St George's (Liverpool) Limited

# St George's Care Homes

## Inspection report

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Tel: 01516306754

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | Good |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Requires Improvement |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

The inspection took place on 27 June 2016 and was unannounced. The home is an adapted former hospital building situated close to Liscard town centre. The home is registered to provide accommodation and nursing care for up to 60 people and 46 people were living there when we visited. On the ground floor, care was provided for people who required general nursing or personal care. The first floor accommodated people who were living with dementia.

The home had a manager who was registered with the Care Quality Commission. 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 and associated Regulations about how the service is run.

During the inspection we found a breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the end of this report.

During the day of our visit we saw that there were enough staff on duty and people did not have to wait for staff to attend to them. The rotas we looked at confirmed that these staffing levels were maintained by using agency staff as needed. Records we looked at did not show that new staff had received training before they started providing care for people. This meant that they may not know how to provide care in a safe manner.

The environment was light, spacious and airy. All parts of the premises were clean, hygienic and safe.

Deprivation of Liberty Safeguards (DoLS) had been applied for appropriately and were awaiting authorisation by the local authority.

We observed that staff members spoke to people in a polite and respectful way, however they did not always promote people's dignity when they were providing care or in the language that was used in people's care documents.

Family members visited during the day with no restrictions. Staff we spoke with had a good understanding and knowledge of people`s individual care needs. People we spoke with said that they were happy living at St George's.

Care records we looked at showed that people's care and support needs were assessed and planned for and the plans were reviewed monthly. However, care documentation was lacking in detail and the confidentiality of personal information was not always maintained.

We saw evidence that regular staff meetings and resident and relatives meetings took place. A significant number of satisfaction questionnaires had been circulated and returned during 2015. We saw records of a series of quality monitoring audits that were carried out. Although these systems were in place to find out

people's views and to monitor the quality of the service, there was no evidence to show how the information gained was used to identify and address any areas requiring improvement or to take the service forward.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Good**

The service was safe.

There were enough staff to meet people's needs.

The environment was clean and adequately maintained.

Medicines were managed safely.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

A programme of staff training was in place but the standard of the training was basic and new staff had not received training to ensure they knew how to provide safe care.

The requirements of the Mental Capacity Act had been implemented.

People received enough to eat and drink and their individual dietary needs and choices were catered for.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Staff responded to people in a well-mannered, polite way. Staff had a good understanding and knowledge of people's individual care needs.

People's dignity was not always promoted when care was provided and this was reflected in some of the language used in care documentation.

The confidentiality of personal information was not always maintained.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People were able to choose how they spent their time.

People's care and support needs were assessed and planned for, however the plans lacked detail and reviews were not always meaningful.

The activities organiser had left the home, but care staff were providing some social stimulation for people.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

The home had a manager who was registered with CQC.

Staff meetings and resident and relatives meetings took place and satisfaction questionnaires had been circulated during 2015.

A series of quality monitoring audits were carried out but there was no evidence to show how information from meetings, surveys and audits were used to identify areas requiring improvement or to take the service forward.

# 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.

The inspection took place on 27 June 2016 and was unannounced. The inspection team consisted of two Adult Social Care inspectors. During the inspection we spoke with five people who lived at the home, four visiting relatives, the manager, the clinical services manager, the administrator and ten other members of the staff team. We also spoke with two visiting healthcare professionals.

We looked at the care records of five people who used the service. We looked at staff records, health and safety records, medication and management records. We carried out a Short Observational Framework for Inspection (SOFI) over the lunch-time period. SOFI is a specific way of observing care to help us understand the experience of people using the service who are not able to express their views to us.

Good

# Is the service safe?

## Our findings

We asked one of the people living at the home if they had received their medication on time and as prescribed and they told us "Oh yes, no question, it is a well-run place." We looked at the arrangements for storage, administration and disposal of medicines. A locked medication room was located on the first floor and contained appropriate storage for controlled drugs and medication that required refrigeration. Medication was stored safely and at the correct temperature.

We looked at a sample of medication administration record (MAR) sheets and saw these had been completed correctly. We also checked samples of stocks of medication that were prescribed short term, in variable doses, and on different days of the week. All stock we checked tallied with the MAR sheets and records of stock held.

