Caring Homes Healthcare Group Limited

St Georges Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

We carried out a comprehensive inspection of St Georges Care Home on 28, 30 April 2015 and 1 May 2015. Breaches of the legal requirements were found. The breaches related to the care and safety of people using the service, as well as matters relating to staffing and the running of the home.

After the inspection, the provider wrote to us to say what they would do to meet the legal requirements.

We undertook an inspection on 6 and 7 January 2016 to check the provider had followed their plan and to confirm they now met the legal requirements. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection by selecting the 'All reports' link for 'St Georges Care Home' on our website at www.cqc.org.uk

We had also received information from the local authority that had concerns about the quality and safety of the service provided for people in the home.

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 56 people living in the care home.

Summary of findings

There was no registered manager in place at the time of our inspection. The manager in charge of the home told us they planned to submit an application to the Commission to become the registered manager. 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 inspection on 6 and 7 January 2016, we found that insufficient action had been taken in relation to the breaches found at the comprehensive inspection. This was a focused inspection and in line with our procedures we have not changed the overall rating of the location.

People did not receive care and treatment that was safe and were at risk from poor hygiene practices. Action had not been taken to ensure hoist slings were used safely and to reduce the risk of the spread of infection. The kitchen was still not suitably clean.

We identified additional concerns. Equipment was not safely maintained. For example, hoists continued to be used when they were faulty. Pressure relieving mattress settings were sometimes incorrect. The call bell system had not been working reliably for over one year. This all meant people were not protected from the risks to their health and safety.

People were not fully protected when they were unable to provide consent to care and treatment. The Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. This is to make sure people are not deprived of their liberty unless authorisations are in place. We made a recommendation following our comprehensive inspection because we identified a risk of people's rights not being upheld in line with DoLS requirements.

At our focused inspection we found action had not been taken in response to the recommendation we made and applications in line with DoLS requirements had not been made.

Staff had not received appropriate training to carry out their roles and staff performance was not monitored effectively. Staff had not received training to ensure they could meet people's needs and care for them in a safe way. For example, staff had not received training in how to care for people living with dementia.

People were not always protected from the risks of unsafe care because care plans did not always reflect current health care needs. Care records did not always confirm why some decisions were made. For example, when some people were taken into communal areas, they spent the day sitting in wheelchairs. Standard wheelchairs are usually used to move people from one area to another and are not suitable or comfortable for sitting in for long periods of time. The reasons were not identified in people's care plans.

Staff performance was not being monitored effectively. This meant people were at risk of receiving inappropriate care.

Systems in place to monitor the quality and safety of the service were not effective. Some risks to people were not identified, and some were identified and not acted upon.

Actions had been taken to address the issues we identified regarding safe administration and storage of medicines. However, we found medicines were still left unattended on occasions. This meant people were still at risk of harm and further actions were required.

The layout of the laundry had been improved to ensure separate areas were provided for clean and dirty laundry.

We found improvements with regard to people being treated with dignity and respect. However we found further improvements were needed to ensure staff were consistent in their approach.

We found eight breaches of regulations at this inspection. You can see what action we told the provider to take at the back 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?

Inadequate

The service was not safe.

Equipment was not maintained safely and people were at risk of harm because unsafe equipment was being used.

Equipment was not appropriately maintained so people were at risk of not being able to summon help when needed.

There was a lack of provision of appropriate equipment to meet people's needs.

The kitchen was not suitably clean and people were at risk from poor hygiene practices.

Hoist slings continued to be stored and used inappropriately which meant people were at risk of the spread of infection.

The storage of medicines had improved, however further actions were required.

The laundry area had been improved to ensure appropriate separation of clean and dirty laundry

Is the service effective?

Requires improvement

The service was not always effective.

Records completed were not always used to inform changes in people's care and treatment and records were not always accurately maintained to ensure people's health care needs were met.

Staff did not always receive appropriate training to carry out their roles and staff performance was not adequately monitored.

