Caring Homes Healthcare Group Limited

St Georges Care Home

Inspection report

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Date of inspection visit:
25 October 2017
26 October 2017

Date of publication:
28 December 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive inspection of St Georges Care Home on 6 and 7 January 2017. At that inspection we found multiple breaches of the Health and Social Care Act 2008. As a result of this the service was rated 'Inadequate' overall. The service was therefore placed into 'Special measures'. Services in special measures are kept under review.

In addition to being placed in special measures, we imposed a condition on the provider's registration relating to person centred care and treatment, dignity and respect, completion of statutory notifications, consent to care, risk management, administration of medicines, safeguarding people from abuse, complaints management, record keeping, quality monitoring and governance, staffing levels and staff supervision and training.

We carried out a comprehensive inspection on 25 and 26 October 2017 to review what improvements had been made at the service since they had been placed in special measures.

St Georges Care Home is a 68 bedded home that provides accommodation for persons who require nursing and personal care. At the time of our inspection there were 40 people living in the care home.

The manager in post received confirmation on 17 November 2017 that their application for registered manager had been successful. 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.

Overall, we found there had been significant improvements in all areas for the home to be taken out of special measures. Further work was needed to ensure that improvements were consistent and embedded throughout the home.

Sufficient numbers of staff were deployed. However, the home was only 59% occupied. Staff performance was being more effectively monitored. Staff had received supervision and training to ensure they could meet people's needs. Additional support and training was provided by the NHS care home support teams.

Staff were kind and caring. We found people were being treated with dignity and respect and we found people's privacy was maintained.

Systems were in place for monitoring quality and safety. However, further improvements were needed.

At this inspection we found a breach of one of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to accuracy of records and quality assurance.

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, further improvements were needed.

People and relatives recognised there had been improvements in staffing levels and deployment but that further improvements were needed.

Risk assessments were completed and risk management plans were in place to reduce and minimise the identified risks.

Staff had been trained and recognised their role in safeguarding people from harm and abuse.

Recruitment procedures were in place and appropriate checks were completed before staff started in post.

Is the service effective?

Good

The service was effective.

Staff received appropriate training to carry out their roles and staff performance was sufficiently monitored.

People had a choice of meals that met their nutritional requirements.

People's rights were protected in accordance with the requirements of the Mental Capacity Act (2005). Where people had been deprived of their liberty, this was in accordance with legal requirements.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect by all staff.

Staff understood peoples' needs and supported people to express their wishes.

Staff provided compassionate, kind and thoughtful care.

Is the service responsive?

Requires Improvement

The service was not always responsive, further improvements were needed.

Most, but not all care plans were personalised and reflected people' current preferences and needs.

Activities were provided to people in communal areas and in their rooms.

A complaints procedure was in place and this was easily accessible.

Is the service well-led?

Requires Improvement

The service was not always well-led, further improvements were needed.

There was a new registered manager in post. Improvements had been made since they had been in post. These were still to be fully embedded in the home.

Systems were in place for monitoring quality and safety and actions were taken when areas for improvements had been identified.

Staff were now supported sufficiently and given opportunities to express their views and concerns.

People noted there had been improvements but concerns had continued due to the frequency of management changes in the home.

St Georges Care Home

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.

We undertook a comprehensive inspection of St Georges Care Home on 25 and 26 October 2017. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by one inspector and an expert by experience for both days. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. A second inspector supported the inspection on day one.

Before carrying out the inspection we reviewed the information we held about the care home. This included the monthly report we received from the provider which set out the actions they were taking to demonstrate they were meeting the legal requirements. We looked at information and reports received from Bristol City Council's quality assurance team, the NHS Care and Support team who had been providing regular support and the local authority safeguarding team.

We looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law. The provider had completed and sent us a Provider Information Return (PIR). This is a document which asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with 21 people who lived at the home and four visitors. We spoke with a visiting chaplain and hairdresser. We spent time with people in their bedrooms and in communal areas. We observed the way staff interacted and engaged with people.