We observed part of the lunch time medication round and saw that medication was administered safely. People were provided with a drink and supported to take their medication and the trolley was safely secured when not in use.

Key pads were fitted to external doors, the lift, and doors leading to the first floor. This meant that people who were unable to access these areas safely were not able to do so without support from staff. Window restrictors were fitted to windows and guards fitted to radiators. We tested a sample of call bells and found that these worked. The grounds at the back of the home were secure and a garden pond was fenced in. Electronic door openers were fitted to hold doors open, but would close in the event of the fire alarm sounding. This all helped to make the premises safe for the people living there.

Personal emergency evacuation plans were held in a "grab file" located in the first floor nurse's office. The reason we were given for this was that this was the only office which remained accessible to staff 24 hours a day. There was also colour-coding on people's bedroom doors to reflect the support they would receive should emergency evacuation be required.

Records showed that weekly fire safety checks covering the alarm system, emergency lighting, extinguishers, doors and closers. Fire drills had been held in December 2015 and January 2016. A fire risk assessment and control plan had been written by an external company in 2012 but no reviews of this had been recorded. The maintenance person told us that he was booked to go on a one day fire marshal training course with the fire service later that week. He hoped that the course would make him more confident and better informed about fire safety.

Service contracts were in place for laundry equipment, waste disposal, the passenger lift, the fire alarm and emergency lighting, the nurse call system, hoists and slings, and electrical installations. The home's gas safety certificate had expired and remedial work was taking place when we visited.

The housekeeper showed us the cleaning schedules for the home. She told us that two bedrooms were deep cleaned each day. She said that she carried out weekly audits, and the manager also reviewed

cleaning records and did spot checks. During the inspection we observed that all parts of the home were clean and tidy. The home's infection control audit score had improved from 59% to 84% and the most recent action plan stated that all of the required actions had been completed. Hand washing instructions were displayed and an ample amount of personal protective equipment was available for staff. The kitchen had a five star food hygiene rating.

We looked at staff rotas which showed there was a nurse and three care staff on duty on the ground floor and a nurse and five care staff on duty on the first floor throughout the day. At night there was one nurse and five care staff on duty. One person who lived at the home required one to one support 24 hours a day and another person required one to one support 12 hours a day. The rotas we looked at confirmed that these staffing levels were maintained by using agency staff as needed. There were also two cooks and three kitchen assistants, two laundry and three domestic staff, an administrator, a receptionist, and a maintenance person.

People living at the home, their relatives, and the majority of staff we spoke with, said that there were sufficient staff working at the home to meet the needs of people living there. Two members of staff explained staff worked as a team and covered extra shifts as needed. Throughout the day we observed there were sufficient staff available to respond quickly to requests for support and to spend time interacting with people on a social basis as well as meeting their care needs. We also observed that when people were funded to receive one-to one support from a member of staff this was provided consistently.

We looked at the recruitment records for four new staff. We found that safe recruitment processes had been followed before they were employed at the home and the required records were all in place. We spoke to a member of staff who had been recently employed at the home. They explained that prior to commencing work they had completed an application form and then been interviewed by the manager. Following this their references had been checked and a copy of their Disclosure and Barring Service (DBS) check had been obtained.

Polices were in place to guide staff on how to deal with any safeguarding concerns that arose or how to whistle-blow if they had any concerns. Staff knew how to access these polices and how to recognise and report any concerns they had. CQC records showed that the manager had sent us notifications of safeguarding incidents that occurred at the home.

Requires Improvement

# Is the service effective?

## Our findings

Staff told us they had received the training they needed to carry out their role. We spoke with a registered nurse who told us they had received clinical supervision from a senior member of staff and had received support to undertake a national leadership qualification. We also spoke with a carer who told us they had been supported to undertake a nationally recognised qualification in care.

The provider had subscribed to a programme of e-learning. During our last inspection we found that this only provided a very basic level of training for staff and lacked any depth of information. The manager told us that this contract was now due to expire and they were looking at new ways to provide training. Moving and handling practical training sessions had been held during November and December 2015. First aid training had been provided for six staff in January, and diabetes training for some staff in March.

