

Prime Life Limited

St Georges

Inspection report

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Date of inspection visit: 19 November 2014
Date of publication: 06/02/2015

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Overall summary

This inspection took place on the 19 November 2014 and was unannounced.

St Georges is registered to provide residential care for up to 36 older people, some of whom are living with dementia. At the time of our inspection there were 26 people in residence. It is purpose built with accommodation on two floors and a passenger lift for access. The service has a range of lounges, a dining room and a central courtyard garden.

St. Georges had a registered manager in post at the service at the time of our 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.

At the last inspection of the 22 February 2014, we asked the provider to take action to make improvements to the recording and administration of medication for people using the service. The provider sent us an action plan which stated they had met the legal requirement. We also found that improvements were needed to reduce the risk and spread of infection and to maintain appropriate

Summary of findings

standards of cleanliness. The provider sent us an action plan which stated they would meet the legal requirement by 16 June 2014. We found these actions had been completed.

Staff demonstrated a good understanding of what abuse was and were aware of their role and responsibilities. The provider had notified relevant agencies where incidents had occurred consistent with legislation and local guidance.

People were safe at the service and staff knew what to do if they had any concerns about their welfare. Records showed staff had thought about people's safety and how to reduce risk. They also knew how to protect people under the Mental Capacity Act Deprivation of Liberty Safeguards (MCA DoLs) and that appropriate referrals had been made to supervisory bodies where people were thought to not have capacity to make decisions themselves.

There were enough staff on duty to meet people's needs and to spend time engaging people in group activities. Staff had the skills and knowledge they needed to provide care, however communication amongst the staff team was not always effectively managed, which meant people did not always receive the care as identified within their plan of care. Medication was kept and administered safely and in the way people wanted it.

People told us that they were mostly satisfied with the food provided and had independent access to snacks and drinks, however the dining experience did not promote people's independence or choice as meals came pre-served on plates without them being asked what they wished to eat. Dieticians and other health care professionals were involved if people needed extra help with nutrition and hydration.

People told us that they were satisfied with the care and support the service provided. They had access to a range of health care professionals. Records showed that staff took prompt action if there were concerns about the health of people using the service.

Records showed complaints and concerns were recorded and that complainants were provided with a response. Quality assurance surveys conducted by the provider showed people were mostly satisfied with the provider's complaints procedure.

Representatives of the provider regularly visited the service to carry out quality assurance audits to ensure the service was running well and that identified shortfalls were being addressed. However their visits did not include speaking with people who used the service or visitors to seek their views to develop the service. Some people told us that the registered manager was approachable, however not everyone knew who the manager was.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

People were protected because staff demonstrated a good understanding of what abuse was and were aware of their role and responsibilities. The provider had notified relevant agencies where incidents had occurred consistent with legislation and local guidance.

Risks to people's health and well being had been identified, assessed and managed in an appropriate way.

There were sufficient numbers of staff available to keep people safe and systems were in place to review staffing levels according to people's needs. Staff had been appropriately recruited to ensure they were suitable to work at the service.

People were administered their medication as prescribed by a health care professional.

Good



Is the service effective?

The service was not consistently effective.

People were supported by staff who had the appropriate knowledge and skills to provide care and who understood the needs of people using the service and who were supported by the management team.

Staff had a good understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005, which had been put into practice to ensure people's human rights and legal rights were respected.

People were referred to the relevant health care professionals in a timely manner, however their instructions were not always communicated effectively.

Requires Improvement



Is the service caring?

The service was caring.

People we spoke with were happy with the care and support they received and the majority of visitors who were there to visit a relative or friend confirmed this.

Staff treated people with dignity and respect and people were involved in day to day decisions about their care and support.

Good



Is the service responsive?

The service was not consistently responsive.

We saw people being supported to engage in group activities by members of staff and visitors told us that activities and events were organised.

Requires Improvement



Summary of findings

We found people's needs were assessed prior to moving into the service and that staff reviewed people's needs and developed the appropriate plans of care.

People's choices and decision making around mealtimes was not sufficiently considered with regards to the promotion of people's independence and choice.

Complaints were recorded and investigated. Relatives we spoke with were aware of how to raise concerns.

Is the service well-led?