We spoke with the regional manager, a support manager, the registered manager, and 13 staff that included registered nurses, care staff, maintenance, housekeeping, hostess, activity and catering staff. We observed

how equipment, such as pressure relieving equipment and hoists, was being used in the home.

We looked at seven people's care records. We looked at medicine records, staff recruitment files, staff training records, quality assurance audits and action plans, records of meetings with staff and people who used the service, complaints records and other records relating to the monitoring and management of the care home. We received feedback from three external health professionals involved with the home.

Requires Improvement

Is the service safe?

Our findings

Most people told us they felt safe and commented there had been improvements that made them feel this way. Comments included, "Yes, the staff, they watch out for you, the doors are locked, there's fire safety" "Yes, always somebody (staff) on call, I feel safe with the care workers" and, "I feel safe enough here." One person told us they were not so confident with new staff and said, "With certain staff, mostly new ones, I'm a bit more concerned." The person went on to tell us they worried because new staff sometimes appeared unsure of what they were supposed to do. They said this was noticeable because there had been a lot of new staff in recent months.

People gave varying views about whether there were enough staff to provide the support they needed. Some people told us staff responded more promptly to calls for support and others told us they had to wait for assistance. A relative told us, "Not enough staff, more than they had which is noticed, but never enough. Needs to increase. Lots of temporary staff that don't know the system of each resident. They are often busy and short. The staff seem more upbeat though, so overall mood is better." The view of another relative was, "Since your (the Commissions) last visit there is a quicker response to the call bell." Other comments from people included, "Staff, yes there is enough of them here to look after me" and, "Yes, two staff always come along and taken me to the toilet."

The registered manager showed us the dependency tool used to calculate staffing levels. The regional manager confirmed in the monthly action plan they sent to us that staffing levels were kept under review and adjusted if needed. The registered manager also checked the call bell computer printout to check staff response times to people's calls. They walked around the home each day and told us they observed for staff responses to peoples' calls. They also obtained views from staff and from people using the service. On the days of our visit, the home was sufficiently staffed.

During the inspection we spoke with staff who told us staffing levels had improved. One member of staff told us there were a lot of new staff which they said was a 'good thing'. They told us they thought it took some time for people using the service to get used to new staff but told us, "It's so much better. We've actually got more staff who really care". A recently employed member of staff spoke positively and commented, "Before I started I was told there were problems, and I saw the last report, but I've seen it get better even since I was first here. We're not as rushed."

At our last visit, we found medicines were not safely managed. At this inspection, improvements had been made and overall, medicines were managed safely. We observed medicines being given to people on each of the two floors of the home. The registered nurses asked people if they were happy to take their medicines and asked if they needed any additional medicines such as pain relief. They waited for people to take the medicines before signing for them.

Medicines were stored safely and arrangements were in place for medicines that required cool storage and medicines that required additional security. We looked at all of the medicine administration records (MARs) and saw there were no gaps which indicated that people received their medicines and staff had signed to

confirm they had been given.

People's preferences in relation to how they preferred to take their medicines was recorded. However, the information was not always accurate. On the first floor, every person had their preferences listed as 'takes tablets one at a time with a glass of water'. This was not correct and we saw people were supported to take their medicines in different ways. For example, the registered nurse gave one person all of their tablets at the same time and the person took them all at once. We brought this to the attention of the clinical lead registered nurse and the registered manager during the inspection. On the ground floor, people's preferences had generally been accurately recorded.

Some people were prescribed medicines to be taken when required, such as for pain relief or medicines for agitation. Although protocols were in place, these did not provide staff with enough information about when people might require them. For example, pain relief protocols guided staff to administer them for pain. They did not specify where or why people might have pain. They did not always provide guidance for staff about how people who were unable to communicate might show they were in pain. Protocols for anti-anxiety medicines did not provide detail of the signs of anxiety that people might display or detail other interventions that could be tried before using medicines. For example the protocol for one person guided staff to administer the medicine when the person showed signs of 'agitation' but did not describe how the person showed they were agitated.