The records we looked at showed that new care staff who had been recruited during 2016 were working at the home without receiving any training. This included two new staff who had no previous experience of working in care. This meant that they may not know how to provide care in a safe manner.

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

The home had seven double bedrooms with all other rooms being single. The manager told us that three of the double rooms were occupied by two people and the other four were currently being used as single rooms with the second bed not being offered to people. The design of the double rooms meant that people may be disturbed by the person they shared with and their privacy compromised. The manager informed us that double rooms were only shared with the consent of the people concerned and/or their relatives.

The home was divided into two units, one on each floor, and there were sitting, dining and bathing facilities on each floor. Sufficient space was available for people to move around their home easily using mobility equipment. Adaptations included grab rails, adapted showers and baths and a lift between floors. We noticed that a number of areas had damaged floor covering.

Memory boxes had been fitted outside bedroom doors, and these could be used to hold a photograph of the person to help them find their bedroom more easily. The upstairs foyer had been fitted with seating, a book case and objects including a full size sticker of a phone box and small replica post box. A second area further along the corridor had a table and chairs located in the middle of the floor. This helped to define areas along the long corridor and also gave people a purpose if they were walking around the home.

Other parts of the environment, particularly some of the bedrooms, appeared bland. Bedroom ceilings were high and walls painted cream giving a clinical appearance to some bedrooms. We discussed this with staff who had some good ideas for how parts of the home could be made to appear more homely.

Relatives of two of the people living at the home told us that staff had been good at noticing changes to

their relative's health and arranging for medical attention or advice when needed. We spoke to two visiting health professionals who told us that they had no concerns regarding the support the home offered people with their health. They confirmed that staff acted upon any advice they gave to meet the persons health care needs.

One of the people living at the home described the food as "excellent". They told us "If you don't like it they get something else." A visitor told us that staff always met their relative's dietary needs including remembering the consistency of food and drink they required. Throughout the day we observed staff offered people drinks and snacks. Information about people's dietary requirements was recorded in their care plans and we saw that staff constantly met these, for example ensuring people had thickened fluids were required.

There was no menu displayed in the ground floor dining room. One person told us "I don't know what we're having. I'll eat it though, it's always good." Another person said "They come round and ask you what you want. I've asked for sandwiches because I don't like beans. The chef asks you."

A number of people living at the home had a blended diet and we saw that this was prepared to make it as appetising as possible. For example, lunch was soup and sandwiches and we saw that people needing a soft diet were offered soup and finely blended bread crumbs. Similarly, cake offered during the afternoon was offered to people crumbled with custard. We spoke to the chef who advised that wherever possible they provided blended meals with each item separately blended and presented. This meant that people could still experience the different tastes of their food.

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 or authorisations to deprive a person of their liberty were being met and found that they were.

A member of staff had been assigned to carry out assessments to establish whether people may need the protection of a DoLS application. Nobody living at the home currently had a DoLS in place, however we saw that a number of applications had been made by the home and were awaiting assessment by the local authority.

Requires Improvement

# Is the service caring?

## Our findings

One of the people living at the home told us, "I am very particular. It's very good, I am well looked after, very comfortable, It's really nice. I like being here." They described staff as "very kind indeed". Another person said "They're very kind to us here. There was a mug of tea waiting for me at 6 o'clock this morning, it was lovely."

A relative told us "It couldn't be better. I visit every day and I've never had any concerns. It's a cheerful, happy environment, the staff are humorous. The care he's had here has been unbelievable, so thoughtful." Another visitor told us that the home had provided "very good care" to their relative. They told us that they had been involved and consulted about their relative's care and any questions they had were always answered. They said that staff communicated with their relative in the way he preferred and told us "There's nobody nasty here."

A third relative told us "Everyone is kind and thoughtful." and added that they felt "very comfortable" about their relative living at St George's. A member of staff said, "I wouldn't think twice about putting my relative here."

During our inspection we found that when staff were talking with and socialising with people they had a caring approach and communicated with the person in a way the person preferred. We also found that staff knew people well and knew how to reassure or distract them if they were upset or unhappy and they took the time to do so.

