

Georgian House (Torquay) Limited

Georgian House

Inspection report

Park Hill Road, Torquay
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Ratings

Overall rating for this service

Requires Improvement



Is the service safe?

Requires Improvement



Is the service effective?

Requires Improvement



Is the service caring?

Requires Improvement



Is the service responsive?

Good



Is the service well-led?

Requires Improvement



Overall summary

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

The inspection was unannounced. We last inspected the service on the 29 July 2013. We raised no concerns at the time.

Georgian House is run by Georgian House (Torquay) Limited. The home is registered to provide care for up to 43 people. It is also registered to provide care for people

in their own homes. The provider stated this service was developed to provide care for people in the community when they no longer required the residential service. This was referred to as 'the step down service' during the inspection. The step down service was supporting one person in the community but this service was not providing any personal care that would require CQC to inspect it. It was not possible therefore to inspect this part of the service.

On the first day of the inspection, there were 36 people resident in the home. On the second day there were 37 people. People in the home had a number of complex needs. They were of differing ages commissioned by both

Summary of findings

younger and older adult social care services. Several people in the home had a diagnosis of multiple issues. For example, some people had a single or a mixed diagnosis of dementia and/or mental health.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Prior to the inspection, concerns were raised about how the home ensured there were enough staff, with the right expertise, to meet the complex needs of the people living in the home. The provider demonstrated they used a local formula to assess they had the right number of staff. Records relating to giving medicines covertly (without the person's knowledge) were not robust, which meant there was a risk they were no longer appropriate. We also found the arrangements about when and how people received "when required" medicines had not ensured they received them when needed.

The majority of staff were caring however at one lunchtime we observed some staff to be less so. Some people were not having their nutritional requirements met because they had not received the correct support or had their food prepared in line with their assessed needs.

People told us they felt safe at the home and felt they were well cared for. They could access their GP when they wanted and felt able to discuss any concerns with staff. There were detailed records about people based on their history, likes and dislikes to ensure staff had the information they needed to care for people appropriately. Staff were also well trained and supported to help understand and meet people's needs.

An appropriate complaints procedure was in place and people told us they would be happy to raise any concerns if necessary and felt confident they would be dealt with.

We found Breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the end of the full version of the report.

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 not safe.

Medicines were being offered covertly without up to date permission. Systems were not in place to ensure people were offered their 'when required' PRN medicines.

The home was aware of their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, MCA assessments were not always current or up to date which meant there was a risk people might be cared for inappropriately.

People told us they felt safe. Staffing numbers were assessed using a locally agreed formula. Staff demonstrated a good understanding of identifying and reporting concerns. The premises and use of equipment were safe.

Requires Improvement



Is the service effective?

The home was not effective. Some people's nutritional needs were not being met in line with their assessment and care plans. The right information about nutritional needs, likes and dislikes had not been shared with the kitchen staff.

The range of training staff received meant people's needs could be met appropriately.

People's general health care needs were met. People could see their chosen medical professional when needed.

Requires Improvement



Is the service caring?

The home was not always caring. Although staff demonstrated good examples of caring and people felt staff were caring, we also saw some poor care practices particularly around lunchtime.

The home had good end of life care processes to support people and families at this time.

Requires Improvement



Is the service responsive?

The home was responsive. People were supported by care plans based on their needs. People and families were involved in this process and saying what was important to them.

Staff were provided with information to help respond to people's changing needs.

The home had a complaints policy in place. People told us their concerns were responded to.

Good



Summary of findings

Is the service well-led?

The home was not well-led.

Although the home had a system in place of governance and leadership and audits to ensure the quality of the service, we found it was not effective. This system had not identified the concerns we found on the inspection

Requires Improvement



Georgian House

Detailed findings

Background to this inspection

The inspection of Georgian House was completed over two days on the 17 and 18 July 2014. There was an inspector and an expert by experience on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case, their experience was of residential services. On the second day another inspector joined the inspection.

Prior to the inspection we contacted a range of professionals who had direct involvement and knowledge of the home. This included GP surgeries, social workers, mental health practitioners and a Physiotherapist. In all, we contacted five GP surgeries and 17 other professionals. We received feedback from GP and social workers. The professionals we contacted before the inspection were complimentary about the home. Where there was a concern raised about the range of need and whether there were enough staff available to meet their needs, we reviewed this on inspection.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR was information given to us by the provider. This enabled us to ensure we were addressing potential areas of concern. In this case the provider was asked for information only on their community based step down service. As this service was dormant we could not inspect it.