The service was not consistently well-led

The manager was approachable, however not everyone knew who the manager was. Visitors of people who used the service told us that communication was not always managed well as information was not consistently shared between the registered manager and staff.

Representatives of the provider regularly visited the service to carry out a range of audits, however this did not include speaking with people who used the service or their relatives to seek their views.

The provider and registered manager notified the CQC and other relevant agencies about events within the service which affected the well-being of people using the service.

Requires Improvement



St Georges

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 the 19 November 2014 and was unannounced.

The inspection was carried out by two inspectors and an 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, their area of expertise was caring for older people with dementia.

We reviewed information provided to us by the local authority that commissions packages of care to find out their views of the service provided.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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 three people who used the service, four relatives or friends of people who used the service, two district nurses, four members of care staff, the registered manager and the associate and regional director. We looked at the records of five people, which included their plans of care and risk assessments, the recruitment files of three members of staff, maintenance records of equipment and the building, quality assurance audits and the minutes of staff meetings.

We asked the provider to submit additional information, which included a record of staff supervision and training, quality assurance visits carried out by directors of the company and maintenance records. These were provided.

Is the service safe?

Our findings

At our inspection on 26 February 2014 we found that appropriate arrangements were not in place in relation to the administration of medicines. We found that medication administration records, which recorded the administration of medication were being signed by staff before people were administered their medication. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan outlining how they would make improvements.

At this inspection we found that improvements had been made. The registered manager told us that staff responsible for the administration of medication had had their competency assessed and that this was undertaken annually. Records within staff files confirmed staffs' competency had been assessed and was kept under regular review.

Medication audit records showed that the registered manager monitored all aspects of medication storage and administration and where shortfalls were identified these were documented and staff were advised as to what action they needed to take.

We observed a member of staff administered medication to people sitting in the dining room at lunch time. The member of staff explained to people that it was time for them to take their medication and supported them to do so and ensured they had a drink. One person asked the member of staff what their medication was, the member of staff explained to them and this reassured the person who then took their medication.

Medication was kept securely and only administered by people trained and assessed as being able to do so safely. We looked at medication records for three of the people who used the serviced and checked them against medication stocks. Records showed that medication had been given on time and staff had signed to confirm this.

At our inspection on 26 February 2014 we found that appropriate arrangements were not in place in relation to cleanliness and infection control. We found areas within the service which required maintenance and cleaning. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan outlining how they would make improvements.

At this inspection we found that improvements had been made. Areas of the home had been decorated and new furniture purchased. A visiting health care professional told us they had noted improvements to the cleanliness of the service.

Environmental audits were being undertaken which focused on specific areas of the service and included, the kitchen and bathing and toilet facilities. Where audits identified a shortfall an action point to address the issue was made and followed up to ensure issues were addressed.

The provider's infection control policy and procedures were thorough, and covered, for example, MRSA, Legionnaires and good hand washing. Cleaning records were also available to confirm that cleaning schedules were carried out. We observed staff using appropriate protective equipment when undertaking personal care tasks, which included the wearing of gloves and aprons. Staff training records showed most staff had undertaken training in infection control within the last twelve months.

A person we spoke with told us "I am safe and they look after me." A visitor who was at St Georges to visit a relative said "I feel that [my relative] is safe overall.

We looked at how the service protected people and kept them safe. The provider's safeguarding (protecting people from abuse) policy told staff what to do if they had concerns about the welfare of any of the people who used the service. Staff training records showed that most staff had undertaken training in safeguarding adults within the last twelve months. Discussions with staff showed they had a good understanding as to what action they would take if they believed somebody was being harmed or abused. Staff were aware of the provider's whistleblowing procedure and telephone service.

Records showed that when a safeguarding incident occurred the service took appropriate action. Referrals were made to the local authority, ourselves, and other relevant agencies in a timely manner. This meant that health, social care, and other professionals outside the service were alerted if there were concerns about people's well-being and the service did not deal with them on their own.

Is the service safe?

People's care records included appropriate risk assessments. These were regularly reviewed and covered all areas of activities related to people's health, safety, care and welfare. The advice and guidance in risk assessments were being followed. For example, where people needed to use particular equipment to keep them safe, such as a hoist this was provided. Staff records showed staff had received training in topics related to the promotion of people's safety and welfare and included topics such as, moving and handling people safely, falls prevention awareness, health and safety and first aid.