On most occasions, staff had recorded the reasons why additional medicines had been given and the effects of the medicine. The exception to this was anti -psychotic medicines that had been administered to one person where staff had not recorded if this medicine had been effective. We brought his to the attention of the clinical lead registered nurse at the time.

We looked at the records for one person who self-administered their medicines. The person's ability to self-administer had been assessed and regularly reviewed. Stock checks of the medicines the person kept were checked regularly.

Medicines audits had been completed. We looked at the last two audits completed by senior staff in the home. The issues we noted had not been identified in the audit. We also looked at the latest pharmacist visit dated 23/05/2017. Issues raised during their visit had led to an action plan, and we saw that all actions had been completed.

Risks to people's personal safety had been assessed and plans were in place to minimise the risks. We found improvements had been made since our last inspection. Risks were accurately identified and risk management plans were in place. For example, risks associated with the use of equipment such as bed rails had been assessed and where used, regular checks were completed to make sure they were used safely. Risk assessments were also completed for nutrition, mobility, moving and handling and tissue viability.

At this inspection, we found accidents and incidents were reported, recorded and analysed. Reports were completed and reviewed to identify trends or patterns with regard to people's falls. People were referred to the GP for consultation, further investigations and referrals to other health professionals if needed. Where appropriate records noted that relatives had been informed. The manager's report for August 2017 had noted, 'Increase in incidents report in general. Seems likely this reflects better reporting from care staff.'

At our last inspection, we found people were not protected from harm and abuse. At this inspection, we found there were improvements. Staff had a good understanding of their responsibilities with regard to safeguarding people from avoidable harm and abuse. They had received training. They were able to

describe how they would recognise abuse, and how they would act on any concerns. Staff told us they were now more confident that concerns raised would be acted upon by senior staff and the registered manager. They told us they also had access to the local authority safeguarding team contact details. One member of staff told us, "I think we all feel we can speak up and know we will be listened to" and a member of the catering staff team commented, "I've been told if I see anything at all I'm concerned about I must report it."

The provider followed safe recruitment practices. Staff files included application forms and records of interviews and references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified.

The environment was maintained to ensure it was safe. For example, water temperatures, legionella checks, electrical and gas safety, lift maintenance and hoist checks had been completed. A fire risk assessment had been completed. The regional manager provided confirmation that required actions had been completed. In addition, a plan was in place to address recommendations that had been made. Personal emergency evacuation plans for each person were completed. They provided guidance about how people could be moved in an emergency situation if evacuation of the building was required.

Good

Is the service effective?

Our findings

When we inspected in January 2017, we found staff had not received sufficient supervision and training and peoples' health care needs were not always being met. At this inspection, we found significant improvements had been made.

Feedback from people and relatives included, "The staff are well trained. They know how to look after me" "Regular staff know the little things that matter and it's the little things that matter to her. If staff are not regular the little things get missed" and, "Constant new ones. Could do with a bit more (training) on hygiene, how to use the bath chair, change catheter bags. I have a bath once a week. The rest of time a quick wash, they never have much time. I need time, the new ones are nervous about the time (they spend with people) and getting talked about."

Staff spoke positively about the support, supervision and training they received. Comments included, "Good support, much better now" "I was welcomed with open arms. If I have any questions I can go to my buddy. I was quite shocked when I read the last inspection report, but still decided to accept the job here. [Name of support manager] was great and [name of registered manager] is really good. It was a bit manic when I first started but it's settling now" and, "Always some training for us to do."

When staff started in post, they completed induction training that incorporated the Care Certificate, a national training process introduced in April 2015, designed to ensure staff were suitably trained to provide a basic standard of care and support. Staff completed initial training then shadowed their allocated 'buddy' until they were confident to work unsupervised.

Staff had received training in a range of mandatory topics. These included moving and handling, fire safety, infection control, Mental Capacity Act 2005, safeguarding and first aid. Where staff were due or overdue for their update training, this was identified within the system and acted upon.

