St George's (Wigan) Limited

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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?	Requires improvement

Overall summary

We carried out this unannounced inspection under Section 60 of the Health and Social Care Act 2008 on 16, 18 and 20 November 2015 as part of our regulatory functions. This inspection checked 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.

At the previous inspection on 18 November 2014, the home was found to be requiring improvement against four of the five questions we ask about services during an inspection: 'Is the service safe', 'Is the service effective', 'Is the service responsive' and 'Is the service well-led'.

At the inspection on 16, 18 and 20 November we found eight breaches of Regulations in relation to the safe management of medicines, infection control, supporting staff, staff training, premises maintenance, meeting

Summary of findings

peoples' needs, assessing monitoring and mitigating risks, and keeping contemporaneous records. You can see what action we told the provider to take at the back of the full version of the report.

St George's Nursing Home provides nursing and residential care and support for up to 62 people. At the time of the inspection there were 43 people using the service and one person was in hospital. The home is a grade 2 listed building in spacious grounds and close to a wide range of community resources and there is a dedicated floor for people living with dementia. St George's provides care for people in a variety of single and shared rooms.

There was not a registered manager at the home, but the provider told us that it was their intention for one manager to become the registered manager for the service and an application to become the registered manager had recently been submitted to CQC. 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.

We saw that surveillance cameras were in place in the corridors throughout the home. People who used the service and their relatives had been informed about the use of these cameras but had not been consulted about their installation.

During the inspection we looked at the way the service protected people against abuse. There was an up to date safeguarding policy in place, which referenced legislation and local protocols, including how to instigate Adult Protection procedures and contact details for CQC, the local authority and the social services duty team. The home had a whistleblowing policy in place.

There was an on-going programme of refurbishment being undertaken at the service, which included bedrooms, a walk-in wet room and decorating, lighting and electrical works. Prior to the commencement of the refurbishment work, the home had informed people using the service and their relatives about what would happen at different stages. Following the completion of the refurbishment work it was the intention of the provider to consult with people and their relatives regarding their choice of furnishings and décor.

We looked at records regarding the premises and equipment and spoke with the staff member who was responsible for carrying out these checks. There were weekly checks for water temperatures, the fire alarm and means of escape. There was a contract file which was all up to date and included a gas safety record, a fire system annual inspection certificate, a hoist examination and service report, a hoist-sling thorough examination report, routine servicing and examination reports for the lift, a pest control certificate, records of washing machine and dryer checks, a legionella report, a hot water boiler check report and COSHH information.

We checked all bedrooms and found that all the rooms had television wires that were loosely hanging down from the television unit which presented a risk of ligature and trips. We spoke with the provider about this and the wires were made safe. Some bedrooms had old taps with no indicating marker that would identify if it was hot or cold water. Some wardrobes had glass-fronted doors which were cracked presenting a risk to people's safety and visual difficulties for some people living with a dementia. Some bedrooms did not have lampshades or toilet seats. The provider told us that a questionnaire had been sent out to people who used the service and their relatives on how they would like their room to be decorated but at the time of the inspection the responses had not all been returned. Additionally some rooms had window restrictors that were broken or loose which presented a falls risk. We raised our concerns about the window restrictors and these were repaired immediately.

These issues meant there was a breach of Regulation 15 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; premises and equipment, because the service had failed to ensure that the premises used by the service were secure, properly maintained and suitable for the purposes for which they were being used.

This was also a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because the service had failed to effectively assess, monitor and improve the quality and safety of the services provided.

Summary of findings

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service. The manager told us that if there was an unforeseen shortage of staff, the home initially contacted existing staff and as a last resort would use agency staff. We looked at four staff personnel files and there was evidence of robust recruitment procedures.

We looked at how the service managed infection prevention and control (IPC). The manager told us that no IPC audits had been carried out by the service.

Since the commencement of the refurbishment there we could not find any evidence of environmental/cleaning risk assessments or audits being undertaken. We saw that the drainage holes in the wet rooms all looked very dirty and staff did not know whether and/or how they were being cleaned. However, at the time of the inspection the wet rooms were not being used and building work was on-going. We found cutlery soaking in an old plastic jam container which contained detergent that was accessible to people using the service.

In one room we saw that staff were re-using single use syringes for feeds and flushes, water used for flushing was stored in old plastic milk containers and there was no notice in the room to say that the person should not be given anything orally.

There were no covers for the tympanic thermometer that was being used to measure people's temperature. We saw that blood pressure (BP) cuffs, used to determine blood pressure, were dirty.

Hoist slings which were repeatedly used for many service users, were not washed regularly and only washed when visibly soiled.

We found that Infection Prevention and Control (IPC) training was being offered by the Trust and three staff members had signed up to this training. We saw from the information that was on a notice board that it was up to the staff members to opt-in to this training rather than the managers nominating people to go. The clinical lead told us that they hoped that all staff would have IPC training.