People's rights were not protected in accordance with the requirements of the Mental Capacity Act (2005). Where people had been deprived of their liberty, this was not in accordance with legal requirements.

Is the service caring?

Requires improvement

The service was not always caring.

Further improvements were required to ensure people are always treated with dignity and respect by all staff.

We saw and heard examples of caring, respectful and compassionate care.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

Care plans were not always person centred and did not always reflect people's changing and current needs.

Opportunities for some people to engage in social interaction and activities were limited, especially for people who stayed in bed and unable to leave their rooms independently.

Is the service well-led?

Inadequate

The service was not well- led.

There was no registered manager in post.

Systems were in place for monitoring quality and safety but these were not effective in improving the service and ensuring that risks to people were well managed.

Staff were not supported sufficiently and did not always feel their views and concerns would be listened to.

Timely and effective actions were not taken to ensure people were safe when there were faults with equipment.

People and staff felt confident with the new manager and expressed confidence they would make the required improvements.

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 focused inspection of St Georges Care Home on 6 and 7 January 2016. The purpose of the inspection was to check whether the improvements planned by the provider after our inspection in April and May 2015 had been made.

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. This was because the breaches found at the last inspection were in relation to each of these questions.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before carrying out the inspection we reviewed the information we held about the care home. This included the report we received from the provider which set out the actions they would take to meet the legal requirements. We looked at information received from other health professionals involved with the care home. We also looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our inspection we spoke with 14 people who lived at the home and with seven visitors. We also spoke with the manager, two senior managers, a visiting health professional, 16 staff and two visiting equipment service engineers.

We observed how people were supported and we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at 15 people's care records. We looked at records relating to the monitoring and management of the care home.

Inadequate

Is the service safe?

Our findings

When we inspected St Georges Care Home on 28, 30 April and 1 May 2015, we found risks to people because of poor hygiene practices. Staff carried soiled laundry through the home, hoist slings were used inappropriately, the laundry room did not provide separate areas for clean and dirty laundry, bins were left uncovered, items in the sluice were stored inappropriately and the kitchen was not clean. This meant people were at risk of the spread of infection.

This was a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 6 and 7 January 2016, we found the provider had not taken sufficient actions to meet this legal requirement.

Slings were still shared and not laundered between use by different people. Department of Health and Health Protection Agency guidance, "The prevention and control of infection in care homes (2013)" states that slings should, "not be shared between residents". We also saw one sling was visibly stained. We asked care staff how often the slings were laundered. One member of staff commented, "If it looks dirty we take it to the laundry room". One member of staff commented, "Management said we would be getting three new slings each month, but we haven't seen a new one for ages".

The kitchen was not suitably clean. The skirting edges around the floor, the door frames, the potato peeler, the base of the sugar storage bin and parts of the hot trolley were dirty and stained. Flour was stored in large open sacks in the food storage area. A bin with sugar had a lid that did not fit. This all meant there were significant risks of contamination and spread of germs. Several times during the day we saw catering staff walk through the home and back into the kitchen without putting on any protective items such as gloves or aprons.

Cleaning schedules were completed and signed, and the home's current, updated action plan stated monthly audits and spot checks were undertaken. An audit completed on 24 November 2015 stated "Not clean behind and under equipment". The action plan stated all staff were to read and sign they had read the Infection Control Policy.

The manager told us they placed orders for staff uniforms on the day of our inspection, in response to the issues we identified. A senior manager told us, in response to our findings, they would arrange for a deep clean of the kitchen. They told us this would be undertaken on 7 January 2016. We received confirmation on 14 January 2016 that the kitchen had been deep cleaned.

This was a repeated breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The general cleanliness in people's rooms was good. Action had been taken to address the unsafe storage of commode pots reported at the last inspection. These were now stored safely.

The laundry room had been reconfigured and provided appropriate separation for clean and dirty laundry.