We spoke with the registered manager and looked at the supervision records. We saw that a plan was in place to make sure all staff received supervisions in line with the provider's policy, over a 12 month period. Following our last inspection, it was recognised that staff needed additional training to support them to understand peoples' health care needs. We saw training had been completed by registered nurses that included medicines management competency updates and syringe driver training. Additional training for staff had been provided by the care home support team. These included training sessions for oral hygiene in end of life care, use of covert medication, a national early warning score (NEWS) tool that assisted staff to recognise and respond when people became acutely ill, and nutrition and hydration.

Where people's care plans stated they needed to be checked at regular intervals, and, for example, needed support to change position, the records confirmed these checks had been completed.

The provider had noted in their PIR that an area for improvement was to continue to improve the recording and reporting of daily records and to ensure care records were accurately updated.

The people we spoke with were positive about the food and feedback included, "Lovely, I'm happy with the food and they give me smaller portions (as the person requested)" "I enjoy it. I choose to eat in my room. I get a choice. They will get you something different if you want" and, "The catering staff go to a lot of trouble. I get choices and have what I fancy, such as eggs on toast in the evening." A relative said, "She is eating plenty, they cater for what she wants, they ask her."

People who had specific dietary needs or who had lost weight had their individual needs recorded and monitored. We checked and the food and fluid monitoring records we looked at were fully completed. The nursing, care and catering staff were all aware and able to tell us about people's individual needs, likes and dislikes. Where needed, additional cream and butter was added to meals, and textured diets were provided when needed.

People were supported to express their food preferences. For example, we heard a member of staff asking one person who had said they didn't mind what they had on toast, "What would you prefer? Maybe some jam or marmalade?"

We observed meal service to people in their rooms and in the dining rooms. The dining tables were laid in advance, with menus displayed, condiments available and serviettes provided. Clothes protectors were offered and provided for people as needed. Where people needed support saw this was provided in a dignified and respectful manner and people were not rushed. One relative told us sometimes the dining room was noisy and this put their relative off eating in this communal area.

People were referred to other health professionals when needed. People had been referred to the dementia well-being team, the speech and language therapists (SALT), social workers and physiotherapists. Where guidance had been provided we saw this was followed. For example, an entry in the care records for one person relating to SALT guidance stated, 'No further input indicated. Appears to be managing current recommendations.' We spoke with relatives who told us that communication had improved and they were now kept up to date and informed when there were changes. A relative told us, "I hope you notice the improvements. They always call me if there are changes and I can discuss her care anytime."

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.

We saw that consent to care had been obtained and recorded, for example, for the use of bed rails. Where people did not have capacity to consent best interest decisions were made on their behalf and these were recorded. The records showed who had been involved in making the decisions. Staff had received training and demonstrated an understanding of the Mental Capacity Act. They told us they understood they needed to obtain consent. We heard people being asked before they were provided with support. For example we heard staff asking, "Can I help you with that" "Would you like me to take you to the hairdressers" and, "Do you want me to help you move into the chair?"

The provider had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). We checked whether the service was working within the principles of the

MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Applications had been submitted to the local authority and assessments and authorisations for some people were pending. We read the records for one person with a DoLS authorisation in place and they had conditions stated within the authorisation. These conditions were being met. The registered manager told us how they had enhanced staff understanding about the MCA and DoLS and aimed to make it, "A daily conversation" with staff.

Good

Is the service caring?

Our findings

When we visited in January 2017, we found people were not treated with dignity and respect. At this visit, the feedback we received from people using the service and relatives, together with observations we made, satisfied us that sufficient improvements had been made to demonstrate compliance with this regulation. From the conversations we had with people, we also noted further work was needed to fully embed the improvements that had been made.

We received the following comments and feedback from people, "A lot of them are wonderful. They are choosing the ones that are kind and understanding, more so than when I first came in" "Kind staff, careful and kind when they undress me. They keep my dignity" and from one person, "Most are kind and compassionate. Some are in the wrong job. It depends, some are abrupt. It varies by the day."