However, we found that when staff were supporting people during the meal time, the support they provided was not personal or caring. We observed lunch on the first floor and saw that people did not receive caring support. No condiments or napkins were provided for people. We saw one person who sat alone at their table with soup on their face for over ten minutes before a member of staff walked up to them and wiped their face without talking to them or explaining what they intended to do.

The same thing happened when the person ate their pudding. Again, staff did not notice and help the person wipe their face in a timely manner. This person sat alone at a dining table unable to reach their food easily. After trying to pull their wheelchair to the table they slid forward in their chair and then had to haul themselves upright to eat. Staff did not notice this and after the first course we observed they lifted the person upright without explaining their actions properly. We then observed the person sliding down to eat their pudding, again alone at the table with a lack of social interaction from anyone.

When people entered the room for the second sitting, some people were served their meal whilst others were still sitting down. This created noise and a feeling of chaos with people being handed meals next to people being supported to sit down. We saw three people eating their meal from their knife as staff were walking in and out of the room and not providing the support people needed. Eventually a member of staff gave one person a spoon. The second person continued to use their knife and a third person resorted to using their fingers to eat baked beans.

During this time, two members of staff stood in the dining room not looking at the people trying to eat their meals, and discussed books they had enjoyed reading. Some people were provided with a drink during their meal and others waited twenty minutes from starting to eat until their drink was provided. Overall we found the mealtime depressing and the approach from staff uncaring.

We also found that when staff discussed people's personalities, the things they enjoyed and the way they communicated, they spoke warmly about the person and with an in-depth knowledge. However, when asked to describe the support people required staff described people as "patients" and "feeds". Similarly we found that some of the language used in care plans was inappropriate and disrespectful. We saw that terms such as "nappies" and "complied" were used.

These are breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Dignity and Respect.

Information about people living at the home was not always stored in a way that kept it confidential. For example, we saw information on a bedroom wall regarding support the person needed with swallowing. This could be read by anybody walking along the corridor. Information kept in people's bedrooms contained a summary of the person's past history and their care needs. We looked at three of these that were in shared rooms and found that only one had been signed to give the person's/their representative's agreement to this file being stored in the bedroom.

In the upstairs lounge, a file relating to the daily care people had received, including details of their personal care, was lying on a table and accessible to people visiting the home. Downstairs a computer used for accessing care records was located on a corridor, which meant that people walking past could read the information.

Mail for people living at the home was stored in a file on the wall in the entrance area. We saw voting cards for people living at the home lying on a table in the hall near to the visitors book. Although the voting date had passed at the time of our inspection, this meant that people had not been given their voting cards and that their personal voting card was not kept securely.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

Requires Improvement

# Is the service responsive?

## Our findings

One of the people living at the home said "I would not have any nonsense, I would tell them, they would listen and it would be sorted." A visiting relative told us that they would not hesitate to raise a concern or complaint. They explained "I go straight to the nurse or manager, it gets sorted."

The home's complaints procedure was displayed in the entrance area. The complaints procedure was concise but provided enough information for people to be aware of who they could contact, both internally and externally, with any complaints or concerns. Some complaints had been recorded, however these were not logged in an organised manner. For example, we saw that a complaint had been made in January 2016 regarding missing personal clothing, however we did not see records of any response from the provider or the manager or any resolution of the issue. A complaint received in May 2016 had been referred to the local authority safeguarding team.

The home had employed a new activities co-ordinator since our last inspection but she had left this employment left shortly before our inspection. Staff told us that activities she provided had included arts and crafts and outings to a local park and cafes. Care records confirmed that people had been supported to go out and about their local community.

A relative told us that the home had offered a lot of different activities of people including arts and crafts. On the afternoon of our inspection we saw staff sitting with people engaging them in conversation or helping them paint their nails. In the ground floor lounge, some people were reading newspapers, some were watching TV, some were chatting to each other, and others were asleep. One person who lived at the home told us "We had an activities woman but she's left. We make our own fun, I like the telly and books. My daughter brings books in for me. My friend likes sport on the TV."

