St George's (Liverpool) Limited

St George's Care Homes

Inspection report

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11 January 2018
12 January 2018
15 January 2018
16 January 2018
17 January 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 11, 12 and 15 January 2018 and was unannounced. At our last inspection in August 2017, we identified breaches of regulations 9, 10, 11,12,13,17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to most aspects of the care and treatment provided to people who lived in the home. At this inspection we followed up these breaches and found that the provider had not taken appropriate action to address our concerns. All of the breaches identified at the previous inspection remained and we also found an additional breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was not ensuring that people were provided with adequate nutrition and hydration to keep them safe and well.

St George's Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home can accommodate up to 60 people. At the time of the inspection there were 36 people living in the home.

The home requires a registered manager. The previous registered manager had left the home in the period after the last inspection. 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.

The home was being managed by two deputy managers and a care consultant who had only been in post for a limited time prior to the inspection. The staff trying to manage the home did not have the time or the resources necessary to make sustainable improvements to the service and staff did not have confidence in the provider's ability to make improvements.

All of the concerns identified at the previous inspection remained. We found that medication was still not safely administered. Risk assessments were poor and did not safely identify or help to manage risk. Safeguarding concerns was still not being dealt with safely or appropriately and people who lived in the home were at risk from harm or abuse.

Staff were not adequately inducted, trained or supported to do their jobs safely. The Mental Capacity Act was not lawfully followed and people living in the home were at risk of having their rights not respected and their liberty deprived without due processes being adhered to.

Staff were not consistently caring and care plans did not fully describe people's needs or how they wished to be cared for.

We also found at this inspection that people were not supported to receive adequate food and drink which placed them at further risk from harm.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People living in the home were at risk from harm as the provider did not deal with safeguarding concerns in a timely or safe manner.

Medication was not always administered safely or when required.

The provider had not ensured that the risks to people's health, safety and welfare were appropriately assessed and managed.

Is the service effective?

Inadequate

The service was not effective.

People's ability to make decisions was not always assessed in accordance with the Mental Capacity Act.

People were not supported at all times to eat and drink safely.

Staff were not adequately inducted, trained or supported to do their jobs safely.

Is the service caring?

Requires Improvement

The service was not always caring.

There were incidences were the conduct of staff was alleged to be abusive and disrespectful to people who lived in the home. These allegations were under investigation at the time of our visit.

At the inspection we did see some positive interactions between staff and people who lived in the home but these were limited.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not up to date and did not always document

people's needs and preferences or provide clear details of how they needed to be cared for.

People had access to activities to meet their needs.

There was a complaints procedure that now included details of who to complain to.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post and the last registered manager had left the service and raised concerns about the care being provided.

Notifications had not been made to CQC when they were required in accordance with the law.

Improvements had not been made following the last inspection and further breaches of regulations had been identified.

St George's Care Homes

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 inspection took place on 11, 12 and 15 January 2018. The inspection was unannounced. The inspection was carried out by three adult social care inspectors and a CQC pharmacy inspector. There was also an Expert by Experience who was experienced in visiting services that supported older people.

Prior to our visit we looked at any information we had received about the service and any information sent to us by the provider since the home's last inspection. We also contacted the local authority quality assurance team for their feedback on the service.

During the inspection we spoke with five people who lived in the home, and of their relatives. We also spoke with the care consultant working in the home, two deputy managers, two care staff, one cook, and one maintenance person. We completed a Short Observation Framework for Inspection Tool (SOFI) in one of the lounges. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We examined a range of documentation including the care files belonging to six people who lived at the home, four staff files, staff training information, a sample of medication administration records and records relating to the management of the service. We also looked at the communal areas that people shared in the home and visited some of their bedrooms.

During the visit we observed people's day to day care and their interactions with staff.

Inadequate

Is the service safe?

Our findings

One relative told us "Staff are always being called away to help other staff with the people who are challenging, this happens a lot."

