St Georges Home Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
St Georges Home Care Ltd is a domiciliary care service that provides care and support for people living with dementia, physical disabilities and mental health conditions. At the time of our visit the service was providing care to 62 people. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
During this inspection, we found shortfalls in how the service was delivered. The three main matters that the service needed to improve were related to poor communication with people using the service and relatives; poor oversight of care visits and timing and lack of development of risk assessments.

During this visit, we found that shortfalls around risk assessment that were highlighted during our last inspection had not been addressed. We found new issues related to care plan reviewing and scheduling as well as monitoring of care visits, and regulatory requirements.

Not all quality monitoring systems were effective as they had not addressed issues identified by us during our inspection.

People and relatives gave mixed feedback about the service. Some said they were happy with the care they received, others had less positive experience.

Staff were recruited safely and staff understood how to protect people from avoidable harm and abuse. There were appropriate infection control and prevention processes in place and staff were provided with enough personal protective equipment (PPE). Medicines were managed safely. Accidents and incidents were recorded, monitored and action was taken to ensure these were not repeated.

Staff were provided with information about their roles and care responsibilities as well as updates related to the service delivery. Overall staff felt supported by their managers and they were happy working for the service.

The service gathered feedback from people about the care they received.

External professionals spoke positively about the managers, staff and the support provided by the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update): The last rating for this service was good (published 6 September 2019). The safe domain was rated as requires improvement as there was one recommendation about the risk assessment process. At this inspection we found improvements had not been made and the provider

was in breach of regulations.

Why we inspected: We received concerns in relation to staffing, the quality of care and the use of personal protective equipment (PPE). As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. We have identified breaches in relation to safe care and treatment and good governance. We made two recommendations on scheduling and monitoring care visits and customer care. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Georges Home Care Ltd on our website at www.cqc.org.uk.

Follow up: We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service was not well-led.

St Georges Home Care Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team included one inspector and one Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing.

At the time of our visit the service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The previous registered manager left the service in January 2020 and the new manager was registered in May 2020. Shortly after our inspection visit the registered manager informed us that they had left the service. Since then we were advised by the provider that a new manager had been appointed and would be registering with the CQC shortly.

Notice of inspection
We gave the service over 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection:
Before the inspection we looked at information we held about the service. The provider had completed a Provider Information Return [PIR]. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We spoke with five people who used the service and six relatives about their experience of the care provided. We used this

information and the previous inspection report to plan our inspection.

During the inspection
We spoke with three members of staff including the provider who was also a nominated individual for the Service, the registered manager and the service manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included six people's care records and medication records. We looked at five staff files in relation to recruitment.

After the inspection
We carried our phone interviews with five members of the care staff team. We spoke with one health and social care professional who previously worked with the service. We reviewed a variety of records relating to the management of the service, including quality assurance records and policies and procedures. We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At our last inspection we recommended the provider sought further guidelines on effective risk assessment and risk management planning. The provider had not made effective improvements.

● Not all risk to health and well-being of people had been assessed. At least two people using the service had been diagnosed with diabetes which was managed with medicines. However, there was no risk assessment in place to guide staff on the risks related to this condition and how to minimise them.
● Identified risks were not always defined, therefore, staff did not have information on exact hazards related to people's health. One person was living with arthritis. Their risk assessment stated there was a high risk related to this condition and the person was severely affected by it. However, it did not say what the actual risk was, how this person was impacted by the condition and how the severity of the risk could be reduced.
● Where risk to people's health and well-being had been identified there was not always enough guidance for staff on how to reduce and monitor these risks. One person had asthma and there was an asthma risk assessment in place. Information included in this document was partially irrelevant to the person as it mentioned a medical device and therapy that the person was not receiving. It did not guide the staff on how to manage the risks related to this person having this condition.
● Information about identified risks was at times scattered across documentation and it took time to locate it. One person had an allergies risk assessment which stated they were allergic to medicines, it did not specify what medicines. This was explained in a medicines risk assessment, however risks associated with allergic reaction were not mentioned. All risk assessments we reviewed asked staff to refer to other documents (care plans and risk assessments) for information on risk reduction measures. However, this information was not always available in these documents.

We found no evidence that people had been harmed. However, the risk assessment and risk management systems were not robust enough to demonstrate people's safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We also saw good examples of risk assessment and these were related to manual handling, Covid19 pandemic and the environment people lived in.

Staffing and recruitment
● Some people using the service and relatives told us staff were often running late and were rushing during the visits. One person said, "To be honest, they're usually in such a rush to get everything done and be off to

their next client that if I manage to snatch a few words with them I'm doing quite well." One relative told us, "They are more often late than they are on time. We have had a couple of missed calls, but to give them their due, these were probably a good couple of months ago now."