During our inspection on 28, 30 April and 1 May 2015 we found medicines were not always stored or administered safely. This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected on 6 and 7 January 2016 we observed parts of four medicine rounds and saw medicine practices had improved. We also saw appropriate hand washing taking place. However, during one round, the registered nurse left the medicine trolley open and unattended, briefly, on two occasions. There were unsecured medicines on the top of the trolley. This meant there was still some inconsistency in practice. There was still a risk that people using the service or any other person could have taken these medicines from the unsecured trolley, which may have caused them harm.

During our focused inspection, we found equipment was not always safely maintained, was not kept in full working order and was insufficient to meet people's needs. We found the provider was not meeting the legal requirements.

There were 10 movable hoists in the home, five for fully lifting and moving people and five for supporting people to stand. The care staff told us they could not remember a time when all of the hoists were in working order. They said at any given time, there would usually be three to four hoists available, one or two on each of the two floors of the home. Staff told us they moved faulty hoists to the stair

wells and the maintenance team would label them as not for use. However, one member of staff told us, "I've given up. We keep moving the broken ones and then other staff bring them back into use".

Contractual arrangements were in place for servicing the hoists. We were told by the maintenance team the service engineer had not fully completed the recent service and three hoists had not been checked. Prior to the inspection we were informed that one hoist recently tipped when it was being used.

During our inspection, we met the hoist service engineer. They examined the hoist that had tipped when being used. They replaced a bolt that was missing from the wheel base. The engineer told us the hoist would now work correctly. One member of staff told us, "We've known for ages the bolt was missing, I lost count of the numbers of times I've taken it away, and others have brought it back to use". The minutes of the Health and Safety meeting on 6 January 2016 stated, "Hoist was ok but taken out of service". This was not what staff told us and not what we were told by the service engineer. This meant people were at risk of harm because equipment was not always safe to use.

The call bell system had been reported as faulty on numerous occasions over a long period of time. We checked records from October 2014 and found several visits and assessments from engineers had failed to identify the cause of the repeated problems and faults. The manager told us they were not able to use the call bell monitoring system. They told us when they switched on the monitoring system, the faults with the call bells increased.

Complaints and concerns about the call bell system have been raised by people living in the home, relatives and other health professionals. On the 6 January 2016, the first day of our inspection, at 8.15am, a call bell sounded. The room number was stated on the call bell panel in the corridor. We checked the room and the person was asleep. They had not activated their call bell. Staff told us that was an example of the "ghost calls" that happened often. They told us they regularly wasted time responding to such calls.

Two rooms did not have call bells available. These call bells had not been working for several months. The Commission had been notified. Providers are required by law to notify us of such events that disrupt the running of the service. One room was not currently occupied. Risk management plans were in place for the person in the other room. They told us they felt safe and comfortable with the temporary arrangement in place. They had an independent bell to ring if they needed assistance.

We met with a call bell service engineer during our inspection on the 7 January 2016. They told us they had just replaced a major part of the system which they believed should resolve the faults with the call bells and the monitoring system. We received confirmation from the senior managers on 14 January the system was still working.

Relatives told us that they thought staff were well intentioned, but sometimes just not able to deliver the care people needed because of the lack of equipment or faulty equipment, shortages of staff or call bell faults. One relative told us, "One weekend about six weeks ago there were just two care staff on this (first) floor from 2-8pm". One person told us about the long wait they sometimes had for call bells to be answered, "Sometimes it's not bad but at other times you can have a long wait, sometimes up to an hour". Other people made similar comments. One person said, "Waiting for the toilet is the worst, just waiting and waiting". We were unable to check the call bell monitoring system because it was not working.

Staff gave examples of how they had not been able to monitor people's health needs because of a lack of appropriate equipment that was safe to use. A registered nurse told us they were unable to check a person's temperature the previous day, after care staff had reported the person appeared unwell. This was because the covers for the electronic thermometers did not fit the thermometer bases. This meant there was a risk of the person's health deteriorating. Their temperature could not be accurately monitored due to lack of appropriate equipment.