Records showed that some people who used the service were, on occasions, reluctant to accept personal care due to their health needs. People's plans of care provided staff with information as to how to support people, by the use of distraction techniques, which for one person suggested staff talked to the person about their family, in order to reassure the person. Staff we spoke with had good knowledge and understanding of people's personal care and how support was to be provided.

People's safety was supported by the provider's recruitment practices. We looked at staff recruitment records for staff. We found that the relevant checks had been completed before staff worked unsupervised at the service.

People we spoke with about staffing levels told us "I feel safe." During our inspection we found there to be sufficient numbers of suitable staff on duty to keep people safe and meet their personal care needs. People who required assistance were seen to receive support in a timely manner. The registered manager told us that staffing levels had increased, which now included a senior member of care staff on duty throughout the day. The staff rota showed that there were between five and six staff on duty during the day dependent upon the time of day and three staff during the night.

Is the service effective?

Our findings

People told us they were satisfied with the care and support the service provided. One person said, "It's alright here." Another person said "They look after me."

Visitors told us, "I think they meet her needs in most cases." Another visitor told us, "They do the best they can."

Records showed staff had received training which reflected the needs of people who used the service. Peoples' records showed that the training staff had received in relation to maintaining peoples' health was effective as people's individual health care needs were being monitored consistent with their plan of care. Any issues of concern were brought to the attention of the appropriate person.

Records showed staff received 'observed practice supervisions' where aspects of their care delivery to people using the service were observed by a member of the management team. This ensured that people received the care and support they needed in an appropriate way. Where shortfalls were found, additional training and guidance were provided to ensure improvements were made.

We talked with the registered manager and staff about the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) and what they meant in practice for the service. They were knowledgeable about how to protect the rights of people who were not always able to make or communicate their own decisions. Care records showed that the principles of the MCA Code of Practice had been used when assessing people's ability to make decisions. The MCA is a law which provides a system of assessment and decision making to protect people who do not have the capacity to give consent themselves.

The registered manager told us that there were fourteen people who used the service that had an authorised DoLS in place, which had been granted by a 'Supervisory Body' many of which were in response to a recent high court ruling. We looked at four people's records who were subject to a DoLS and found that the provider was complying with the conditions where these had been applied by the 'Supervisory Body'. A DoLS assessment and authorisation is required where a person lacks capacity to make a decision and needs to have their freedom restricted to keep them safe or to have their needs met.

People using the service told us that meals overall were "quite good" and one visitor talked about how staff cooked meals on a Friday each week, (main meals on other days were provided by a central kitchen off site of St. Georges). They also said about the meals. "Plenty of selection and different things there's no problem there." People we spoke with told us, "The dinners aren't any good but you get plenty." Another person told us "I'm ok and I get fed well." People's nutritional needs were risk assessed and regularly reviewed. The majority of people who sat in the dining room at lunchtime were seen to eat their lunchtime meal, and had a choice of drinks.

Staff served a choice of hot drinks and snacks during the day. Snacks, such as fruit and crisps and drinks were available for people in the dining room and lounges of St Georges. The dining room also had a glass fronted refrigerator with snacks inside. We saw people independently go the refrigerator and fruit bowls and help themselves to whatever they wished to eat.

Where concerns about people's food or fluid intake had been identified, they were referred to their GP, SALT (speech and language therapy) team and dieticians. People's weight was monitored in accordance with their assessed need and staff were aware if people needed extra support with their nutrition. Where people required a diet to meet their cultural needs this was provided by an external caterer.

People in some instances had been assessed by a health care professional as requiring a soft or pureed diet, which was provided. However, we saw one person who had been assessed as requiring a soft diet being offered a biscuit, which had it have been eaten had the potential for the person to choke. We discussed this with the registered manager who told us the person's care plan recorded the need for a soft diet. A visitor who was visiting their relative at the time spoke to us about this saying, "Communication between the manager and the actual staff that carry out people's care appears poor. I will agree something with the manager and the information doesn't appear to filter down." We brought this to the attention of the registered manager. The registered manager said they would look at introducing a system to improve communication and ensure staff had access to significant information about people using the service by the introduction of notes which staff could carry on their person.