● Some staff who were scheduled to visit several people in one day said they struggled to visit people on time. This was because visits were scheduled too close to each other and there was not enough time to travel. When we compared records of actual visit times with the staff rota we saw that, on multiple occasions, staff were not visiting service users at the time the provider had said they would.

● People and relatives were not always informed about staff lateness or which staff would be visiting. One relative said, "It's one of my biggest issues with them. We don't even get a list each week which says roughly what time and who should be coming." Another relative told us, "Some days when it's getting on for over an hour after the time the carer should've been here, still no one calls me and it's up to me to have to phone them and hope they can find out what's happening."

We recommend the provider seeks further training and guidance on effective care visits scheduling.

We discussed staff punctuality with the senior management team during our visit. They told us they were making improvements to ensure staff visited people on time and spend full allocated time with them. They showed us records which confirmed this. These included a new calls control centre and employing drivers to transfer staff between visits.

● Care staff were recruited safely. We looked at recruitment records for three staff members who commenced their employment within the last 12 months. Recruitment checks were undertaken as required by the national guidelines. These included two references from the previous employer, proof of identity and Disclosure and Barring checks (DBS). DBS checks for all staff had been completed. The DBS helps employers make safer recruitment decisions and prevent the appointment of unsuitable people.

Using medicines safely

● Although there were some matters we identified that the provider needed to put right, the overall medicines arrangements were clear. For one person not all medicines listed in their care plan were included on their medicines administration records (MARs). Shortly after the inspection the service's manager provided us with evidence that medicines' records for this person have been updated. They assured us that all medicines changes were discussed with people's GP and the pharmacy and updated on the electronic MARs. Staff confirmed they used MARs for people's most up to date medicines.

● Overall, people's care plans had up to date information about what level of support with medicines people required, who was managing medicines administration, who was responsible for ordering and collecting of medicines from the local pharmacy and where in people's homes medicines were stored. In two instances the level of support was not clear. We discussed this with the management team, and they said this would be addressed.

● Staff recorded medicines administration on paper and electronic MARs. We saw these were completed with no gaps. There was sufficient information on MARs about medicines included on this document and the person receiving them.

● Staff received training in medicines administration. Staff understood how to administer medicines safely.

Systems and processes to safeguard people from the risk of abuse

● People felt safe with staff who supported them. One person told us, "I'm much happier when my regular carer is here because we get on well, he knows exactly what I need help with. He always does any extra jobs that I'm struggling with. He certainly makes me feel that I'm well supported and safe."

● Staff received training in safeguarding. They knew what action to take if they thought somebody was at

risk of abuse. One staff member told us, "Safeguarding means preventing people using the service from avoidable harm related to their health condition, environment they live in or abuse. I must report any safeguarding concerns to my manager. If the manager does not take action, I should inform a social worker, the local safeguarding team and the CQC."

● The managers took action when they were told a person using the service was at risk of harm. One staff member said, "I was concerned about one service user and I told my manager about this. She immediately contacted social services and action was taken to ensure the person was safe."

Preventing and controlling infection

● Staff were provided with personal protective equipment (PPE) such as gloves and aprons, face masks, foot covering and face shields. Family members told us that overall care staff adhered to infection control measures, however, at times they needed to remind staff about safe practice. One relative said, "Some of the carers are extremely good and always have their mask on before they come through the front door. They have their gloves and they do wash their hands usually when they first get here and again before they leave. Unfortunately, I have had to remind a number of carers to put their mask on before they actually come into my home and on one occasion a carer refused to put one on." We fed this back to the management team and they assured us this would be addressed.

● Staff had received training on infection control and prevention measures. Additionally, this had been discussed in care staff meetings, memos sent to staff and managerial spot checks. Staff we spoke with knew safe and effective infection control measures.

● The provider had an infection control policy and procedure to provide staff with guidance on how to avoid infection. The policy has been updated with the current Covid19 guidelines.

Learning lessons when things go wrong

● The service had an accidents and incidents procedure in place and staff were aware of it. Staff understood what action they needed to take when they witnessed an accident or incident. This included contacting emergency services, informing the manager and completing an accident and incident form.

