St George's (Liverpool) Limited

St George's Care Homes

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

St George's Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The home provides accommodation for people who require nursing or personal care. The home can accommodate up to 60 people. At the time of our inspection, there were 32 people living in the home.

There was no registered manager in post 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 our last inspection in January 2018, the home was rated inadequate. This was because the provider had breached multiple health and social care regulations which placed people at significant risk of harm. We undertook this visit because we had received information that people continued to be placed at significant risk because the service remained unsafe and poorly led. This type of inspection is called a focused inspection and this report will only cover our findings in relation to the domains of safe and well-led.

At our last inspection people's needs and risks had not been properly assessed and managed. Information in relation to people's care was confusing, contradictory and difficult to follow. At this inspection additional information had been added to people's care plans but the information about their needs and risks was still insufficient and contradictory. People's information was stored in two, sometimes three different places and records did not always correspond with each other or match professional advice given in respect of people's care. This placed people at risk of unsafe and inappropriate support.

For example, one person's care records indicated that they had pressure sores on their body. There was no adequate wound care assessment in place or clear information about the clinical care they required in respect of these wounds. Wound management is a basic aspect of good nursing care.

Nutritional information about people's special dietary requirements was unclear. Some people's records identified that they needed a specific diet to maintain their well-being or to prevent them from choking. Catering staff did not always have accurate information about these needs to ensure people received the diet they needed. This placed people at risk of harm.

The management of medication continued to be unsafe. One person's records indicated that on an almost daily basis they had received too much of their medication and that the required time period between doses had not always been adhered to. Records relating to prescribed creams and other topical medications were inconsistent and did not show that people received the medicines they needed to maintain their skin integrity.

At the last inspection, accidents and incidents were occurring frequently and had not been appropriately reported. At this inspection, accidents and incidents were not being properly recorded or audited by the provider and it was difficult to ascertain the true number of accident and incidents that had occurred since the last inspection. This lack of adequate monitoring placed people at risk of continued accidents and incidents of the same nature.

We did not hear call bells ringing for long periods of time during our visit which would suggest that people's needs were being met by sufficient staff. We observed however that at times a visible staff presence was sparse and some people who needed one to one support did not have this support at all times. We also found that there were gaps in people's care records which indicated they did not always receive the care they needed. A staff member told us that there were not enough staff on duty to be able to complete all of the tasks required of them each shift. At the last inspection the number of staff on duty was insufficient and the provider had no effective method of determining what safe staffing levels should be. At this inspection, we saw that the number of staff on duty had been determined by the using a dependency tool designed to calculate safe staffing levels. We found however that the tool was meaningless as there was insufficient detail as to how staffing levels had been worked out.

At the last inspection a significant number of safeguarding incidents had not been appropriately identified, investigated and reported. At this inspection we found no improvements had been made. Safeguarding records were extremely poor and did not match what had been reported to the Local Authority or CQC. In addition, a number of safeguarding incidents had been logged by the provider but there were no records for the majority of these incidents to show that they had been investigated or responded to in a robust way. We found that the provider continued to fail in their duty to protect vulnerable people from potential abuse.

Records showed staff were not always recruited or managed in a robust way. One staff member had been recruited recently to work at the home, but their previous employment background was unclear and appropriate references had not been sought. We also saw that appropriate disciplinary and safeguarding procedures had not been followed in relation to another member of staff. This meant the provider did not have robust procedures in place to ensure that the staff employed were safe, suitable and fit to work with vulnerable people.

The service was not well-led. The provider's audits and oversight of the service continued to be inadequate. The audits in place failed to identify continued concerns with risk assessment and care management, medication, safeguarding, accidents and incidents, staff recruitment and management and staffing levels. In discussions with the provider they failed to show that they were accountable for the service or that they had the knowledge and the competency to ensure the service was safe and well-led. During discussions we found that the provider failed to recognise the gravity of our concerns or the serious impact this could have on people's health, safety and welfare.