A document called, 'About me' had been written for people. We looked at several of these and found them well written with information about the person's life, choices and preferences as well as their support needs. These document provided good guidance for staff to follow reflecting the knowledge staff had about people and the information relatives gave us about the person. One person told us "I like sitting in the lounge but she likes going to her room, they don't force you."

We looked at care records for six people who lived at the home. These showed that people's care and support needs were assessed and planned for and the plans were reviewed monthly. Records showed that people received services from external healthcare professionals and were supported to attend hospital and clinic appointments as needed. Some of the people who lived on the first floor were supported by NHS mental health professionals.

The main care records were on an electronic system, but not all records were on the electronic system. For example, wound care records were on paper so these had to be viewed in a separately held individual file for the person. We found that having two different records made triangulation of risk, care planning, and external agency involvement was not easy to follow. People also had care notes written by the care staff and

kept in people's individual bedrooms and it was unclear how this information fed into the electronic plans.

We spoke with a senior member of the care staff. They told us they had responsibility for day to day management and supervision of the care staff. They provided details of four people who were being looked after in bed on the day we visited and showed good knowledge of their needs and choices, however not all of this was found in their care plans.

We looked at the electronic care file for one of the people who was looked after in bed. This lacked detail, for example the moving and handling plans mentioned the use of a hoist and sling when transferring the person, but did not give information about how the person should be repositioned when they were in bed. A pain management plan had been written in March 2016 but monthly reviews did not provide any information about whether the person's pain was being managed, for example had it improved/deteriorated. We had also been told that the person had a skin problem, but we did not see any documentation for this.

Requires Improvement

# Is the service well-led?

## Our findings

Staff told us that they felt supported by the management team. One member of staff commented "I love it here, it's a nice environment, you want to come to work." Staff told us that they found the manager supportive. One member of staff said "Without a doubt she listens. I have never gone to her with a problem that has not been solved. She is hands on." A second member of staff described the manager as "really approachable". They told us "She has an open door you can express your opinions." A person who lived at the home said "I think it is well run." and a relative told us "[Manager's name] is very approachable."

The home had a manager who was registered with CQC, The manager was not a registered nurse so a clinical manager had been appointed. We spoke with the clinical manager who had only been in post for a short while, but showed awareness of the strengths and areas for improvement in the service. CQC records showed that the manager was aware of the notifications that were required to be sent to CQC.

We saw records that regular staff meetings took place and monthly meetings for people who lived at the home and their families had been held up to March 2016. A resident and relative meeting planned for 29 April 2016 did not take place due to 'lack of attendance'. We did not see any evidence that other ways of finding out people's views had been used. A significant number of satisfaction questionnaires had been circulated during 2015 but none so far in 2016.

Records showed that the home's policies and procedures had been reviewed in August 2015. These included infection control, infectious outbreaks, food hygiene, hand hygiene, untoward events (business continuity plan), health and safety, risk management, quality management, complaints, safeguarding and whistleblowing.

We saw records of a series of quality monitoring audits that were carried out and it was clear that a considerable amount of effort was spent in completing various audits. However there was no evidence to show how the information gathered was used to identify and address any areas requiring improvement or to take the service forward.

An infection control audit was completed monthly. We did not see any action plans following the audits, however the home's infection control score had improved significantly. Monthly audits of five care files did not identify any improvements needed. There were also monthly checks of people's weights, medication, wound care, meals, and falls, but it was not clear what action was taken for those people experiencing a high incidence of falls. We looked at a file containing falls risk assessments for all of the people who were living at the home in January 2016. The relevance of these was not clear, nor was there any record to show how this information had been used.

A detailed monthly medicines audit was recorded, however this was very much the same every month and the provider may find it useful to try different formats, for example focusing on the medication for a number of individuals. The form used to record wound care audits was not fit for purpose, however staff had made their own notes which were good. Accident and incident audits recorded in November and December 2015

and March 2016 lacked any detail or value.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The provider had failed to ensure that people who used the service were treated with dignity and respect. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Records relating to people who used the service were not always maintained securely. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff had not all received the training they required to work safely. |