St George's Court Healthcare Limited

St Georges Court Care Centre

Inspection report

Russell Street
Cambridge
Cambridgeshire
CB2 1HT
Tel: 01223 712135

Date of inspection visit: 12/13 January 2015
Date of publication: 30/03/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

St Georges Court Care Centre is a care home with nursing which provides a service for up to 76 people over three floors. At the time of our inspection there were 66 people living in the home.

This unannounced inspection took place on 12 and 13 January 2015. The previous inspection was undertaken on 25 and 26 June 2014. During the inspection of 25 and 26 June 2014 we found that three regulations were not being met. We received an action plan that stated the required improvements would be completed by 31 August 2014. We required the provider to make improvements to ensure that people's legal rights were upheld regarding making decisions about their care and welfare. We found that this action had been completed. We also required that improvements were made to ensure that each person had their individual needs assessed and planned for and that care was delivered in a way that met people's needs. We found that the necessary improvements had not been made in all areas of people's care. We also required that improvements were made regarding keeping accurate records. We found that this improvement had not been made in all areas of people's care.

Summary of findings

At the time of this inspection there was no registered manager in place. However, the current manager was in the process of applying to become a 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.

Although people's healthcare needs were monitored the issues weren't always consistently acted upon in a timely manner. For example, although staff were aware that some people needed to have their dressings changed this wasn't always completed when it should have been. This meant that people were at risk of receiving care or support that could put their health and welfare at risk. Care plans and records did not always contain all of the information that staff required so that they knew how to meet people's needs in a consistent manner. We also found that staff did not always follow care plans so that people received care in the manner that they preferred. For example, the care plan for one person stated that staff should assist them with nail care daily. However we found during the inspection that this had not be carried out.

The provider had quality assurance processes and procedures in place to improve, if needed, the quality and safety of people's support and care. However, the provider had not identified the issues we found during our inspection and this placed people at risk of receiving inappropriate care.

People felt safe living at the home and staff were aware of the procedures to follow if they suspected anyone was at risk of harm. There were a sufficient number of staff employed at the home. However, there were sometimes delays of people receiving the care they needed. People received their correct medication on time by trained staff.

Staff were only employed after a thorough recruitment process had been undertaken. Staff received an induction which included training and shadowing experienced members of staff. Staff felt supported and could discuss any concerns they may have had with a member of the management team.

People were provided with adequate amounts of food and drink to meet their individual likes and nutritional and hydration needs.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Action had been taken to ensure that if people did not have the capacity to make decisions then these were made in their best interests and in line with the legislation.

People's privacy and dignity were respected and care was mainly provided in a caring and compassionate way.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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?
The service was safe.

The risk to people of experiencing harm was reduced because staff had a good understanding of what abuse was and how to report it.

Risks to people safety have been assessed and appropriate action had been taken to reduce risk where possible.

People received their medication as prescribed by trained staff.

Good

Is the service effective?
The service was not always effective.

People did not always receive the support with their health care needs that they required.

People were supported by staff who had the skills, knowledge and support they required to carry out their roles.

Staff demonstrated a clear knowledge of the Mental Capacity Act (2005) when supporting people who lacked capacity to make decisions for themselves

Requires Improvement

Is the service caring?
The service was not always caring.

The majority of people we spoke with told us that they felt that they were well cared for and treated with dignity and respect. However we saw that staff did not always treat people in a respectful manner.

Staff spent time supporting people and talking to them in a kind and gentle manner.

Requires Improvement

Is the service responsive?
The service was not always responsive.

Although people's care needs had been assessed not all of the information staff required was included in people's care records. This put people at risk of receiving inconsistent care.

Staff did not always follow people's care plans to ensure that people received care and support in the way that they preferred.

There was a procedure in place which was used to respond to people's concerns and complaints.

Requires Improvement

Is the service well-led?
The service was not always well-led.

Requires Improvement

Summary of findings

Although systems had been put in place to monitor the quality of the service being provided these had not always been effective in identifying whether improvements had been sustained.

People were encouraged to make suggestions for improvements and action had been taken to make the improvements.

Staff were supported to work as a team and were able to raise concerns to management.