The overall rating for this provider remains 'Inadequate'. This means it will remain in 'Special measures' by CQC and will be closely monitored by CQC in accordance with our enforcement powers.

The purpose of special measures is to:

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

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The assessment and management of people's risks remained poor and did not protect people from avoidable harm.

Safeguarding allegations were not always properly documented, investigated, reported or responded to by the provider.

Staff recruitment was not always robust and procedures were not always followed.

Staffing levels were not always sufficient and people who had one to one support needs did not always receive this support.

The management of medication was not safe as people's medicines were not given as prescribed. This placed people at risk of harm.

Is the service well-led?

Inadequate

The service was not well led.

The provider continued to fail in their duty to provide safe and well-led care.

The quality assurance systems in place failed to identify serious concerns with the service and people's care.

The provider failed to demonstrate the competency or responsibility to improve the service so that people's health, safety and welfare was protected.

St George's Care Homes

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 20 February 2018. Prior to our visit we received information from different sources that raised concerns about the service. These concerns alleged poor staffing levels and staff management, unsafe medication administration, inadequate clinical care, poor nutritional care and food hygiene standards and lack of adherence to adequate fire safety arrangements. We undertook an urgent and responsive inspection due to these concerns. The inspection was unannounced and carried out by two adult social care inspectors. The inspection focused on the domains of safe and well-led.

During the inspection we spoke briefly with two people who lived at the home, a nurse, a senior care assistant, a health and social care professional and the provider.

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

During the visit we observed people's day to day care.

Inadequate

Is the service safe?

Our findings

At our last inspection in January 2018, we found that the safety of the service was inadequate. The provider had breached regulations 12 (safe and appropriate care), 13 (safeguarding of vulnerable adults) and 18 (safe staffing levels) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At the last inspection there was no registered manager in post. The provider employed a consultant to drive up improvements at the home. At this inspection, there continued to be no registered manager in post and we found the breaches we had identified previously remained. Due to pre-arranged annual leave the consultant was not able to participate in this inspection but the provider was present.

We looked at five people's care files and a sample of daily records. We saw that the assessment of people's risks and the plans in place to advise staff how to mitigate these risks remained poor. People's daily care charts continued to show that care and treatment was inconsistent and that people did not always receive the care and support they needed.

For example, one person had specialised dietary requirements that required them to have their nutrition and hydration needs met via a peg tube. PEG stands for percutaneous endoscopic gastrostomy. A PEG is a thin tube through which is inserted through the skin into the stomach through which nutrition, fluids and medication can be passed through. A PEG is usually used for people who are at risk of choking or who are at risk of food and drink 'going the wrong way' and passing into their lungs causing aspiration pneumonia.

We checked the advice given to staff with regards to the management of this person's PEG and saw that there were four different care plans in place. The information across the four care plans was confusing and did not always correspond. For instance, one care plan stated that a dietician had advised that the person was to be given 100mls of cooled boiled water pre and post medication but a second care plan with the same date stated that the person was to receive 500mls of cooled boiled water pre and post medication. This did not make sense. Furthermore a document provided by the dietetic department of the local NHS trust contradicted both of these care plans, stating 60mls should be given.

One person's skin integrity care plan specified that they had a mixture of pressure sores and moisture lesions on their skin. We found that this person's wounds had not been assessed properly and the care the person required with regards to the dressing and management of these wounds had not been properly documented for staff to follow. We saw that a tissue viability management audit in January 2018 had stated that the wounds were to be measured, dated and photographed to enable clinical staff to monitor the progress of the wounds and to assess whether the wound care provided was effective. This had not been done at the time of our visit. This meant it was not possible to accurately assess the effectiveness of this person's wound care.

One person's records showed that they had lost five kilograms (10% of their bodyweight) between December 2017 and January 2018. There was little evidence that any action had been taken to investigate this for example by referral to a dietician and there was no evidence that any food charts had been put into place to monitor the person's dietary intake to ensure it was sufficient. When we asked the provider and

senior care assistant about the person's weight loss they were unable to provide an explanation.