Some equipment was not used appropriately. Several people had been provided with pressure relieving mattresses. These are in place for people who have pressure ulcers, or who have been assessed as at risk because of their skin condition or health status. The required pressure settings on the mattresses in use were determined according to the person's weight. A system was in place to confirm the required setting for each person. Staff were expected to check the setting each day, and record the checks they completed on a monitoring chart kept in the person's room. For two people, we found the

Inadequate

Is the service safe?

settings were not correct. For one person the care records stated the setting should be at 2-4. This was the setting required for a person with a weight of 50-75kgs. The person's last recorded weight stated they weighed 69.1kgs. The actual setting was at 5-6, which was the required setting for a person weighing 76-100kgs. The last record of a pressure mattress check was recorded on 2 January 2016. For another person, their weight was recorded as 84.4kgs. The required pressure mattress setting stated on the care chart was 4-6, as required for a person weighing 76-100kgs. The actual pressure setting was at 8-9. This was the setting for a person weighing more than 100kgs. The chart had not been updated since 2 January 2016. This person had a pressure ulcer. This meant people may have been at increased risk of tissue damage or further tissue damage because the equipment was not being used in accordance with manufacturer's instructions. This was reported to senior managers during the inspection. At the end of the inspection they told us they had addressed the issues above, and they told us the settings had been corrected.

These failings were breaches of Regulations 12 (2) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

When we inspected St Georges Care Home on 28, 30 April and 1 May 2015 we found records relating to people's care and treatment were not fully completed. For example, where people had fluid and diet charts in place, these were not being completed and total daily amounts were not recorded. This meant people were at risk of not having their health needs met.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 6 and 7 January 2015, we found the provider had not taken sufficient actions to meet this legal requirement.

Records showed that the recording of diet and fluids had improved and the amounts people had taken during a 24 hour period were recorded. However, the records were not always used to inform any changes to people's care and treatment that may be needed.

For example, for one person who had fluids recorded, the targeted daily amount for the person was not stated. For three days in the week leading up to our inspection, the person had total amounts recorded for a 24 hour period as 475mls, 330mls and 600mls. The care records for the person stated, "Fluids to be encouraged", however the records did not show additional fluids had been offered. The person was at risk of dehydration because they were not receiving fluids consistent with national guidelines.

One person had been reviewed by the Speech and Language Therapy (SALT) Team. The consistency of the diet they required was changed by the SALT team. However, the care records provided conflicting information about the current consistency required. The correct guidance was displayed in the person's room. The staff we spoke with were aware of the correct consistency required; however, there was a risk of the person being given the incorrect textured diet, because of the inconsistent and conflicting documentation.

We also found care records were not fully completed for people who had been assessed as needing hourly checks by staff. The records had been fully completed during the day. They had not been fully completed during the night. For example, for one person their records for the week leading up to the inspection confirmed they were checked every two or three hours. The person was not able to use their call bell, their verbal communication was limited and they were immobile.

The provider's action plan stated senior staff were to check all charts on a daily basis. The plan also stated "Handover of food and fluid charts to be completed shift by shift and action to be taken".

This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected St Georges Care Home on 28, 30 April and 1 May 2015 we found not all staff had received appropriate training to carry out their roles. Staff had completed training when they started in post. They had not all received refresher training when it was due. The training matrix was not fully completed. Staff had requested training, for example, to help them support people living with dementia. They had not received this training.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected on 6 and 7 January 2016, we found insufficient actions had been taken to meet legal requirements.

Staff told us they had not received all the training they needed in their roles. For example, one member of care staff said, "We have lots of residents with dementia, and people for palliative care, but we don't have training on either." Comments from registered nurses included, "We all need to do refresher training. We have gentlemen here who will require re-catheterising, but none of the nursing staff have attended updated training". We were later told by the manager they were able to undertake this procedure, however the registered nurse had not been made aware of this. This meant people who required this procedure may not be treated in a timely manner. However, one registered nurse told us they felt supported with the training provided and they attended training with registered nurses from other homes within the company.