St Georges Court Care Centre

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 12 and 13 January 2015 and was unannounced. The inspection team consisted of one inspection manager, one inspector and a specialist professional advisor. The professional advisor was a specialist in wound management.

Before our inspection we reviewed the information we held about the home. We reviewed notifications the provider had sent us since our previous inspection. A notification is important information about particular events that occur at the service that the provider is required by law to tell us about. We contacted local commissioners to obtain their views about the service.

During our inspection we spoke with ten people who lived in the home, three nurses, three care assistants, the manager and the regional director. We observed care and support in communal areas, spoke with people in private and looked at the care records for ten people. We also looked at records that related to how the home was managed including recruitment records, training records, health and safety records and audits.

Good

Is the service safe?

Our findings

All people spoken with said that they felt safe. One person said, "I am so pleased that I moved in this home. I didn't feel safe when I lived on my own, I feel much safer now that I am living here. Another person said, "Yes I'm very safe with all of the staff around me."

Staff were knowledgeable in recognising signs of potential abuse and were able to tell us what they would do if they suspected anyone had suffered any kind of abuse. A nurse spoken with was aware of the agencies involved in safeguarding people and one member of staff said that they, "Would make sure that the person was safe and would then go and speak with the person in charge."

A nurse confirmed that no form of restraint was used in the home. They told us that if people became upset and staff were concerned about their own safety they would move away from the person for a while to allow then to calm down. This showed us that people were supported in a safe way.

Assessments had been undertaken to assess risks to people and to the staff supporting them. The risk assessments included information about action to be taken by staff to minimise the chance of harm occurring. Risk assessments were also in place where actions taken to help reduce risks could be seen as a form of restraint. For example, when people required bed rails to keep them from falling out of bed. People or their representative had been asked to give authorisation for their use.

Six people spoken with said that there was enough staff on duty. One said, "When I need staff they always come straight away". Another said, "When I press the buzzer someone always comes. Another person said, "Staff always have the time to care for me" and another said, "Staff are fine, there are enough of them and they always come when I need them."

Staff told us that there was usually enough staff on duty. They said that if someone went off sick at short notice it was often difficult to find an additional member of staff from the agency. Staff told us that they did not feel rushed and that they did have the time that they needed to look after people. One member of staff said, "I really enjoy working here. I do my best for the residents and know all of them really well."

One person said that the staff were, "Very good, but sometimes there isn't enough of them." They told us that they had woken up at 09.45 and asked to get out of bed. The member of staff said that they would find another member of staff to help her. Five different staff came into their room from 09.45 until 11.00 and each said that they would get another member of staff. The person were helped to get out of bed at 11.15. One person told us that they had been refused a shower because it was not their rotated shower day. Their records showed that they hadn't had a shower for six days. Their previous shower had been on a day that wasn't there assigned day. Staff confirmed that there was a bath/shower rota and stated that unless someone refused a shower or bath there would not be capacity to assist an extra person with a shower or bath if it wasn't there rotated day. The management team stated that this was not the home's policy and people should be able to have a shower or bath when they required. This meant that for some people their care needs were not met in a way they wanted.

Staff confirmed that they did not start to work at the home until of their pre-employment checks had been satisfactorily completed. One staff member told us that they had an interview and had to wait for their references to be returned before they could start. A nurse told us that the relevant checks were completed to ensure they were suitable to work with people living in the home before they was employed.

We observed a nurse administering medicines. They followed the correct procedures and took time to administer the medicine in the way people preferred. We did note that the nurse was interrupted many times by colleagues whilst they were trying to administer the medicines. This could increase the risk of people not being safely administered their medication. The medicines administration charts had been completed appropriately and the medicines were stored securely.

Requires Improvement

Is the service effective?

Our findings

We found that people were not always receiving the support they required with their health care needs. Some people were not having their dressings changed as frequently as their care plan stated they should. For example, the body map overview for one person showed the time between changing dressings had exceeded the recommended three to five days for that person. On one occasion the time between dressing changes had been 10 days and on another occasion the time between dressing changes had been 11 days.