We also spoke with a person who we had spoken with when we last visited the home. At our last visit, we found and reported to senior staff, that the person was not receiving the care they needed. At this visit they told us, "It's so much better here now. Yes the staff are lovely, really kind. You get the odd one or two like you would anywhere that are not so good, not rough or anything, just not quite so good as the others."

Relatives told us there were better relationships with staff and commented, "The carers are more attentive now, and since you were here last, things have improved" and, "I hope you notice the improvements. The staff, especially the carers are lovely. They can improve her mood by knowing what she wants and needs."

The staff we spoke with told us how they treated people with kindness and compassion. A member of staff we had also spoken with when we last visited commented, "Staff have left and that's been a good thing. We got a lot of new ones and can show them the right way, and how residents should be treated."

We heard a member of staff speaking with a person they were taking into the hairdressing salon, "Oh, you will look fabulous when you get back." We heard staff comment after people had visited the salon with comments such as, "You look so nice, your hair looks lovely."

Staff told us how they provided kind and respectful care to people. Comments from staff included, "I always think how I'd want my Mum or Nan to be treated and if it wouldn't be good enough for them, then it's not good enough" and "I think being caring is all about checking what else we can do for the resident. I always ask if there's anything else I can do before I move on." We saw staff encouraging and supporting peoples' independence. We heard words of encouragement from staff that included, "You're doing really well, a few steps more and you're there."

Staff knew how to communicate with people who were not able to communicate verbally. The staff we spoke with described how people expressed their views. We heard how some people used picture boards, nods and shakes of their head, and one person who gave a thumbs up or down to let staff know what they wanted. The details were also recorded in people's care plans.

People were provided with information that was displayed on a notice board in each person's bedroom. This included information and reminders about meetings for people and their families, appointments, the weekly menu and the activities programme.

We read recent compliment cards and letters received in the home. They included the following, compliment about a specific member of staff, 'She is caring, attentive and the family has total trust in her' and, 'Thank you for the care and kindness you showed when [name of person] was with you.'

Requires Improvement

Is the service responsive?

Our findings

At our last visit, we found that people did not receive care that was personalised and responsive to their individual needs. At this visit, although we found actions had been taken, and people received a much improved personalised care service, further improvements were required to make sure all the records fully reflected people's current needs and preferences. Of the seven care plans we read in detail, four were complete, personalised and up to date. Three care plans were not accurate, complete or up to date.

We found a shortfall in the recording and monitoring for one person who had developed a pressure ulcer on 2 June 2017. The follow up records were not consistent in that the review records from July until 9 October 2017 noted the person continued to be at risk of developing pressure ulcers, but that their pressure ulcer had healed. The record entry dated 24 October 2017 stated the person, whose condition had deteriorated, had been referred to the tissue viability service because they had a significant pressure ulcer. The summary guidance for care staff noted to, 'maintain skin integrity' at the time the person had a pressure ulcer. We also found the records for this person had not been fully updated to reflect their change of condition. In addition their dietary intake record had not been updated to reflect they were not eating the textured diet they were recorded as requiring in their plan. We brought this to the attention of senior nursing staff, the registered manager and the support manager. The person's care plan was updated before the end of our visit.

We found records that indicated staff had not acknowledged previous entries. For example, in one care plan it was recorded the person preferred female care staff, but on the following page it was recorded the person had no preferences to the gender of staff supporting their personal care needs. In another person's care plan it had been recorded they could 'at times become confused, causing her to become agitated and physically abusive'. The guidance for staff was limited to 'ensure her safety, then leave and return when she is more settled'. There was nothing recorded to indicate that staff had identified any causes for the agitation or any details of support measures that could be used to help relieve the agitation.

We saw and heard that one person called out over a long period of time. When we looked at the care plan for this person, it had been recorded they were unable to communicate. Later in the plan it stated 'Can communicate with others if they speak up' which contradicted the previous entry. There was no guidance for staff about the circumstances in which they called out or if there were any support measures in place.