This is a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; controlling the spread of infections, because the service had failed to operate systems to assess, detect, prevent and control spread of infections.

We looked at the care records for a person using the service and saw that records relating to the management of their wound were unreliable as the wound had previously been assessed as grade 3 then subsequently grade 2, then grade 4. If (the persons') wound had deteriorated to a grade 4 the tissue viability nurse should have been asked to review the position but this had not been done, which meant that the person was at risk of further deterioration.

This meant there was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care, because the service had failed to ensure people's care and treatment was appropriate and met their needs.

We looked at how the service managed people's medicines. We found that the medicines room was securely locked and medicines were stored appropriately with regular fridge temperature monitoring in place. Controlled drugs were also stored correctly and the nurse on duty held the key to the locked controlled drugs cabinet.

We looked at the MAR charts on the first floor and found that the majority were without a photograph of the person concerned and in some cases we found that the persons' allergy status was not included. On the first floor we saw MAR charts that had missing signatures with no explanation.

We found that one person that had gone for nine days without receiving medication. The home had not investigated this or filled in any form of incident report. The GP had not been notified and all the medication was re-started without medical advice after a nine day medication-free period.

There were no body maps to explain where creams should be applied and it was unclear if it was the job of the nurse or a carer to apply creams. We saw that prescribed creams were also kept in other rooms insecurely, for example in a person's in a bedroom.

We observed medicines being administered at lunchtime on the ground floor and saw the nurse retrospectively filling in MAR charts for medicines that they said they had administered in the morning. We found there were significant gaps in some MAR sheets that were not accounted for.

Summary of findings

We asked the manager about staff competency checks and they explained that these had not been carried out. There was no specific reporting for medication errors or evidence of investigations and shared learning. There was a medication policy which was up to date and relevant but lacked a PRN policy.

This was a breach of Regulation 12(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the proper and safe management of medicines, because the service did not have appropriate arrangements in place to manage medicines safely.

We looked at staff training, staff supervision and appraisal information and saw that there was a staff training matrix in place. All care and nursing staff had recently completed training in safeguarding. Care staff had also undertaken training in challenging behaviour, COSHH, equality and diversity, infection control, fire training, dementia and DOLS, food hygiene, and manual handling. We asked the clinical manager for a copy of the staff training records in relation to PEG care and found that only 14% of staff who delivered care to a person between the period 13 November 2015 and 16 November 2015, when the electronic care planning system was unavailable, had done this training. This meant that staff may not understand how to ensure the safe delivery of PEG care.We looked at the training records for tissue viability training and saw that there was a tissue viability nurse in post.

These issues meant there was a breach of Regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service had failed to ensure that persons providing care or treatment to service users have the qualifications, competence and skills to do so safely.

We could not find any evidence of a staff supervision matrix and the manager and staff told us that these meetings had not been happening.

This is a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, appropriate supervision and appraisal because persons employed by the service had failed to receive appropriate supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

People told us the food at the home was good. We observed the lunch time meal in the first floor dining room using SOFI. We saw that staff who were giving meals to people were wearing an apron but not wearing any gloves. A staff member told us they had been instructed not to use gloves as this was impersonal. There was a four week seasonal menu in use and this was displayed on the wall in the dining room. The dining tables were sparsely laid with no table clothes, no other form of table decorations, and very few available condiments. This meant that the dining room did not feel homely or welcoming. We checked the food stocks in the kitchen and found that there was an adequate supply of fresh and dry goods and the freezers were well stocked.

There was a food hygiene policy and we saw that staff had completed training in food hygiene.

There were appropriate records relating to the people who were currently subject to DoLS. There was documentation of techniques used to ensure restrictions were as minimal as possible. There were appropriate MCA assessments in place, which were linked to screening tools and restrictive practice tools which outlined the issues and concerns. There were applications for DoLS where the indication was that this was required and these were up to date.

There was a 'consent for change or shared allocation of room' document in use but this had not always been fully completed for every person using the service. There was also a 'consent to treatment' document in use but this had not always been completed for each person.

The home had a dementia café, providing a safe environment for people who used the service to socialise with each other and members of the local community. There was a memory lane reminiscence room decorated with items to stimulate people's memories and facilitate conversation. On the day of the inspection, this was cluttered and unusable due to the refurbishment work being undertaken.

People were able to personalise their bedrooms with individual items such as family photographs and personal objects but some bedrooms were sparsely furnished and impersonal. The provider told us that some people had chosen not to personalise their rooms and this was their choice.

Summary of findings

We saw staff responded and supported people with dementia care needs appropriately. However, there were few adaptations to the environment to make it dementia friendly or that would support these people to retain independence within their home. We saw people's bedroom doors did not have their photograph on it, which could make it difficult for people to find their room.