During the inspection we spoke with 11 people who lived in the home, one relative and eight staff. Several people were unable to speak with us. We observed how care was given and we used the Short Observational Framework for Inspection (SOFI) on the second day at lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also read information held by the home on people's care. We spoke with one visitor. We read information about seven people to follow their care in more detail. We call this 'pathway tracking' this means we read all the information held on a person and then reviewed whether the care they received matched what was planned. Where we could we spoke with these people and observed their care.

We read documentation held by the provider in relation to the safe recruitment, training and supervision of staff; policies and procedures and complaints.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Is the service safe?

Our findings

We asked the manager what their assessment process was to ensure they had enough staff on duty with the right skills to meet people's needs. The provider advised us they used a locally agreed formula to assess the number of staff required to meet people's needs. Also, they stated "We use our extensive and practical knowledge through our long years of experience also tells us what a client needs". They added staffing numbers were then adjusted according to need and what staff said was needed. For example, extra staff had been introduced at breakfast as staff stated more help was required. There were also different staff employed to carry out the role of activity worker. The provider also told us they never used agency staff

We observed there was wide range of need in the home, for example elderly dementia, mental health, autism spectrum and physical disabilities. Prior to the inspection health and social care professionals raised a concern with us about whether the service had enough staff to meet the range of need. People in the home did not have a specific view about staffing levels but staff had mixed views. Most staff felt there were enough staff to support people to go out on activities or to appointments. However some staff also commented that it would be helpful to have additional staff at certain times, for example, in the mornings. The provider responded to these concerns by stating that shifts are always covered when staff are absent. If staff are unable to provide cover, management will provide cover as necessary.

The home was aware of their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

Staff told us they had been trained in the MCA and demonstrated they understood what this meant for people living in the home. One member of staff told us: "Always got to give people a choice" and another said "They have just

as much right to make a decision as everyone else". Staff told us they would try to seek consent while giving day to day care. Where people were unable to give direct consent staff told us they would use methods such as reading people's non-verbal communication. For example, reading people's facial expressions. MCA Assessments were on people's records but were in a process of transition from the paper to electronic system. . The registered manager and provider told us people's MCA assessments were being updated during the transfer of records to the new system. .

People confirmed they received their medicines at the correct time and repeat prescriptions were ordered as necessary. Although staff had received training in the safe administration of medicines, we noted in people's records some concerns about how people received them. For example, some people were subject to covert medicine administration. This meant some people were receiving medicines without their consent and knowledge. We saw that in most cases permission had been given by their prescribing medical professional, however, this had not been reviewed regularly. For example, one person's records showed that permission to give medicines covertly was last given in June 2011 and therefore the person's needs might have changed during the following three years. This meant this person could be receiving their medicines inappropriately.

We also found people were not having their 'as needed' (PRN) medicines offered routinely. We were told one person was not being offered their PRN medicine because they would take all medicines offered and 'over medicate'. There was no written consent from the prescriber or information in the risk assessment or any other documentation to indicate this approach was appropriate. We were told staff would use their knowledge of the person to judge if it was needed. This knowledge would generally be based on people demonstrating negative behaviours. We were told the staff did not use any form of pain measurement scale to assess people who could not verbalise their level of pain. This meant people could be experiencing pain before medication relief was given.

One person's care plan stated they were provided with a behaviour control medicine that was PRN. This was to be administered in the case of their 'showing aggression to staff'. There was no other guidance for staff to ensure the administration of this medicine was appropriate and what other methods staff should use first before giving

Is the service safe?

medication. For example, there was no guidance on trigger factors, trying distraction techniques, or finding out if the person was in pain. The care plan did not state who could or could not give the medicine, how this should be recorded and if a mental health practitioner or GP, should be notified if this medicine was required. This meant this person was at risk of being medicated inappropriately. The evidence relating to medicines demonstrates inappropriate arrangements for their management. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, , which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at the home. Some added the staff ensured they were safe. One person told us they were content that the staff trusted them when they went out on their own. They told us they were free to come and go as they wanted to. Staff expressed their commitment to keeping people safe. Staff demonstrated they understood

how to recognise abuse and how they would raise a concern. They told us they would raise their concerns with a senior carer or head of care. Staff felt action would be taken to keep people safe. They stated they would whistleblow on any poor practice if required.

