supplied by the new pharmacy provider; a new fridge had been ordered.

Requires Improvement

Our findings

At the last inspection on 14 and 15 September 2016 we had concerns regarding the quality of care planning and recording and this was a breach of Regulation 17(2)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this focussed inspection on 03 January 2017 we found the service was still not meeting the requirements of this regulation.

On the day of the inspection the new electronic care planning system (called Fusion) was not fully operational and not all people's information had been fully inputted onto the system to date. However this process was on-going and had taken an increased amount of time than first thought due to the need to thoroughly review and update all information before entering it into the new electronic system. The manager said staff training for the new system was on-going using a cascade approach within the home and both managers had been fully trained in its use.

We looked at both the electronic system and paper copy records for people who used the service. With both systems in place care documentation was difficult to follow for one person. Paper copy records were missing or did not correspond to risk assessments. This meant that certain care aspects could not be tracked with any efficiency. An example of this was wound care management. Wound management documentation was initially difficult to find but we eventually ascertained that it matched up with the dated body maps.

The Manager accessed wound management charts from a pressure sore file that was not part of the individual person's care notes.It was evident that Community Tissue Viability had been involved on a regular basis.

Care plans existed for pressure care, diet, hypertension, falls and medication. There was no care plan relating to behaviour yet a risk assessment detailed behaviour issues. A record relating to consent to share information with relatives existed and was signed in the relatives section. A record relating to clinical photography which included skin integrity existed but was not completed.

Evidence indicated that regular review by the community dietician was on-going. In a correspondence dated in November 2016 the dietician commented that on visiting the home they had been informed by a nurse that the supplement drinks they had prescribed had not been given during the month because the home had not received the prescription of drinks. The manager advised that this had been rectified immediately, supplement drinks had been obtained and the person had received their supplement drinks throughout the

month. The manager said that this had not been recorded accurately for each occasion the drink was given.

We looked at records for another person who used the service. Reviews of risk assessments and care plan on both the electronic system and paper copy records did not mirror each other in either content or reviews.

Wound management documentation dated 08 November 2016 indicated sore to right toe. There was no evidence of a review on the wound management chart or evidence to suggest the progress of healing in the wound management documentation we saw. There was however documentation that the person had been reviewed by Community Tissue Viability Team and guidance given.

It was documented in the care records that the person suffered anxiety in regards to care intervention resulting in a reluctance to comply. An anxiety assessment was completed on 22 November 2016 but there was no documented evidence with regards to behavioural modification or approach techniques for staff to follow as guidance.

These issues meant there was a continuing breach of Regulation 17(2)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because the service had failed to maintain securely and accurate, complete and contemporaneous record in respect of each person using the service. You can see what action we told the provider to take at the back of the full version of this report.

Inadequate

Our findings

During our last inspection on 14 and 15 September 2016 we found audits had not been effective in identifying and rectifying some of the issues we found during the inspection. This meant there was a continuing breach of Regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because at a previous inspection carried out on 16, 18 and 20 November 2015, the service was found to be in breach of this Regulation. At this focussed inspection on 03 January 2017 we found that further improvements were needed to meet the requirements of this regulation.

At the previous inspection on 14 and 15 September 2016 there was no registered manager in post. At that time a person had been appointed as manager but had left the organisation before becoming fully registered with CQC. At an inspection carried out on 16, 18 and 20 November 2015 there was also no registered manager in post. At this inspection we found there was still no registered manager at the home. 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. A person had recently taken up post as manager and was in the process of registering with CQC at the time of the inspection.

We looked at the managers audit file. We saw that different audits were carried out by different managers and these covered care files, falls and weights, medicines, wound care, complaints, fire safety, bed rails, infection control and the kitchen.

We found that five care files had been audited in December 2016 and complaints had last been audited in November 2016. Medicines, wound care plans and meal times had also last been audited in December 2016. The last kitchen audit was completed in January 2017 and a 'walk-around' of the premises was last done in July 2016.

Accidents and incidents had been audited on four occasions in 2016. These identified any common recurring themes and the action required to reduce the potential for a reoccurrence, the implications for staff training/resources and the implications for policy and practice review.

An audit of infection control standards had been completed in September 2016 and this covered beds, trolleys, dressings, wheelchairs, handling aids, corridors, cleaning equipment and cleaning stocks. There had also been separate audits of public areas including store cupboards, the laundry, corridors, lounges, the

dining room, meals, nurse call-bells, bathrooms and toilets.

An audit of 14 bedrooms had been carried out in September 2016, however we could not find any evidence of the remaining bedrooms being audited. A formal environmental assessment tool had also been completed, which identified if the environment was dementia friendly.

Weekly medicines audits designed to identify if medication administration (MAR) charts had been completed appropriately were carried out, however it was not clear what action had been taken to address any problems identified in some of the audits.

Because audits had not been effective in identifying and rectifying some of the issues we found during the inspection this meant there was a continuing breach of Regulation 17(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service had failed to effectively assess, monitor and improve the quality and safety of the services provided. You can see what action we told the provider to take at the back of the full version of this report.

The clinical manager told us the new electronic care planning system had an audit functionality and when it was fully operational, audits would be logged into this system which we were told would provide a much more detailed analysis of the information inputted. At the time of the inspection there were four tablet PCs and two desktop PCs that were available for staff to use to access the new electronic care planning system. Each staff member had a password protected log-in which assisted with the protection of personal information and there was no limit to the number of people who could access the system at any one time.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to maintain securely and accurate, complete and contemporaneous record in respect of each person using the service. Regulation 17(2)(c)(d Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance. The service had failed to effectively assess, monitor and improve the quality and safety of the services provided. Regulation 17(2)(a)