Is the service effective?

Staff we spoke with told us that any changes to people's needs were communicated through the staff handover at the beginning of the shift. However not everybody attended handover as some people started work at different times. This had the potential for people using the service not to receive the care and support they need as staff may not have an up to date picture of people's needs and wellbeing.

Visitors of people using the service told us, "I know that if [relative] isn't well they will have the doctor out."

People had access to a wide range of health and social care professionals. These included GPs, CPNs (community psychiatric nurses) district nurses, psychiatrists, chiropodists and social workers. Records also showed staff at the service took action if there were concerns about the health of any of the people who used the service.

Is the service caring?

Our findings

Visitors we spoke with had differing views about the service their relatives received. They told us, “90% of the staff do a brilliant job,” and “Most of the staff are wonderful.” A visitor also said, “Always very good, always announce who they are and very kind and gentle with him.”

However other visitors told us “Staff are gentle, courteous and heartfelt but unless you put any pressure on them then they never act.” A visitor also said “There doesn’t seem to be a lot of interactions, communication between staff and residents. We discussed the negative comments with the registered manager who was aware of the person’s concerns in relation to the care of their relative and had met with them to discuss the issues.

People’s preferences about their care and support were recorded within their plan of care. This included information about what time they wished to get up or get to bed, how and where they wished to spend their time and their likes and dislikes. Plans of care included information for staff about what the person could do for themselves and the role of staff in encouraging and promoting people’s

independence and choice. In addition they included guidance for staff about how people communicated pain or discomfort if they were unable to verbally express themselves.

People we spoke with and their relatives were happy with care in relation to dignity and respect. One visitor gave an example of when the staff showed dignity and respect, saying; “Yes definitely, well if they have to change [person using the service] as they are incontinent, they’ll be changed in private.”

Throughout our visit we saw staff treating people with respect and dignity. For example they spoke with people in a sensitive manner when asking them a question about their personal care. We saw a person being supported by two staff with the use of a stand aid, staff spoke with them throughout and explained what was happening, the person remained calm and relaxed throughout the process. Records showed that most of the staff had received training in dignity in care within the last twelve months.

People’s told us that their bedrooms were respected as their own space and the décor and furnishings reflected their individual tastes and interests. Bedroom doors in some instances had been decorated with a personal item, such as a photograph to help the person identify which bedroom was theirs.

Is the service responsive?

Our findings

A member of staff we spoke with described how peoples' plans of care identified specific needs such as their religious and cultural needs. They told us "[Persons name] has culturally appropriate meals."

We asked people for their views about taking part in activities. People we spoke with said "They could do with a few more staff but they are very good." A second person told us "Perhaps they could do with a few more staff."

Staff we spoke with told us "We meet people's needs on a basic level, but we could do better," and "I think the care could be better, we could take people out but we don't have the time." On the day of the inspection we saw staff spending time with people and we observed some good interactions between people using the service and staff. Staff encouraged people to sing along to a music CD which was playing in the dining room, whilst others were encouraged to take part in art and craft activities. In the morning we saw a member of staff open a 'memory box' the theme for the month being 'school days'. The member of staff talked with and encouraged people to look at and interact with the items. People talked about their experiences from their childhood saying they remembered some of the items contained within the 'memory box'.

A visitor told us that their relative did not always take part in activities but that the service did organise a range of activities which were provided by community groups that their relative joined in with. The visitor told us, "The Church in the area do a service once a month, and [name of school] come into St Georges to take part in a Choral Service. Once a month a fete or event takes place for example a lady with a keyboard."

On the evening of our inspection the provider had organised a 'jingle bell bingo' event, which was open to relatives of people who use the service and their friends.

Regular religious Church services were held for people who used the service. A member of staff described the activities available to people which included creative activities provided by a charity, trips and outings and group exercise sessions. The carer explained how people using the service were involved in decisions around activities, and said. "We do talk with them about what they like to do, some people require more prompting to join in."

Communal areas of the service were furnished with essential items of furniture such as tables, sofas and chairs but did not include items of interest for people to look at or interact with such as books and magazines.

A visitor told us that they felt involved in the decision making with health care professionals with regards to their [relative] and how the care staff at St. George's kept them involved and informed. They said "They do ask me what I would like to do, what has been proposed, they keep you informed."