We saw staff were employed through a formal recruitment process. Their backgrounds were checked to ensure they were safe to work with vulnerable people. Staff underwent a formal induction process which included opportunities to be shadowed by experienced staff. Following a probationary period, their suitability would be reviewed. This meant people were cared for by staff suitable for the role.

The equipment people used was kept in good working order and was tested to ensure it remained safe. People's safety in the event of a fire was assured through regular fire safety checks and appropriate evacuation procedures.

Is the service effective?

Our findings

We observed lunchtime in the dining room on both days. On the first day the lunchtime period was two hours long. Some people began to demonstrate anxiety related behaviours. The dining room was crowded and noisy. We were told by the provider more people chose to come to the dining room that day than normal. One person told us: "You always have to wait a long time between courses." When the food arrived it was already plated up. However we observed a member of staff ask people which of the two fish dishes they would like. This was the only occasion when a choice was offered. People confirmed to us they were not told what was on the menu or asked in advance what they would like to eat. On the second day we observed people were asked for their choices.

The majority of people told us they were happy with the food. All said they received ample food and drink and some people were aware they could request evening snacks. No one could recall being asked what their favourite meal was. People confirmed that if they were out at a mealtime, provision was made for a meal when they returned. This was cooked from scratch. There was a choice of a second, smaller cooked meal or sandwiches available in the early evening. We observed drinks and snacks were offered outside the routine 'drinks rounds'. However we observed people were not receiving their food as stated in their care plan. On the first day, people, who required their food specially prepared to prevent choking, were offered food that was liquidised altogether. There was no distinction between the types of food. This meant liquidised food was not presented in an appetising way. One person's record stated they were to be provided with a 'soft diet'; another stated their food should be 'chopped small' and another stated their food should be 'mashable'. None of these people were provided with the food as described in their care plan. This meant people were not receiving food in a way that met their needs.

One person, who had verbal communication difficulties, was given a large dish of liquidised food placed in front of them. We observed they became distracted as they ate; moving cutlery and the tablecloth. A staff member came along after some time and offered some support however

the person lost interest in the food and ate very little before it was removed by staff. They then ate a small dessert. When we raised a concern with the management we were told this person was at risk due to poor nutritional intake.

One relative told us: 'I feed my husband every lunchtime, but I do not know what happens at breakfast and teatime. The one lunchtime I arrived later than usual he was sat with his food in a mess on his lap.' The registered manager assured the person was being supported at meal times but would keep the situation under review.

We discussed with the chef how they ensured people had their food prepared correctly. We were shown a file that had a number of names of people under the titles of 'liquidised' and 'no sugar'. There was no mention of people's likes and dislikes. Everyone who was unable to eat food normally prepared had their food liquidised regardless of any assessment in place, for example, mashed, forked and chopped small. The direction not to give sugar was applied to people on a reducing diet as well as those with a diagnosis of diabetes. People who required a diabetic diet were not offered a choice. For example, the dessert for people with diabetes was 'fresh fruit' at every meal. We were told by the chef the home did not buy in any specific foods for a diabetic diet. This meant people's choice and nutritional needs to support an adequate diet were not being met. The chef confirmed they relied on the verbal communication of the head of care. The head of care agreed to address this.

The above evidence demonstrates some people were not being offered food that met their need or had the necessary support to eat and drink. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our feedback, on the second day of the inspection, we saw staff asking people what they wanted to eat. People who required support to eat their food were to have a separate sitting to ensure staff could concentrate on their needs. People who required their food prepared so they could swallow it were still having all their food liquidised however, the separate food items were now visible on the plate. People who required a diabetic diet were still not having choice. This meant people continued to be at risk of not having their specific nutritional needs met and were at risk of choking.

Is the service effective?

People told us they felt staff were trained to meet their needs. Comments included: “I think so”, “Staff are quite good” and “I know they go on lots of courses”. Staff told us they had supervision every six to eight weeks. They also told us they felt they were trained appropriately to meet people’s needs. Each member of staff had received standard training in areas such as fire safety; first aid; infection control; manual handling and safeguarding vulnerable adults. Some staff had also attained specialist qualifications in care. Different staff had been trained on topics such as dementia care; challenging behaviour and

palliative/end of life care. There was a system to ensure staff training was updated. One staff member told us: “If we ask for training we get it; management are open to implementing new ways of working”.