We found that action hadn't been taken by staff in a timely manner for one person who was unwell. Staff were not able to tell us what action had been taken in response to the person's blood sugar level being elevated. We also found that although at the staff handover from the night shift stated that the person should be seen by the district nurse and a doctor this had not been arranged because the staff member responsible had forgotten to do this. This meant that although people's healthcare needs were monitored we could not be confident that the issues identified were acted on in a timely manner. This put people at risk of receiving care or treatment that was unsafe or inappropriate.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they thought that the staff had the skills and training they required to meet their needs. We found that people were supported by staff that had the right skills. All staff confirmed that when they started work at the home they received an induction which included shadowing experienced members of staff, and receiving training including fire safety, moving and handling and safeguarding. Staff said that they felt supported by the managers. They said that they received supervision at least every two months but could have it more frequently if requested. A nurse confirmed that she supervised people every two months but also continually monitored their working practices and would discuss any concerns with them at the time rather than waiting for this to be discussed with them at their next supervision session.

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) sets out what must be done to make sure that the human rights of people who may lack capacity to make decisions are protected. Staff we spoke with about the MCA and DoLS showed us that they were knowledgeable about how to ensure that the rights of people who were not able to make or to communicate their own decisions were protected. We looked at care records which showed that the principles of the MCA Code of Practice had been used when assessing an individual's ability to make decisions. This meant that people were only deprived of their liberty where this was lawful.

People spoke favourably about the quality, quantity and choice of food available. There were menus on the dining tables and people spoken with said they could have an alternative if they preferred this. One person who was having the breakfast was offered a range of options including croissants and a cooked breakfast. One person said, "The food is very good, if we want something else, the girls will always get it for us." Another person said that they particularly enjoyed the roast dinners that they had on a Sunday. Another person said, "The food is excellent, I am diabetic and I enjoy the special ice cream that the staff get me. I had porridge and bacon and eggs for breakfast this morning and it was very nice." People were seen being offered a choice of drinks and snacks. People were assured that their hydration and nutritional needs would be met.

Requires Improvement

Is the service caring?

Our findings

Most people told us that they thought the staff were kind and caring. One person told us that they didn't think that they mattered to staff. One person told us that the staff, "Treat me with kindness." One member of staff said, "I really enjoy working here. I do my best for the residents and know all of them really well."

Care plans were written in a caring style and in a manner that promoted people's independence and dignity. They prompted staff to treat people with respect and involve them in their care and decision making. For example, one person's care plan stated, "Please speak to me very clearly and ensure that I understood what you have said to me and to also encourage me to speak about my feelings."

We saw that staff knew people well and generally treated them in a caring manner and with dignity and respect. Staff referred to each person by their name and took time to ask them how they were and talked to them about things they found interesting. People told us they they were treated with respect and we saw staff knocking on bedroom doors and waiting until they were told they could enter before going in. People were asked discreetly if they needed any assistance with personal care.

However, we observed one member of staff assisting people to put napkins on whilst they were eating their dinner without explaining what they were doing. People looked shocked that staff were putting something on them and one person tried to eat the napkin as it was tucked into their clothing. We informed the management team of this finding at the end of our inspection and they stated that this was not acceptable.

People told us that their friends and relatives could visit and were made to feel welcome.

Staff told us that they treated people how they would want a family member to be treated, with kindness and respect. The management team told us that they regularly worked shifts with staff so that they could observe how they worked and ensure that people were being treated with dignity and respect.

We found that people had access to information in relation to advocacy services. Although no one was using an advocate in the home the information about how to contact agencies that could supply an advocate were on display.

Requires Improvement

Is the service responsive?

Our findings

We found that the care plans and wound care charts did not always contain the information that staff required so that they were aware of what people's needs were and how these needs should be met. The care plan for one person did not contain information about the reasons why both of their legs were bandaged and how often the bandages should be changed.

Information provided in care plans was not always being followed by staff. During the previous inspection we found that one person had not had the support they needed with nail care. Although their care plan had been updated to include information about nail care we found that staff were still not still not following this and the persons nails required cutting and cleaning. We talked with the person and asked them if they had been offered with their nail care and they told us they hadn't but would like help to clean their nails. We asked the staff if they had followed the care plan and they told us they thought the person's family member normally supported them with nail care.