The lack of accurate and up to date records was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Other care plans we looked at were written in a personalised way and identified the likes, dislikes, preferences, choices and abilities of people. They included how people liked to be supported to get up, at what time, where they usually spent the day and clothing preferences. The plans provided details about the equipment used to support each person. For example, 'Needs to be hoisted for all transfers. Uses an Oxford hoist and a medium sling.'

The care plan for a person with Parkinsons included information such as the importance of the person

receiving their medicines on time to ensure maximum effect, encouraging the person to maintain as much independence as possible and to avoid rushing them. The same person experienced episodes of low blood pressure when standing and the plan guided staff to encourage the person to change their position slowly to reduce dizziness. The care plan for a person with diabetes provided details of the signs and symptoms of low blood sugar levels and there was guidance for staff about the actions they needed to take to respond to the person's needs at such times.

People we spoke with told us they felt involved in their care planning. Comments included, "I choose clothes from my wardrobe, and shower every three days" and, "I am not sure about reviews but get the chance to talk about my care." We saw that relatives were involved, informed of changes and invited to care review meetings.

The staff we spoke with told us they referred to the care plans when they knew there were changes in a person's condition. They told us they obtained their day to day updates from the handover meetings held at shift changeovers. Registered nurses also completed 'RN accountability daily checklists that provided reminders of checks they were required to complete. These included checking of fluid and food charts, bed rails, pressure relief mattresses, MAR sheets, incident and accident records. This was to make sure all records had been fully completed. For example, the record we looked at confirmed one person's pressure relief mattress was not working properly at 7.30am. The records stated the maintenance staff had completed a repair by 8am. Additional comments were recorded that noted people who were unwell, had been visited by the GP, other health professionals had visited, staff sickness and other information that would be useful for the on-coming shift to be aware of. The checklists were reviewed by the registered manager each day.

During our inspection we saw activities were provided. We spoke with the activity staff and discussed the activity programme for the next three months. This included a 'round the world' theme, starting with India and ending the year with a staff Christmas production of the royal variety show. One of the lounges had been decorated with a 'Taj Mahal' theme. The local primary school had been invited to join in the Christmas festivities and attend a carol concert. A list of daily events was provided and distributed to people in their rooms.

Records called 'engagement booklets' were located in people's rooms These provided detail about people's interests and preferences. Social interactions and activities people had participated in were recorded. During our visit, the hairdresser visited. There was a lot of friendly banter between people, staff and the two hairdressing staff. The visit was a social activity that was clearly enjoyed by the people who participated and had their hair done. One person enjoyed a day out to visit their local football team ground. They wore the team supporter's hat and scarf. We saw the staff appeared as excited for the person who was going out. When they returned, again, the staff were interested to know how the outing had been and if the person, who needed support with their communication, had a good day. Whilst we were nearby the person smiled and gave a 'thumbs up' sign.

A complaints procedure was in place and was readily available to people and their relatives. A recently introduced 'We value you opinion' had been distributed. This included information about complaints, compliments, suggestions, whistleblowing and duty of candour. We looked at the complaints file and saw that complaints were now managed in accordance with the provider's policy. On the first day of our visit, we heard a person making a complaint to a member of staff. We checked later in the day and the complaint had been forward to the registered manager who confirmed the actions they were taking to address the issues raised.

Requires Improvement

Is the service well-led?

Our findings

When we visited St Georges Care Home on 6 and 7 January 2017 we found audits had been undertaken but had not identified the multiple failings found at the inspection. At this visit we found improvements had been made. However, we continued to find shortfalls as reported on in the safe and responsive sections of this report. For example, whilst we found improvements in medicines management, shortfalls continued and the provider was not following their own policy with regard to PRN protocols. This had not been identified in the provider's internal medicine audit checks. We found incomplete recording and monitoring of a person's pressure ulcer. The RN accountability daily checklist and the provider's monthly audits had not identified the shortfalls we found. We found the auditing and checking systems had not identified the additional shortfalls we reported on in the responsive section of this report.

We found further improvements were needed to comply with the legal requirements and to make sure the changes that had been made were embedded consistently throughout the home.