We received the mandatory training matrix after the inspection. The matrix confirmed 83% staff were up to date with mandatory training. This training included, manual handling, fire safety, food hygiene, infection control and

Requires improvement

Is the service effective?

emergency first aid at work. However, for people moving, 61% staff were confirmed as up to date with the training. This meant 19 staff were not up to date with this training. Records relating to other training were not made available.

We read a memorandum to staff dated 15 December 2015 reminding them to attend supervision meetings. The current action plan stated, "Staff allocated on a shift by shift basis to undertake training" and "Weekly monitoring of training compliance and identification of target areas for training" The action plan also stated, "All staff to receive supervision six times per annum". The target date for completion was September 2015. The manager told us they had completed some supervisions in December 2015, and the remainder of staff were scheduled for supervisions in January 2016. The supervision records were incomplete for 2015. They showed that most staff had not received regular supervisions. An audit was completed by a regional manager in December 2015. One of the audit areas, "All staff supervision files are up to date and completed at least on the bi-monthly basis" stated this had not been achieved. The following comment was recorded, "Manager is doing them but this will not show five in a year as previously they were not up to date". Supervisions provide opportunities for staff to be given feedback about their performance, and for staff to voice their views individually. This meant people were being cared for by staff that were not supported in their roles.

This was a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected St Georges Care Home on 28, 30 April and 1 May 2015 we recommended the service reviewed the process for ensuring compliance with the conditions attached to a Deprivation of Liberty Safeguards (DoLS) authorisation. DoLS is a framework to authorise the deprivation of liberty for a person when they lack capacity to consent to care and treatment. Staff we spoke that were not aware of who had a DoLS in place. This meant people's rights may not be upheld in line with legal requirements

During our focused inspection we identified shortcomings with regard to consent, mental capacity and DoLS. The recently appointed manager told us of 14 people they had identified as requiring DoLS applications because they were unable to provide consent to care and treatment. Many of these people had lived in the home for a considerable period of time.

We looked at 15 people's care plans. We saw "Best interest decision plans". These were not always completed in full, and sometimes the information was not clear. For example, in one care plan, "Family assist with best interest decisions", "On-going need for MCA" and "My son will support my need to make best interest decisions". The documentation did not state what decisions the person was able to make or the decisions that would be made on their behalf.

We found consent had not always been recorded when required. For example we saw records for people with bed side rails in place. Best interest decisions for the use of bed side rails were not always detailed in care plans we looked at. This meant people may have been unlawfully deprived of their liberty. They did not have the protection of DoLS authorisations in place.

We found this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Requires improvement

Is the service caring?

Our findings

When we inspected St Georges Care Home on 28, 30 April and 1 May 2015 we found people were not always treated with respect. For example we observed staff entering rooms without knocking, providing care without speaking to people, staff playing music people did not want or like and staff not attending to people's needs when requested to do so.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected on 6 and 7 January 2016, we received feedback from people and from visitors about how the approach from the care staff varied, often according to the numbers of staff they had on duty. Comments from relatives included, "Some staff are exceptionally kind, but there are times when they are very short staffed" "They are really good carers here, but there are not enough of them and sometimes there are long waits for the call bells to be answered" and "The staff are generally lovely, they do their best".

People had white boards on walls just inside their rooms. Information about personal care needs had been recorded on the boards which were visible when walking past people's rooms. For example, one white board recorded personal information about the person, including, "Check bowel movements daily". This was not a dignified or confidential way of passing on information to staff about the person's needs. One relative told us they insisted the white board was used because they did not have confidence care would be monitored effectively unless staff were given obvious prompts.

People, relatives and staff commented and acknowledged delays in responding to people's calls for help. They told us this was not because staff were uncaring, it was because of a combination of staff shortages, on-going faults with the call bell system and lack of equipment. This meant that people were at risk of being left in undignified situations, such as not receiving personal care and support when they really needed it.

We spoke with staff who talked about the people they cared for in a compassionate manner and emphasised the quality of care they felt they provided as a team. One member of staff said, "I do think we provide people with good care here". Staff were able to tell us how they showed respect to people. They told us they always made sure doors were closed when they provided personal care, and they knocked on doors before entering.