One member of staff told us that one person had stated that they did not want to go to hospital if they became unwell. However, their care plan stated that they did want to go to hospital. This could cause staff some confusion and needed updating to ensure that the person was cared for in the way they preferred.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that there were lots of activities to take part in and also that they went on trips outside the home regularly. They told us that they went to a bird sanctuary and a garden centre recently. Another person said that they had enjoyed the trip to Kings College. They said that there was a show in the home every month and that there were. "Lots of activities." On the day of our inspection several of the people in the home were taking part in a game of bingo. One person told us that she liked to go to the shops and that a member of staff took her to the shops when she asked to go. One person told us that they enjoyed doing word searches and that staff would take them to the shop to buy puzzle books. Another person said that they read the free paper that came each week but they would like to have a copy of the local paper each day. This information was fed back to the manager. People also told us that religious services were held in the home.

We found that people had access to information in relation to complaints and they knew how to raise a concern if required. There were posters displaying the complaints procedure in the home and people said they would speak with a member of staff if they were not happy about something. One person said, "If I wasn't happy I would go to the office and tell the people in there." Staff spoken with were aware of how to deal with complaints. A nurse told us that if people had a complaint she would try to deal with it straight away and would inform the care manager. If she wasn't able to deal with a complaint she would pass this to the care manager for them to respond to. Staff spoken with told us that they would pass any complaints to the person in charge of the shift on their floor.

Records of compliments and complaints were kept in the home. The two most recent complaints seen were looked at, and it was noted that the complaints procedure was followed. The person raising the complaint received a letter acknowledging their complaint, whom would be investigating it and the date by when the written response would be received.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in place at the time of the inspection. A manager had recently been appointed and stated that they would be applying to the commission to become registered. Management support had been provided to the home by a peripatetic manager with support from the clinical lead and the provider's regional team.

Staff told us that they were happy working in the home and felt supported by the management team. They also felt that if they needed to they could raise any issues with the managers.

Various audits had been put in place to enable improvements to be made to the service. For example accidents and incidents were being regularly audited to see if any action was needed to prevent similar accidents or incidents occurring. However there was no clear process to show that action had been taken as a result of the audit findings. For example, the records showed that one person had suffered two falls and also stated that they should have been referred to the GP. There was no information recorded in the person's records to show that the referral had been made

During our inspection on 25 and 26 June 2014, we found that not all of the care plans contained all of the required information in respect of the support people needed to meet their needs. As a result of our findings, a process had been put in place whereby a full review of the care needs of a person and their care plan was undertaken each day.

However, this had not always been effective in ensuring that all people received the care they needed. For example, it had not highlighted the fact that people's dressings were not being changed as regularly as their care plan's stated.

During our previous inspection we found that people didn't always have access to their call bells. Although action had been taken to assess people to see if they could use their call bells action had not been taken to ensure that where necessary they had access to them. We found that one person could not access their call bell if they needed it as it was tied to the bed even though they were sitting in a chair. This meant that some of the necessary improvements hadn't been made or sustained to improve the quality of the service provided.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their family and friends were involved in making improvements to the home. People told us that they had regular residents' meetings and that there were minutes of these. They said that they discussed trips that they would like to go on during the meetings and also talked about the food. Dates of both the relative and residents' meetings were displayed in the home and minutes of these meetings were maintained. Minutes from recent resident meetings were seen. It was noted that concerns raised during these meetings were actioned. One example was a request for more transfer equipment including hoists and rotator stands being met as people sometimes had a long wait due to equipment not previously being available. This showed us that the provider responded to make improvements to the service people received.

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	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision There was not an effective system in place to regularly assess and monitor the quality of the service provided that identified, assessed and managed the risks to the health, safety and welfare of service users. Regulation 10 (1)(a)(b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services You were failing to take proper steps to ensure that care plans are current and/or regularly updated to reflect people's changing care needs so that people in your care are receiving care that is appropriate and safe. You are failing to carry out assessment of needs to ensure the care delivered meets their needs and is planned for. You are failing to plan and deliver care that meets the needs of people who are at risk of skin sores. Care planning does not meet the individual needs of the service users and ensure their welfare and safety.

The enforcement action we took:
We served a warning notice on St George's Court Healthcare Limited which must be complied with by 13 March 2015.