All the five people we spoke to at St George's Care Home said they felt safe at all times. One said "I feel really safe, I have never felt threatened or unsafe." Another said "I always feel safe here, the staff look after me well."

At the last inspection in August 2017, CQC inspectors found that the management of medicines was not always safe and records showed that people did not always receive the medication they needed to maintain their well-being. Since the inspection, we noted the provider was working closely with a consultant to improve the medicines arrangements in the home. However, on this inspection we found continuing shortfalls.

Topical preparations were stored in people's bedrooms, to be applied by care staff during personal care. We observed that bedroom doors were left open and cupboards were not lockable. This meant these medicines were not stored safely.

We looked at the medicine administration records (MAR) for eleven people in the home. All records had a cover page that had personalised information to help staff identify them. Each person had a photograph, date of birth, GP details and any allergies recorded. However, we found that some information was incorrect, for example if a person required thickened fluids or had their medicines administered covertly. This meant there was a risk that staff would not know how to care for people properly.

Some people had not received their medicines as prescribed. According to the medicines administration record (MAR) one person's medicine had been out of stock for six days prior to the inspection. Staff could not say why this medicine had not arrived. Another person had run out of one strength of their medicine twelve days before the end of the monthly cycle in December 2017 and as a result, had to take three lower strength tablets each day instead. During this time, an administration error was made with these tablets.

We asked to see the medication audits undertaken by the provider to check that medication administration practices within the home were safe. We saw that there were audits in place but found that these were ineffective in identifying the serious concerns we identified during our inspection with regards to the management of people's medications. We asked to see evidence that staff had received training in how to administer medication safely and had their competency to do so checked. We were not provided with any records so there was no evidence that staff were skilled and competent in handling medicines.

This meant there was a continuing breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We saw that risk assessments were in place, however they were of little use as the risks identified has not

been properly described in people's care plans and staff lacked sufficient guidance on how to manage people's risks. For example, the risk assessment for one person dated January 2018 had identified the risk of epileptic episodes but staff were provided with no guidance on the action to take when an epileptic episode occurred in order to mitigate risks to the person's health and welfare.

Another person's risk assessment dated December 2017 indicated that the person had skin integrity risks that placed them at risk of developing a pressure sore. Staff were advised to ensure the person was repositioned every two hours to reduce the pressure on certain areas of their body. We looked at the person's repositioning records and found that there was limited evidence that the person had received the repositioning support they required to mitigate the risks of a pressure sore developing.

The records of another person with similar skin integrity risks also did not show that the person had received the support they needed to maintain their skin integrity.

Other risk assessments in respect of one person's care referred to the person by a different name. This was a concern as a high number of agency staff were working at the home at the time of our visit and the use of different names to refer to the same person would have been very confusing.

All of the care files and risk assessments we looked at during the inspection were people whose care and treatment the provider has assured us had been reviewed and updated since our last inspection. This was concerning, as we continued to identify serious concerns with the way people's risks were assessed and managed and their care provided. It also clearly demonstrated that since our last inspection, the provider had clearly failed to act on our concerns in order to protect people from avoidable harm.

This was a continuing breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

At our last inspection we found that the provider did not have robust procedures and processes in place to prevent and protect people from the risk of abuse. Immediately following this inspection we were made aware of two serious safeguarding investigations that had occurred at the home. The two safeguarding investigation involved serious concerns about the conduct of some staff members towards the people who lived in the home. Investigations by the local authority and the police with regards to these concerns are currently in progress. At our last inspection, the way the provider identified, responded to and reported safeguarding incidents was inadequate. As a result people continued to be placed at risk of potential harm and abuse. At this inspection, we found that the provider had still not made any improvements to the systems in place to manage incidents of a safeguarding nature. This showed that the provider failed to take accountability for the protection of vulnerable adults.