We saw and heard interactions between staff and people that were respectful and kind. For example we observed a meal time in one dining room. Music was being played quietly in the background. The action plan stated, "People are asked if they wish to have music during the mealtime experience and suitable music is selected". We saw this happened. People in the dining room enjoyed the music and were heard to comment about the clothes they wore at the time the music was originally played "Back in the 40's and 50's". We heard staff encouraging people to eat and we heard comments such as, "Can I tempt you with this", "Would you like something different".

Overall we found that actions had been taken to meet the legal requirements although further improvements were required in some areas.

Requires improvement

Is the service responsive?

Our findings

When we inspected St Georges Care Home on 28, 30 April and 1 May 2015 we found care plans had not been reviewed within the timescales specified by the provider. People's individual needs, preferences and choices were not always recorded. People's needs were not always met. Care staff told us they did not read the care plans and were therefore not always kept up to date about people's current needs. People told us the opportunities to take part in activities of their choice were limited. Staff told us they did not have time to provide people with person centred care that met their needs for activities and companionship.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected St Georges Care Home on 6 and 7 January 2016, we found insufficient actions had been taken to meet legal requirements.

Care plans were not always person centred and did not always reflect people's changing and current needs. For example, we looked at the care plan for one person who, we were told by the manager, was receiving palliative care. The care plan did not reflect the person's need and stated they could walk short distances and eat independently. The member of staff providing care for the person told us about the care and support the person required. They told us, "(Person's name) is for palliative care, so we are keeping them comfortable. We will get (person's name) out of bed for an hour later so that we can assist them with lunch, but they will be back in bed later". The person was not able to walk or eat independently. The care plan was last updated on 17 October 2015. The care plan was updated on 7 January 2016, the second day of our inspection.

We saw records for people with wounds and wound care plans were in place. However, these did not always contain up to date information. One person was assessed as having a moisture lesion on 24 December 2015. The wound dimensions were recorded. There was no photograph although staff had recorded the photograph was awaited. Another person had been admitted to the home with a significant pressure sore in August 2015. Two photographs had been taken, one was dated 3 September 2015, and the other was not dated. The current documentation did confirm the wound was healing well, however, there were no up to date photographs to confirm the current status of the wound. We saw photographs that were blurred which meant the size or condition of the wound was unclear. This was noted at our previous inspection and staff had told us, "The camera is hard to focus, we need a new one". At this inspection, staff told us they continued to report concerns about the camera but no action had been taken. We showed the photographs to one of the senior managers who told us, "Ordering a replacement camera shouldn't be a problem".

People who spent time in communal areas remained in the wheelchairs used to move them from their rooms. We did not find detail in the care plans to support the reasons why people remained in wheelchairs rather than be transferred to armchairs. We did not hear staff offer to move people into armchairs. One member of staff told us they did not have enough suitable chairs in the lounge for people who needed more support .They also told us the armchairs were too low for people. One relative commented, "Many of the residents seem to sit in their wheelchairs all day, it seems so long and they aren't asked if they want to move into an armchair".

People remained in wheelchairs in the dining rooms. For example, during our inspection seven people had lunch in one of the dining rooms. They all remained in wheelchairs. They were not asked if they wanted to transfer to a dining chair. The height of the wheelchair arms meant the wheelchairs could not be placed close to the table. Some people could not lean forward in their wheelchairs and so were not positioned closely enough to promote their independence with eating. We saw food drop from cutlery because of the gap between the table and sitting position of the person.

Records called 'Engagement booklets' were located in people's rooms These provided detail about the social interactions and activities people had participated in. We spoke with staff that were enthusiastic. They told us they wanted to make a real difference and provide opportunities for people in their rooms and communal areas to participate in activities of their choice. They told us they wanted to provide opportunities for people in their rooms to have daily 'one to ones'. They told us they had not been able to achieve this to date. We saw where people stayed in their rooms or were nursed in bed, the frequency of social

Requires improvement

Is the service responsive?

interaction was irregular and limited. For one person we saw from 24 December 2015 they had social interaction recorded on 24, 30 and 31 December 2015 and 4 and 5 January 2016.