We observed care in the home throughout the day. Interactions between people who used the service and staff members were warm, conversations were of a friendly nature and there was a caring atmosphere. We heard positive chatter between staff and people thorough the course of the inspection. Staff spoken with could give examples of how privacy and dignity was respected.

The home had a Service User Guide and this was given to each person who used the service. The Guide contained information on how to make a complaint but the contact details were out of date.

A number of 'thankyou' cards from people who had previously used the service were displayed on a notice board in the entrance area.

We saw that prior to any new admission a pre-assessment was carried out with the person and their relative(s) where appropriate.

We looked at the care planning records for people using the service. The home used both an electronic and paper copy care plan system. On the first day of the inspection the electronic system was not working and the home relied on paper copy care records in people's care files. Some of the care plans we looked at did not have a photograph of the person. The plans were person-centred and contained a profile of the person concerned including basic personal information such as height, nationality and previous occupation, food preferences and social activity preferences, but were not always fully completed for every person.

The home employed an activities coordinator and activities on offer were displayed on a notice in the entrance area which included arts and crafts, relaxation, pamper sessions, and dominoes. Other activities included hand massages on a 1-1 basis and information on people's recreational preferences was recorded in their care plans. Pictorial versions of activities were being developed which would help people to understand what was being offered.

There was a 'Supporting Residents Outside the Home' and 'Religious and Cultural Issues' policy in place and we saw that information about personal preferences, social interests and hobbies was recorded in people's care files.

Residents and relatives meetings were not carried out regularly which meant that the views of people using the service and their relatives may not have always been identified and the opportunity to present such views was not provided.

There was a 'Residents' Complaints Procedure' in place and we looked at examples where complaints had been raised and responded to in a timely manner.

Staff told us there was inconsistency in the management team and room for improvement.

There was no registered manager at the home. 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 the time of the inspection a person was in the process of applying for this position and registering with the CQC.

On the date of the inspection, we found that the electronic care planning system had not been working for the previous three days and there was no contingency plan in place. The paper based care plans did not contain all the latest information and some information was missing.

This meant there was a breach of Regulation 17(2)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because the service had failed to maintain securely and accurate, complete and contemporaneous record in respect of each person using the service.

We looked for evidence of service audits and found that although some audits had been carried out there were no audits for people's beds, mattresses and cushions, infection prevention and control.

Summary of findings

There was also a complaints audit completed for the period March to October 2015 and we saw that the appropriate people had been involved where applicable and the complaints had all been resolved to the satisfaction of the complainant in a timely way.

There was a contingency planning handbook in place that identified actions to be taken in the event of an unforeseen event such as the loss of utilities supplies, pandemics, flood disruption and lift breakdown. Policies and procedures were all up to date, having been reviewed in August 2015.

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 consistently safe.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service.

No infection prevention and control audits had been carried out by the service.

The service did not have appropriate arrangements in place to manage medicines safely.

Is the service effective?

Requires improvement

The service was not consistently effective.

There was no staff supervision matrix and the manager and staff told us these had not been happening.

People who used the service and their relatives said the food was good and there was a four week seasonal menu in use.

There were appropriate records relating to the people who were currently subject to DoLS.

There were few adaptations such as contrasting handrails, directional signage or themed areas that would have assisted people living with dementia to mobilise round the building or understand where they were if assisted by staff.

Is the service caring?

Requires improvement

The service was not consistently caring.

The relatives of people using the service told us they felt the staff were caring.

Staff attitude to people was polite and respectful using their names and people responded well to staff. Staff spoken with could give examples of how privacy and dignity was respected.

We saw that one person was sitting on a dirty cushion on a bench seat and partially undressed.

There was no evidence to identify that people using the service had been involved in any prior, meaningful engagement that supported the decision to install CCTV cameras.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Summary of findings

The home used both an electronic and paper copy care plan system but the electronic system had not been working for a period of three days prior to the inspection which meant that staff did not have access to all the latest relevant information.

Care plans contained gaps in information and some records were disorganised and difficult to follow.

Residents and relatives meetings were not carried out regularly.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

Staff felt there had been inconsistencies in the management team and communication was poor.

There was not a registered manager at the home, but the provider told us that it was their intention for one manager to become the registered manager for the service and an application to become the registered manager had recently been submitted to CQC.

There was no contingency plan for when the electronic care system was not working.

There were no audits for people's beds, mattresses and cushions, infection prevention and control.

St George's (Wigan) Limited

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 16, 18 and 20 November 2015 and was unannounced.

The inspection team consisted of one adult social care inspector, a specialist advisor (SPA) in nursing and a pharmacist inspector. An adult social care inspection manager attended in the afternoon, on the first day of the inspection.