We saw that this person's fluid intake was monitored. Their drinks were recorded on a medication administration chart. When we checked these records we saw that the person sometimes went without access to a drink for significant periods of time. For example, on 16 February 2018, the person last drink was recorded as being given at 1pm until the next drink was given at 8am the next morning. On the 19 February 2018, the last drink was recorded as being given at 5pm, until 8:50am the next morning. This meant that at times, the person's records indicated they went without access to a drink for over 12 hours.

In the morning and afternoon of our visit, we checked this person and found them sat in their bed alone and in their underwear. In the afternoon they smelt strongly of faeces and we had to ask for staff assistance. We found no evidence or explanation to justify why the person had been left in bed all day in their underwear. The person's medication administration charts advised staff to apply barrier cream each time they supported the person's continence needs to mitigate risks to their skin integrity. We looked at this information and found the application of barrier cream to be inconsistent. The information recorded did not show that the person was supported appropriately with their continence needs and corresponding skin care. For example, one some days, the person was assisted with their continence needs and skin care every two hours, on other days it was every four hours and on one occasion records showed that the person did not have support for over 12 hours.

These incidences were a continued breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed.

During the morning of our visit, a healthcare professional visited to review a person's care. Shortly after they arrived they reported to inspectors that they had found the person without their one to one support from staff. This placed the person at risk of harm. In the afternoon of our visit we went to check on this person again and found they were without their one to one support for a second time that day. We spoke with a staff member about this who told us that the person did not always receive one to one support. They said that the comfort and lunch breaks undertaken by one to one support staff were not covered by other staff members. This meant the person was at risk of being left without adequate support.

A staff member told us that there were not enough staff on duty to meet people's needs. Since the last inspection a dependency tool had been put into place by the consultant to determine safe staffing levels. A dependency analysis is a tool used to determine staffing levels based on people's needs and risks. We looked at the dependency tool in use and saw that it failed to show how information on people's needs and risks had been used to do this. The consultant was not available during our visit as they were on annual leave and no-one else at the home understood how the dependency tool worked. This meant it was difficult to tell if the number of staff on duty was sufficient.

During our visit, we did not hear people's call bells ringing for long periods of time to indicate people's needs were not being met. It was clear however that some people did not have the capacity to use their call bell to call for help and other factors such as the significant gaps and inconsistencies in people's care records suggested that what the staff member had told us in respect of the number of staff on duty was correct.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider was not able to demonstrate that sufficient staff were on duty at all times to ensure people's needs were met.

At the last inspection, we found significant concerns with the way the provider had identified and responded to incidents of potential abuse. During this visit, similar concerns were found. Prior to our visit the local authority advised CQC that there were currently 17 open safeguarding investigations underway at the service but when we visited, the provider was only able to locate records relating to two of these incidents. This did demonstrate that robust processes and procedures were in place to identify, document and respond to incidents of potential abuse.

We reviewed the records relating to one of the incidents that the provider had records for. We found that these records were incomplete and did not demonstrate that adequate action had been taken to protect people from the risk of abuse in accordance with local safeguarding procedures. We asked the provider about this and they were unable to tell us what action had been taken. We asked them to investigate and respond to the allegation of abuse immediately and to report to CQC what action they had taken by 10am the next day. The provider failed to do this and had to be re-contacted to remind them of their legal responsibility to follow safeguarding procedures.

Three days after the inspection, we were told by the provider that some of the records relating to this safeguarding incident had been found but they said they were still unable to find all of the records. They submitted the records they did have to the Commission later the same day. We reviewed the records and did not find the outcome of the investigation to be robust. The investigator's name had not been cited on the report and the investigation report had not been dated. This meant it was impossible to know who had undertaken the investigation and whether they had the skills and competency to do so.