For example, during the inspection we also became aware of a number of allegations of abuse that had been made by people who lived in the home. These allegations had not been dealt with appropriately or safely, leaving the person at risk from continuing harm and abuse. These issues had not been referred to safeguarding or notified to CQC.

This was a continuing breach of Regulation 13 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We looked at the personnel files of six staff. All of the files included evidence of a formal, fully completed application process and checks in relation to criminal convictions and previous employment. This meant that the provider had ensured staff was safe and suitable to work with vulnerable people prior to their

employment at the home.

We also looked at the information held in respect of the agency staff employed to work at the home. We saw that there were a profile on each staff member that included their training and their criminal records checks. We saw that some of the profiles for agency staff were out of date and we brought this to the administrator's attention who assured us this would be rectified.

At our last inspection we found a breach of Regulation 18 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 as the provider could not demonstrate that there was adequate staff on duty to meet people's needs. At this inspection we found that some improvements had been made to the number of staff on duty. We looked at the rotas for the previous four weeks and saw that there was usually sufficient staff on duty to support the people living in the home.

We looked at premises safety and repairs and renewals and saw that a scheme of improvements was on-going. We saw that flooring had been replaced since the last inspection and that parts of the home had been decorated.

Inadequate

Is the service effective?

Our findings

People we spoke with gave positive feedback about the food provided at the home. Comments we received included "There are always two good choices of food, I always eat one of them and they are very good and tasty" Another said I like the food, there's plenty of choice and I always eat it. They provide drinks all day." Another said "We have two choices of meals, I don't always like the choice so they give me sandwiches. We have lots to drink through the day."

At our last inspection we found that the provider had made improvements to staff training and support. At this inspection we found that these improvements had not been sustained.

We looked at the files for six staff member and did not see evidence of an induction in three of them. This meant we could not be certain that staff had received appropriate support at the start of their employment.

We were provided with a supervision matrix by the provider and we looked in staff files to see if staff had records to show that they had received supervision and an appraisal of their skills and abilities. Supervision provides staff and their manager with a formal opportunity to discuss their performance, any concerns they have and to plan future training needs. On checking staff files we found that some staff files contained no evidence that staff had received supervision. For example, some of the new staff members who had worked at the home for three months at the time of our visit had no evidence that they had received any supervision in relation to their job role.

This is a breach of Regulation 18 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

A number of people in the home were prescribed a powder to thicken their drinks because they had difficulty swallowing. The home did not manage these requirements safely. A notice board in the kitchen had a list of people that required thickened drinks but we found it to be incomplete with names missing and no specific consistency requirements. Kitchen staff told us they did not add thickener to drinks but were responsible for providing drinks. We found a person with a speech and language therapist recommendation and no prescription or supply of thickening medication. This was escalated and resolved during the inspection. On the ground floor staff told us they used one person's supply to make all the drinks required. No records were kept when thickener had been added to a drink. People are at risk of choking if drinks are given that are the wrong consistency. This was an issue raised at the last inspection.

We were provided with nutritional care plan records that showed that people's nutritional risks and needs. We saw that some people needed their dietary intake to be monitored or needed support from staff to ensure their dietary intake was sufficient for their needs. We checked a sample of people's food and drink charts and found all of the records to be poorly and inconsistently completed. This meant that there was no accurate record of what people's dietary intake was each day for staff to be assured that people were eating and drinking enough to prevent malnutrition. For example, one person's food and drink chart for January 2018 had a record that the food provided was a roast dinner in a bowl given at midday. No other food was

recorded as being provided to that person on that day and they were assessed as being at risk for their nutritional input.

One person who required food and drink to be provided via a PEG tube had a care plan in place that advised staff to ensure the person's food and fluid intake was monitored by staff. This person was extremely vulnerable as they were dependent on staff at all times to ensure they had sufficient nutrition and hydration to meet their needs. When we checked this person's food and fluid intake charts we found they were poorly completed. This meant it was impossible to tell if the person's nutrition and hydration needs had been met. These issues meant that the provider failed to ensure there were systems and processes in place to ensure people's nutrition and hydration needs were met to prevent the risk of malnutrition and ill health.