The lack of person centred care was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

When we inspected St Georges Care Home on 28, 30 April and 1 May 2015 we found audits had been undertaken but had not identified the failings found at the inspection and some concerns had not been acted upon. These included infection control audits, call bell failures and pressure ulcer monitoring.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

When we inspected the home St Georges on 6 and 7 January 2016, we found insufficient action had been taken to meet legal requirements. In addition we found further shortcomings with the monitoring and checking of equipment to ensure it was safe to use and available in sufficient quantities. These were further breaches of this regulation.

We received information from the local authority that had concerns about the management of the quality and safety of the service.

The home did not have a registered manager in post. We were told by the senior managers the current manager who had been in post for approximately one month was going to apply for registration with the Commission. The manager told us the plan was for them to be in post for approximately two years.

During the inspection we were provided with a copy of the provider's updated action plan. The senior managers told us the action plan sent to us following the last inspection had been updated and incorporated improvements and actions recommended by other agencies. Although some actions were recorded as completed, most were recorded as on-going. We found inaccuracies in the action plan. For example, it was recorded that individual slings had been provided. The action plan update for 30 December 2015 stated, "Three slings to be ordered a month, all existing slings have been identified and allocated". This had not been completed. Slings were still used between people and stored in communal storage cupboards.

There was no satisfactory system in place to ensure hoists were only used when they were in full working order. The following comments from one member of staff were similar to several other comments received. "Fed up with reporting lots of things and with this hoist we knew it was an accident waiting to happen. Just glad no one has been hurt really badly" and "Some of the hoists have battery packs that don't hold charge, I'm just sick to the back teeth of saying the same things over and over again and nobody higher up ever listens".

We found the ongoing faults with equipment such as call bells had not been addressed until the day of our inspection. The ongoing and repeated faults were evident in reports we looked at dating back to October 2014.

The system in place to monitor pressure relieving equipment was not always followed. Pressure settings were not always checked to ensure they met people's needs. People were at risk of further tissue damage

An internal kitchen audit had recorded on 24 November 2015 "Not clean behind and under equipment". Actions had not been taken to satisfactorily resolve the issue which we identified at our last inspection. During this inspection, one of the senior managers told us they disagreed with our findings that the kitchen was not clean. On 7 January 2016 they told us they had looked again, and agreed a deep clean was required. They told us this was booked for overnight on 7 January 2016. We were informed on 14 January 2016 this had been completed.

The manager told us the staffing levels had improved very recently and new staff had been recruited. However, they also told us the staffing levels were still inconsistent at times, and this was often because of staff sickness. The manager, who was new in post, told us they planned to hold a team building staff meeting in January 2016.

Staff were unable to check people's temperatures because the equipment was not in working order.

Staff were not confident the 'senior managers' would listen to or act on concerns staff raised. Several staff told us they were not confident that the provider would address some of the issues and concerns they had. Two staff told us they had not raised concerns in recent meetings because they were afraid if they spoke out their jobs would be at risk. Other staff told us they often did not receive responses to requests they made to 'Head Office'. Staff were critical of the senior managers they referred to as, "Head office managers".

The above were repeated breaches of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

We did receive positive comments about the new manager in post. Staff told us they thought the manager was approachable. We spoke with people who were pleased to have a new manager in post and hoped they would stay in their role.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People who did not have capacity to make decisions were not lawfully deprived of their liberty.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff had not received appropriate training to carry out their duties.** **Staff did not receive regular appraisal of their performance.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Records relating to people's care and treatment were not fully completed to ensure people's needs were met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems to monitor quality and safety were not effective.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Equipment was not always available, safe to use or properly maintained. Equipment was not always available in sufficient quantities. The home was not suitably clean.

The enforcement action we took:
A warning notice was issued. The provider is required to meet the requirements of Regulation 12 by 1 April 2016.