People’s general health needs were being met. Everyone said they felt able to discuss health matters with the head of care. Medical appointments were arranged by the care manager or by the resident. People told us they were weighed regularly and could talk about what was concerning them.

Is the service caring?

Our findings

A relative told us most staff were caring however they told there were ongoing problems with their relative's clothes. They stated: "I take everything home to wash and bring in clean clothes every day but my husband is often wearing clothes that are not his and I have seen someone wearing his things. Some of his items have disappeared. I have raised this with the manager without success." We raised this during our inspection and were told this had been given to the new deputy manager to resolve. The family member confirmed this was now being tackled.

We found some staff were not always caring towards people during lunchtime. We observed one member of staff interacted well with people. Humour was evident and appropriate conversations were had, for example, when asking people if they wanted to wear a tabard (that was made of fabric). However we also observed a member of staff place plastic aprons on people without first seeking consent. This member of staff was also heard speaking to people with aggression. For example, to one person, whose emotions had become heightened, they told the person to "sit down" and "stop it, calm down." They also left a person who they had been supporting mid-way through offering the person a spoonful of food. The member of staff did not communicate and left the person with their mouth open. As the time progressed, staff in general failed to notice people who were not coping and had heightened moods. In general, staff did not interact with people to support them in line with their needs. This meant people's emotional needs were not being met at this time. Staff practices were not being monitored effectively despite being told by the head of care that the managers worked alongside staff delivering care, to observe practice.

During the inspection we spent time with both the head of care and head of senior carers. They had a deep knowledge of people's needs. They demonstrated how they 'led by example', how they felt other staff should treat people.

When we discussed our observations in the dining room on the first day, they were upset and described how they intended to carry out observations in this area to review why staff were not acting as they should.

On the second day of the inspection we observed the lunchtime atmosphere and care to be improved. We saw good interaction between staff and people. We did not see any negative moods or interactions. As people came into the dining room staff asked people where they wanted to sit and who they wanted to sit with. Staff worked at a relaxed pace and were respectful of people. Staff supported people to do their own thing and fun was seen to be had by people. Staff demonstrated they knew different individuals, for example, one person was very restless and agitated and staff reassured and comforted them. Staff included people in conversations and staff appeared genuine in their interactions.

Although we found some staff were not always caring, most people told us they felt staff were caring. One person told us: "Absolutely, they do what my needs require". Another stated: "The staff care a lot" and a third: "Yes mostly – there are always one or two who don't". Another told us: "Respect? Yes some of them" and another: "They do their best". People told us they were content that the staff knew them well enough to be aware of their needs, likes and dislikes. Everyone told us they were involved in their care and were asked what they wanted. They felt staff always met their individual needs.

Staff were trained in grief and loss and end of life care. Staff told us there was no one receiving end of life care at that time. The head of care and head of senior carers demonstrated how important they felt it was to support the person and family at that time. They told us family were supported with accommodation, food and their time if required. We saw some people had Treatment and Escalation Plans (TEPs) in place. These had been completed with them or their family and with their GP, as required. This meant staff had thought about how people would want to end their life and had plans in place to manage this, when required.

Is the service responsive?

Our findings

People told us they felt the home would meet their needs as required and said they were supported to express their views. Some explained they were free to come and go as required. This included going on their own to nearby shops. People told us they had frequent conversations about their care with the head of care. Visitors told us they were made to feel welcome. Health and social care professionals told us they felt the home was responsive to people's needs.

Staff told us if they found the person had a need they would speak to the head of care who would ensure this was met. People saw a health professional such as their GP, district nurse, occupational therapist and mental health practitioner as required.

People were assessed before coming to the home by the provider who told us they would ensure they could meet this person's needs. They told us part of the preadmission assessment was to gain as much information as possible from the referring agency. This included risk assessments and care plans. We were told people could be refused at this point if they were unable to meet their needs.