The above was a breach of Regulation 17 Health and social Care Act 2008 (Regulation Activities) Regulations 2014.

We acknowledge in this report that the home was 59% occupied at the time of our visit. The provider must ensure when they increase the numbers of people living in the home, they are sufficiently resourced to manage the changes.

We received positive feedback from people and relatives about the current management arrangements, with feedback including, "He seems really nice, hope he'll stay."

People and relatives told us they still had concerns because there had been so many changes. They were concerned the current management arrangements may change again. We received several comments and feedback from people about the 'differences' when the registered manager or the support manager were not in the home. In addition to the comment we have reported on in the 'safe' section of the report, a relative commented they 'rarely' saw the management team when they visited late afternoon and at weekends. Another relative told us they "Really don't know where you stand at any one time. Problem is, there hasn't been stability." We received feedback from one person that, "There is resentment between the two floors." This was a concern we identified at our previous visit. Our observations during this visit showed there were improvements and staff worked more effectively as a team. We did not identify specific areas of concern relating to the 'upstairs/downstairs' divide we had identified during our last visit.

The registered manager had planned and diarised meetings with people using the service and separate meetings with relatives. Feedback had been obtained and an action plan agreed in July 2017. The actions included improvements to safety, cleanliness, food and drink, home décor, and being treated with respect and dignity. Updates were being obtained at planned meetings.

The provider told us in their PIR how they planned to further strengthen the management team in the home.

They had replaced the deputy manager role and had employed two clinical lead registered nurse roles, one for day and one for night duty. From the feedback we received from people using the service and relatives, the benefits of these recently introduced roles had not yet been fully recognised.

During the inspection we checked progress against the provider's action plan. This had been completed in response to the issues identified and the breaches of regulation from the last inspection. We had received updates each month since the last inspection. The action plan confirmed the actions taken and the progress being made with the changes and improvements. In addition a range of audits and monitoring checks were completed by the management team.

The registered manager also identified and acted on issues they identified during their daily walk around the home. They told us they had taken action to make sure staff adhered to the code of dress policy. They told us this had now become 'self-policing', as they had intended, through peer pressure. They told us they were pleased that staff would now remind one another if their colleagues were not conforming to the dress code, and for example, were wearing inappropriate jewellery or painted finger nails.

Staff had the opportunity to express their views and regular staff meetings were held. We looked at the minutes from a series of meetings held in September 2017. Topics for discussion included completion of monitoring records, infection control, learning and development, use of peoples preferred names and improvements to the evening meal service. The meeting record also confirmed the provider's plan to complete the redecoration programme for all communal areas.

At a meeting held with the registered nurse team, the registered manager confirmed, 'the nursing role is a leadership role within the home' and 'the nurse in charge should direct and check on the care given and ensure that work is completed to a satisfactory standard.'

The staff we spoke with were more positive and told us they were better supported and provided with direction and guidance. They told us there was a clearer understanding of their roles and responsibilities and of the provider's vision and values for the home. We saw registered nurses providing direction and guidance to staff during our visit. Staff feedback was also sought in annual surveys and we looked at the feedback from the survey completed in April 2017. An action plan had been agreed that included a refurbishment programme and more effective management of staff sickness.

The registered manager held a daily heads of department meeting where they obtained updates from the maintenance, catering, administration, housekeeping and laundry, activities and care teams. The daily accountability handover sheets completed by the registered nurses were also discussed at this meeting.

Comments from staff included, "It feels better now. The management team are fair, organised and get things done. Morale is much better" "[Registered manager] is strict but fair which is good. He knows what he's doing and will tell you" "I trust [registered manager] and feel I can discuss any concerns or ask for advice and know what we discuss in the office stays in the office." A recently employed member of staff said, "I've learnt so much from other staff and the registered nurses and we all work really well as a team."

The registered manager was able to tell us how they kept up to date with current practice. They also told us they were provided with information and guidance from the provider.

The manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate up to date records were not always maintained. Quality assurance systems were not fully effective and did not always identify shortfalls in care provision.