This evidence demonstrates a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have robust procedures and processes in place to prevent and protect people from the risk of abuse.

We looked at the arrangements in place for the safe management of medication. We found that some people's medication was not given in a safe way. For example, one person was prescribed a medication designed to prevent and treat long term chest pain. The person's records indicated that they received double the prescribed dose of this medication on a regular basis. This was extremely unsafe and placed the person at risk of an overdose.

This person was also prescribed an anti-inflammatory gel and a strong pain killer for pain relief. These medicines need to be given at specific times in order to work properly and to avoid unwanted and potentially dangerous side effects. The person's anti-inflammatory gel was to be given at intervals of not less than every four hours. On the 20 February 2018, records showed that this person's gel had been applied 23 out of 46 times (50% of the time) without a four hour interval in between applications. The person's prescribed dose of pain relief medication was to be given at intervals of not less than 12 hours in between doses. Throughout February 2018, this 12 hour interval between doses had only been adhered to once. This placed the person at risk of unwanted side effects. When we checked this person's stock of medication we also found that they had anti-histamine medication that was not listed on their medication administration records. There were only five out of 30 antihistamine tablets left but despite this no records had been kept to show when it had been administered and by whom. After our inspection we referred this person's care to the Local Authority safeguarding team for further investigation.

We saw that some of the people who lived at the home had medication administration charts in place for the application and use of prescribed creams, ointments and other external preparations. We found that there was little or no information in the person's care records or medication administration records for staff to follow in order to ensure these products were applied correctly. For instance there was no information on

where or how the creams were to be applied. When we checked people's records we saw that the application of these creams was often inconsistent and irregular.

A number of people who lived at the home required a prescribed thickening agent to be added to their drinks to help prevent them from choking or aspirating. At the last inspection there was an insufficient stock of thickener in the home. At this inspection we could see that everyone who needed this medication had it in place. Some of the information in relation to the use of thickening agents however was still unclear. For example, some people's records specified that they only needed thickening agents to be added to their drinks when they became 'unwell' but it was unclear what type of illness would warrant the use of thickening agents and the methods by which staff were to assess that they were needed. There was also no guidance with regards to whom on the staff team was authorised to make this decision on the person's behalf. This meant there was a risk that people's thickening agents would not be used appropriately.

These incidences demonstrate the way in which some of the medication was stored, administered and recorded was not safe. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that since our last visit the provider had painted the first floor of the home in pleasant colours. This brightened up the environment in which people lived but when we walked around the building, we still found that parts of the building were in need of repair or were unclean.

For example, one bedroom on the first floor and the communal dining room still had duct tape on various parts of the floor where it had split. Some of the windows in the home were still obscured with condensation which meant that people were unable to see out of them. Three of the communal toilets contained faeces and had not been flushed and one of the toilet seats also had faeces on. The radiator covers in one bathroom and one toilet which were designed to protect people from the risk of a burning themselves were loose and a handle on the sink tap was missing. In one person's bedroom, their pressure cushion was ripped exposing the foam innards, which meant that cleaning it for infection control purposes would have been difficult.

The home's kitchen and food hygiene standards were inspected by environmental health in February 2017 and received a rating of two out of five. A score of two meant that food hygiene standards required improvement. Records showed that the service also received a rating of two in a subsequent environmental health visit in September 2017. This demonstrated that the recommendations made by the Environmental Health Officer at the February 2017 visit had not been acted upon in full to ensure that improvements were made to food hygiene standards. Since our last inspection, the cook had left the employment of the provider and a care assistant was managing the preparation of people's meals.

These incidences were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as parts of the premises required repair and were unclean.

We looked at four staff files. We found that staff recruitment and the provider's on-going review of the fitness and suitability of staff members was not always robust. For example, one staff member was recruited without adequate previous employer references being obtained. The person had worked for the provider before. Instead of seeking a reference from the person's last employer, the provider had relied on a reference from an internal referee. This meant that the provider had not ensured an objective employer based reference was sought to ensure the person remained suitable to work in the home before they were re-employed.