On admission people's care needs were quickly evaluated to ensure they had an initial care plan in place. Their needs were then communicated to staff at the next handover. Staff could then read the initial care plan. People's needs were assessed continually over the next few days. A full care plan would be developed with the person. We reviewed a person who had been admitted to the home as an urgent admission. We saw this person's room had been prepared to make them feel comfortable. Also, time had been spent with them to help them settle in. Staff spent time with the person to develop their initial care plan. We saw that immediate risk assessments had been completed and information gained from the previous carers. This information was passed on to staff taking over their care for

the night and the following morning. We saw from the records staff had checked on them regularly, taken cups of tea and supported them to become familiar with the new home.

People had detailed care plans to ensure care was safe and appropriate. There were sufficient levels of information to ensure staff were able to meet the individual person's needs. There was information about people's histories to enable staff to talk with them about their past. Staff were also given extra important information about how the person liked to live their lives before their health or needs deteriorated. For example, one person was described as a very private person who had little need for health care previously. Staff were given clear guidance on how to support this person with respect and dignity while still meeting their needs.

There was a consistent pattern to how care plans were developed. This meant staff could find the information they required quickly. Each person's care plan was specific to them. People's likes and dislikes were clearly recorded. All care plans were reviewed each year but sooner if required. People had the appropriate risk assessments in place and these were also reviewed regularly. Where people had specific risks these were highlighted in their care plans.

There was a complaint procedure and we saw that on the whole complaints were looked into. People told us they would speak to the head of care if they had a concern. They felt this would be heard and effort made to resolve the concern. A visitor expressed some issues with us when we spoke with them. They agreed we could share this with the management. They stated the new deputy manager had taken on their concerns and was seeking to sort things out for them. We discussed their concerns with the registered manager and new deputy manager. We saw the situation was being looked into.

Is the service well-led?

Our findings

The home told us they sought to ensure the quality of the service through their quality monitoring systems. However these systems had not identified the concerns we found during the inspection. For example, the issue with people's medicines had not been found when they audited the service. The monitoring of care practices, particularly during lunchtime had not identified these concerns. We also found there had been a recommendation in May 2014 that the water temperature was running too hot in one room. There was no record that the recommended action had been completed. There were also places where the floor was observed to be uneven. Both could lead to injury to people. We discussed these concerns with the registered manager and provider and we were assured these would be resolved. However we still had concerns their quality monitoring system were not effective.

The provider had a range of policies that looked at how the home monitored the service and were reviewed by the registered manager annually. The policies were based on the CQC essential standards. To review these, they marked against each essential standard to say if they were compliant or not. The accountability for implementing these policies was delegated to the head of care. We found the policies lacked a person centred approach. For example, there was no detail of how they involved people in the home, staff or relatives, as part of their implementation and review.

The provider and other senior managers had been at the home for a number of years offering consistency of leadership. They aimed to ensure their knowledge and practice was up to date by seeking guidance on best practice from others working in similar fields. People were involved in the service and were asked their views. There

were regular residents meetings. The most recent looked at the menu and what people wanted. They had stated they wanted cream teas and a barbecue and this was being arranged.

People identified that the head of care was in charge when we spoke with them. They also spoke about the provider and their role in the home stating that they saw them daily. They were both described as approachable by people who lived in the home. Staff also identified the head of care as being the person in charge. The inspection team also identified the visible; day to day running of the home was the responsibility of the head of care and the head of senior carers.

We found the head of care and head of senior carers to be very committed to person centred care delivered to the highest standard. They took responsibility for care planning; assessing new people when they came into the home, and meeting their day to day needs. They also played a key role in supervising staff and observing practice. We discussed leadership with the provider and registered manager as we were concerned the service was reliant on these two members of staff. The provider told us they recognised these two people were good in their role and important to the service. We were also told the new deputy manager would take some of the leadership role for care once they had completed their induction.

The head of care told us they were supervised by the registered manager every three months. Both the head of care and the head of senior carers felt the provider and registered manager supported them to carry out their roles fully. Some staff told us that they felt that management did not always know what was happening in the home and that they were not always listened to. However some staff also stated the provider and registered manager were "open to listen" and supportive at a professional and personal level.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines</p> <p>which corresponds to Regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The medication system did not ensure that covert medicine arrangements were reviewed regularly.</p> <p>The arrangement for people's PRN medicines did not ensure people received them appropriately.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs</p> <p>Regulation 14(1)(a)(c)</p> <p>which corresponds to Regulation 14(1)(4)(a)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>The registered person had not made adequate provision to ensure people received food suitable to their nutritional needs and the appropriate support they required during mealtimes.</p>