This is a breach of Regulation 14 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

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.

At our last inspection we found that the service was in breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. This was because the provider did not have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment. At this inspection we found that no improvements had been made

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). We checked that 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. We found this legislation was not properly followed.

We saw that some people's care files contained evidence that mental capacity assessments had been carried out when a person's ability to make a specific decision was in question. None of the files we looked at however contained evidence that any best interest meetings had taken place in relation to any decisions made on people's behalf.

The consultant working in the home told us that they had found some paperwork in a drawer at the home that related to DoLS applications made in relation to some of the people who lived at the home. They told us that some of these applications were now out of date. The consultant told us they were working through the paperwork and was trying to rectify the out of date DoLS that they were finding. This meant that people were being deprived of their liberty unlawfully.

We saw that there was CCTV in the home and no evidence was provided to demonstrate that consent issues in relation to this had been explored. This was despite us raising concerns with the manager and the provider at the last inspection that clarification needed to be sort from the Information Commissioner in relation to the use of CCTV and the gaining of people's consent.

During the inspection we spoke with two staff members who informed us that neither of them had completed any training in relation to MCA or DoLS.

This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider still did not have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment

Requires Improvement

Is the service caring?

Our findings

We spoke with two relatives and both were happy with the care being provided at the home. "All of the staff are respectful and polite". "Excellent care given to my relative, I can't fault the staff".

People who lived in the home gave positive feedback about the care that they received. They told us "I can have a shower when I want one, I don't like a bath. I decide what I want to wear each day as I wash and dress myself."

Another person said "I am only ever given a bed bath, I cannot do anything for myself. I chose my own clothes and like wearing my Everton tops. I am a Catholic and on a Sunday someone comes from Church and prays with me."

When the service was inspected in June 2016, we had concerns with the culture of the service and the practices employed by staff which did not always ensure people were treated with dignity and respect. Some of the language used by staff to describe people's needs was inappropriate and the support provided to people at mealtimes, was not always dignified. This was a breach of Regulation 10 of the Health and Social Care Act.

When the service was inspected in August 2017 some improvements to the support provided to people during mealtimes had been made but the way in which staff referred to people and described their needs continued to disrespectful. This meant there was a continued breach of Regulation 10 of the Health and Social Act.

At this inspection we became aware of a number of serious concerns about the way that staff behaved towards people who lived in the home. These concerns are currently subject to a police and serious safeguarding investigation. It was clear that there continues to be concerns with the way people who live at the home are treated by staff.

This is a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As some people had communication difficulties due to declining mental health, we completed a Short Observation Framework for Inspection Tool (SOFI) in one of the lounges. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

Using the SOFI, we saw that the staff interactions with people were positive. We observed staff asking people if they comfortable, offering to assist them with their posture, drinks and having a laugh and a joke with people. This showed us that some staff worked hard to be caring but this was not consistent across all of the staff team.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found a breach of Regulation 9 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. This was because the provider had failed to ensure that people's care and treatment was appropriate, met their needs and reflected their preferences.
At this inspection we found that no improvements had been made.

We saw that people's care plan records and documentation were stored on the provider's software system called 'Fusion'. We were told by the provider and a consultant working in the home that records were designed to be person centred but we found that this was not the case.

We found that people's care plans had not been completed appropriately or thoroughly to inform the staff team what care and support the person needed. There were omissions and contradictions in people's care records which meant that some of the information relating to people's needs and care was confusing. This placed people at risk of receiving unsafe and inappropriate care that did not meet their needs There was also a lack of information about people's likes, dislikes and preferences in relation to how their care was provided. This meant staff had little information on how to provide person centred care and support in accordance with the person's wishes.

Records in respect of people's on-going health and support monitoring were incomplete and inaccurate and indicated that people did not receive the care and support they needed from staff to keep them safe and well.