● Accidents and incidents were recorded and monitored for patterns or trends. Records showed action had been taken to respond to occurring accidents and incidents and to reduce the risk of them happening again.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Risks to health and wellbeing of service users had not always been fully assessed. We described it in detail in the safe domain of this report.
- Quality monitoring systems in place were not effective to ensure care was always provided safely, as agreed and as required by the regulations. For example, quality assurance processes had not identified gaps in risk assessment of people's care. The provider's call monitoring system was not fully effective in monitoring care visits. It showed that 91% of calls schedules within the four weeks prior to our inspection had been completed. However, information on how many care visits took place on time, were late or earlier was not available at the time of our inspection. Therefore, the provider could not evidence that staff attended care visits on time and stayed for agreed length of the visit.
- Risks to health and wellbeing of staff had not always been assessed effectively. We saw a sample of three lone working risk assessments for staff. These identified no hazards related to working with people. Manual handling risk assessment for individual care staff had been completed. However, this was in the form of a knowledge check on staff understanding of manual handling, rather than assessing hazards to health and wellbeing of individual care staff.
- The registered manager had not informed the commission about one safeguarding event. They should have done this to comply with the requirement of the Regulations. We are looking into this matter further.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We also saw examples of effective monitoring systems, these were related to staff training, supervision and recruitment. Staff also told us they had spot checks from their managers. One staff member told us, "Spot checks, it is a frequent thing they do. They also ask people if there are any issues with carers."
- Risk assessment for each staff member related to Covid19 had been completed.
- Staff were provided with information about their roles and care responsibilities. Staff received a statement of terms and conditions explaining rules and procedures relating to working for the service. They received an induction to their role and range of policies was also available for staff to view and follow.
- The service's rating was displayed on the provider's website and was easy to view for prospective

customers.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People and relatives gave mixed feedback about the service. Some said they were happy with the care they received, others had a less positive experience. In a "thank you" email to the service a family member said, "My experience has been so far, excellent. Please keep up the good work we appreciate all of you very much." In another email a different relative stated, "….some carers are helpful and proactive whilst others have to be advised and spoken to by family members of what our [relative's] needs are, as she hasn't been able to get this level of service performance. Also, the confusion of different carers coming and going."

● People and relatives thought overall the care was safe. However, they were also concerned that issues around timing, the length of visits and at times frequently changing care staff had been affecting overall care outcomes for people. One relative said, "It frustrates me that sometimes [my relative's] 8:30am call can be as late as 11 am and then that impacts on the lunchtime call which should be at 12:30 pm."

● Communication between people, their relatives and the service had not always been effective. We noted some discrepancies between the procedures and outcomes of the service monitoring, and experience of the service by people and relatives. Although records showed the service carried out reviews of people's care, some people and relatives said their care had not been reviewed since they started receiving the service. The management team assured us that people and relatives were promptly informed about staff lateness and changes. Most people and relatives said they needed to reach out to the service for this information themselves.

We recommend that the provider seeks further training and guidance on a customer service and effective communication with people and their relatives.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider acted on formal complaints and acted to address issues raised. One relative told us, "In my experience, things improve for a few days, but then they go back to how they were before and we find ourselves back at square one." We fed this back to the management team.

● The registered manager understood their responsibility under the duty of candour. They said, "We have the responsibility to be transparent and honest and inform our service users about any mistakes, especially with medicines."

● We saw that when required the managers worked with the local authority and other stakeholders to investigate concerns raised with the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Working in partnership with others

● The service carried out service users surveys. The last one took place between January and August 2020 and 56 people participated. Overall, the feedback from the survey was positive. We saw that the management team analysed the responses received and formulated an action plan to act on improvements.

● Staff felt supported by their managers. They thought their opinion about care provided to people mattered and managers were always available for additional support. One staff member told us, "Managers are always contacting us about how we are doing and how we use PPE. We had online meetings about three times and in person two times."

● The service carried out external professionals' survey to gather their opinion about the service. We saw examples of three completed surveys and the feedback was positive.

● External professionals told us, "I haven't had any issues with them. Very willing to cooperate with recommendations. They had gone out of their way to accommodate the service user and their family."

Continuous learning and improving care

● The provider had a business continuity plan (BCP) in place. The document set out main points around what action the service would take in case of business interruption. The BCP had been updated with information on the Covid19 pandemic.

● The management team had analysed accident and incident, safeguarding concerns and complaints. Action was taken and improvements plans had been formulated to drive the overall service improvement.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured care was provided in a safe way for service users because: They had not done all that was reasonably practical to assess and mitigate risks to care and treatment of people who used the service. Regulation 12 (2) (a) (b)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not operated effective systems to: Assess, monitor and improve the quality of the service. Regulation 17 (2) (a) Assess, monitor and mitigate the risks relating to health, safety and welfare of service users. Regulation 17 (2) (b)