Another member of staff had been involved in several safeguarding investigations. Despite the provider commencing disciplinary proceedings, these proceedings were not completed appropriately and the person was not referred to the disclosure and barring service (DBS) or the nursing and midwifery council (NMC) for further investigation. This meant that the provider failed to have robust systems in place to respond to concerns about a person's fitness to practice and work with vulnerable people. They also failed to inform other regulatory bodies of these concerns in order to ensure this person's fitness to practice was properly re-assessed.

These examples were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have robust recruitment procedures that ensured staff members were safe and suitable to work with vulnerable people.

Inadequate

Is the service well-led?

Our findings

At our last visit to the service in January 2018, we identified that the service did not have adequate governance arrangements in place to ensure that the service was well-led. This was a breach of Regulation 17 of the Health and Social Care Act. At this inspection we found that the provider had failed to take the necessary action to address this and the service continued to be poorly led. This meant there was a continued breach of Regulation 17 of the Health and Social Care Act.

At this inspection, there was no registered manager in post but the provider told us they were in the process of recruiting. Whilst recruiting for a new manager, the provider had employed a consultant to work at the home to drive up improvements. At the time of this visit, there was little evidence that the service had improved or that the concerns identified at the previous inspection had been addressed.

At this inspection concerns were identified again with the accuracy and completeness of people's care records. This was because some of the information was confusing and contradictory which made it difficult to follow. This meant there was a risk that staff would not fully understand and deliver the care and treatment some people needed. The gaps and inconsistencies in people's daily care records indicated they did not always receive the care they needed. These concerns were identified at the last inspection and again at this inspection. This did not demonstrate that the provider had taken immediate and effective action to address this. This meant that the delivery of care continued to be poorly led.

There were still no adequate systems in place to identify and respond to incidents of a safeguarding nature. There was no analysis of safeguarding events to enable trends in the type of safeguarding incidents to be picked up and addressed. Records showed that the governance arrangements in place for safeguarding incidents failed to be effective in mitigating risks to people's safety. This meant the way in which the provider protected people from potential harm continued to be ineffective and poorly led.

There was limited evidence that accidents and incidents information was used to enable staff to learn from and prevent accidents and incidents from re-occurring. The record keeping system in place to record accidents and incidents was inaccurate. This was because the provider's paper based accident records did not match the electronic records held on the provider's computer system. This meant that the recording and mitigation of the risks associated with accidents and incidents continued to be ineffective and poorly led.

The governance systems in place to ensure the management of medication was safe were ineffective. For instance, the systems in place had not identified that some people were receiving too much of their medication or that some staff members were not abiding by the manufacturer's instructions when administering the medication. They had also not picked up that staff lacked sufficient guidance on when and how to administer 'as and when required' medication or that people's topical medications were applied irregularly. This meant that the system in place to manage and mitigate the risks associated with medication management continued to be ineffective and poorly led.

The governance arrangements in place to ensure the premises were safe, suitable and clean remained ineffective. This was because although some improvements had been made to the décor, a full programme of improvements had not been achieved. Areas of the home were still unclean, the kitchen's rating had not been improved upon and parts of the home were still in need of repair.

We spoke with the provider at the end of our inspection. We explained that we still had serious and significant concerns about the service and people's care. During these discussions, it became evident that the provider had limited knowledge of the way people's care was delivered and the gravity of the concerns we had about people's health and well-being. It was concerning that despite the provider having met with both CQC and the Local Authority after the last inspection, wherein the concerns about the service were discussed in detail, the provider had still not taken any effective or proactive action to address these concerns. We found that this lack of proactivity to improve the service was reflected once again at this inspection. The provider did not appear to understand that the service was unsafe or poorly led and did not demonstrate the knowledge, competence or commitment to improve the service in a timely manner to protect people from avoidable harm.

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