For example, we looked at the care plan records for one person. The care plan recorded that the person was to be predominately cared for in bed, yet when we had a discussion with the person we were told that they asked staff to get them out of bed constantly but staff did not. Staff spoken with told us that they did get the person up at least once a week but they asked to go back to their room immediately as they did not want to sit in the lounge. Records indicated that the person liked to go to church and enjoyed music, we did not see any records to show how the provider was meeting these interests or exploring how they could improve their daily routine.

This is a continuing breach of Regulation 9 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We saw that activities were in place for people to access and people told us that they enjoyed a variety of different social activities including Bingo. People's feedback showed that their social and recreational needs were considered by the service. People told us that they enjoyed the activities on offer. Comments we received included "I take part in all the activities, I like the quizzes and bingo" and "If I am in the lounge I take part in some of the activities like quizzes. I like it when singers come in and have a good sing a long."

Records showed that other healthcare and social professionals were involved in people's care. For example we saw that GP's, tissue viability services, speech and language therapy, dieticians, optician and chiropody

services supported people's well-being as and when needed. People we spoke with told us that staff got the doctor quickly if they became unwell. This meant people had access to medical advice as and when needed.

We saw that there was a complaints procedure displayed in the home. It was updated during our last inspection and we saw that it now contained details of who people could complain to.

Inadequate

Is the service well-led?

Our findings

When we inspected the service in June 2016, we identified that the service did not have adequate governance arrangements in place to ensure that the service was well-led. This was a breach of Regulation 17 of the Health and Social Care Act. At our inspection in August 2017, we found that the provider had failed to take the necessary action to address this and the service continued to be poorly led. This meant there was a continued breach of Regulation 17 of the Health and Social Care Act. After the August 2017 inspection we met with the provider, the manager and the local authority to discuss the serious concerns we had identified with regards to the service. The provider told us and provided evidence of an action plan designed to improve the service with immediate effect.

Subsequent to this meeting, the manager of the service resigned from post and advised the Commission on their continuing concerns about the service and the provider's ability to make the required improvements.

At this inspection we found that the concerns identified by the manager and reported to the Commission were substantiated. The service continued to be poorly led and people continued to experience poor care and support that placed them at risk of avoidable harm. We found little evidence that any proactive or consistent action had been taken by the provider to address the serious concerns identified at the last inspection. This raised serious concerns about the provider's competency and accountability to ensure people received safe and appropriate care.

At this inspection, the provider had employed a care consultant to work within the home to try to drive up improvements, They had commenced working in the home in December and they were in the process of setting up governance systems to enable the provider to monitor the quality and safety of the service. At the time of this inspection, insufficient progress had been made on these systems to enable us to assess whether they were robust and effective in identifying and managing risks to people's health, safety and welfare.

During our visit we found that there was a poor culture in the home and a difficult relationship between staff and the provider. We were informed that a staff meeting had been requested by the staff and they had asked for the provider not to be in attendance, only the care consultant. The provider had refused to allow this to happen and had insisted on chairing the meeting. The meeting was not productive and some staff walked out. We have seen the minutes from this meeting.

Staff we spoke with said that they did not feel supported by the provider. One staff member stated "If it comes to purchasing stuff then no problem, not when it comes to talking".

Feedback was positive about the care consultant but staff recognised that they were not there permanently and that there was a limit to the improvements that they could make. There was also no registered manager in place at the of our inspection to take any improvements forward. We received information from the provider following the inspection that the care consultant had agreed to stay at the home for a further 12 week period to support the deputy managers. There was no clear leadership or ownership of the problems

in the home and there was a 'fire- fighting' approach which was not proactive or conducive to improvements being made or sustained.

All of the breaches from the last inspection remained and an additional breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified at this inspection. This demonstrated that the service had deteriorated even further since we raised serious concerns in August 2017.

This evidence demonstrates that the provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.