People in some instances required additional monitoring due to their health needs. For example people being cared for in bed were at risk of the development of pressure sores and this was highlighted in people's plans of care. Staff were instructed to change people's position regularly and complete charts to confirm this had been done. Similarly, people at risk of poor nutritional intake or dehydration had food and fluid charts in place for staff to complete. Records showed charts were being completed to reflect the care people received. Records showed people's plans of care were reviewed on a regular basis, and updated when people's needs changed.

Health care professionals told us that people's turn charts and fluid charts were now being completed and that staff knew the people well.

We observed that staff at lunchtime asked people which of the two options from the menu they wished to eat. However, staff had already served the food onto the plates, which included the vegetables, potatoes and gravy prior to asking people what they wanted. This meant that people did not have a choice about what they ate or the size of their portion. We noted that the dining tables were not laid with cutlery, condiments or napkins prior to the meal, which meant people had to wait for staff to provide them before eating their meal.

People using the service and their visitors we spoke with told us that overall they were happy with peoples' care and did not have any complaints. One visitor said "Not any real complaints because they talk to [my relative]."

Complaints received by the service were recorded along with notes about the investigation and a copy of the response to the complainant. Complaints were monitored on behalf of the provider by the associate and regional director who visited the service as part of the quality assurance system. This helped to ensure that complaints

Is the service responsive?

were responded to in a timely manner. The registered manager told us he had an 'open door policy' and the people who used the service, relatives and others were welcome to approach him at any time if they had concerns. A relative we spoke with told us the manager was approachable and they had discussed their concerns, however they felt communication between the manager and staff meant issues discussed and agreed were not always consistently acted upon.

We looked to find out how the service listened to and learned from people who used the service and found that the service did not organise regular meetings for people who used the service to attend. We discussed this with the registered manager who advised us that they would look to develop one to one discussions between people who used the service and a member of staff and that these discussions would be recorded. This would then be monitored to ensure that people's views were listened to and acted upon.

Is the service well-led?

Our findings

We noted when we walked around the service speaking with members of the management team that they understood the importance of person centred care for people using the service. They spoke to us about the development of the service and our observations during the day showed people were responded to individually. However we saw instances where resources to support people had not been used. For example we were shown a notice board which was for the purpose of writing messages and thoughts for the day, however it was blank on the day of the inspection. We also saw that the menu for the meal of the day was not displayed on the menu board.

A person using the service we talked with about management did not think they were readily available and said, “No, there is no opportunity to talk to the manager.” Whilst a second person said “No I never speak to the management, I don’t know who they are.” The management of the service had recently changed and the registered manager had organised meetings with people using the service and relatives to raise their awareness of their role.

The provider’s regional and associate director had visited the service regularly and produced a report about their findings. This included their observations, information about staff training and complaints and compliments and comments from visiting social care professionals. However the reports did not include information about whether they had spoken with people who used the service, their relatives or staff. This meant opportunities for people to share their comments and develop the service was restricted.

We asked the registered manager for their views about the values and visions of the service, they told us. “To provide quality care in a safe environment, through the provision of staff training and the on going auditing and monitoring of the service.” The registered manager had submitted information to the CQC, which included information on events which occurred in the service that affected the well-being of people, which are referred to as ‘notifications’ in a timely manner. They had also liaised with a range of health and social care professionals in the best interests of people who used the service where incidents had occurred in the service, which included safeguarding concerns.

The service had a dedicated telephone number operated and managed by the provider for staff to ring where they could whistle blow (report concerns) anonymously.

Staff told us they had regular supervisions and appraisals and that they attended staff meetings, which meant staff were supported by the management team. Records we viewed confirmed this. One member of staff said, “The manager is always available if you need them.” Staff told us they felt valued and listened to and that the new manager was approachable, staff were positive about changes that were being introduced.

The Provider Information Return (PIR) included their plans for development over the next 12 months and focussed on improvements in the development and cascading of information, through the introduction of newsletters and bulletins to communicate policy implementation. Their identified areas of improvement were reflective of the findings of the inspection.

The PIR included key areas of learning, to include the MCA and DoLS and whistle blowing, along with health and safety.