Prior to the inspection we reviewed information we held about the home in the form of notifications received from the service such as accidents and incidents. We also contacted the Wigan Local Authority Quality Assurance Team, who regularly monitor the service, and the local Healthwatch. Healthwatch England is the national consumer champion in health and care.

We did not ask the service to complete a Provider Information Return (PIR), which is a form that asks the provider to give some key information about the service.

We spoke with five people who used the service, four visitors and eight members of staff including care staff, the manager, the clinical manager and proprietor. We also looked at records held by the service, including six care files and four staff personnel files. We undertook pathway tracking of care records, which involves cross referencing care records via the home's documentation, in order to establish if people's needs were being met. We observed care within the home throughout the day including the morning medicines round and the lunchtime meal.

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.

Inadequate

Is the service safe?

Our findings

We looked at how the service managed people's medicines. St George's accommodates people over three floors of the building. There was a central clinical room on the ground floor where medication was stored, which was securely locked. Medication was stored appropriately with regular fridge temperature monitoring in place. Medicines were provided in blister packs and stored in a secure medication trolley.

Some prescription medicines are controlled under the Misuse of Drugs legislation and these medicines are called controlled medicines or controlled drugs. We found controlled drugs were stored correctly and the nurse on duty held the key to the locked controlled drugs cabinet.

We spoke with the nurse on duty on the first floor of the building who explained they had experienced difficulties identifying individual people as many Medication Administration Record (MAR) charts had out of date or missing photographs of the person concerned. We looked at the MAR charts on the first floor and found that in some cases the person's allergy status was not included. On the first floor we saw MAR charts that had missing signatures with no explanation.

We asked the nurse on duty about the gaps in the records and they told us the service had been using lots of agency staff. We asked the nurse on duty about any medication training they had received and they told us they were waiting to access a medication course.

On the ground floor we spoke with an agency nurse who had been at the home for five weeks. They raised concerns about medication arriving in a timely fashion due to problems with the supplier. We checked records and saw that there had been delays between requesting and receiving some medicines.

We found that one person who had gone for nine days without receiving medication. This included medication to prevent a stroke and also antipsychotics. The home had not investigated this or filled in any form of incident report. The GP had not been notified and all the medication was re-started without medical advice after a nine day medication-free period. This issue was referred to the local safeguarding authority at the time of the inspection.

We looked at the management of topical medicines, such as creams. There were no body maps to explain where creams should be applied and it was unclear if it was the job of the nurse or a carer to apply creams. One person had been prescribed a cream on their MAR chart but the cream was located in the person's unlocked wardrobe and the absence of MAR chart entries meant we could not confirm if it was being consistently applied.

We saw that prescribed creams were also kept in other rooms insecurely such as diprobase, which was kept in a person's bedroom. The clinical manager told us there was a separate folder for topical products but they were unable to produce this and none of the staff we spoke with had knowledge of it.

We observed medicines being administered at lunchtime on the ground floor and saw the nurse retrospectively filling in MAR charts for medicines they said they had administered in the morning. On inspection of these MAR charts we found there were significant gaps that were not accounted for. This meant that an accurate record of the administration of people's medicines had not been kept and it was not possible to determine if the medicines had been administered as prescribed.

There was no specific reporting for medication errors or evidence of investigations and shared learning. There was a medication policy which was up to date and relevant but lacked a PRN policy. PRN medicines are medicines that are taken 'as needed'. We saw that some medication audits had been undertaken by the service but there was no evidence of them being used to improve practice.

These issues meant there was a breach of Regulation 12(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the proper and safe management of medicines, because the service did not have appropriate arrangements in place to manage medicines safely.

We looked at how the service managed infection control. The home had an 'Infection Prevention & Control' policy. This stated that staff should not leave the home in uniform . There were no changing facilities for staff within the building and staff had to wash their uniforms at home, which meant that they were still wearing their uniform when they left the building, in contradiction to the written policy.

Inadequate

Is the service safe?

We saw that two people, who shared a room with a permanent partition between their beds, had undergone a percutaneous endoscopic gastronomy (PEG). Staff told us that one person had previously had MRSA and we saw from care plan information that this person had wounds on their sacrum and feet. Because both people had invasive devises and wounds, this meant there was a potential cross infection risk. There were no records available to identify the management of this issue. Staff were unclear about whether the syringes they were using for PEG care were single use only, or could be used more than once. There was no guidance available for staff about this.

There were no covers for the tympanic thermometer that was being used to measure people's temperature. We saw that blood pressure (BP) cuffs, used to determine blood pressure, were dirty. This meant that there was a potential cross infection risk.

We observed a person sitting in the lounge on the ground floor in a very old reclining chair. The chair frame and the foam cushion were badly soiled and it was clear that this chair had not been cleaned properly. The arm of the chair was heavily patched with tape which was unhygienic. Another person was sitting in the first floor lounge and not wearing slippers or footwear, with their feet resting on a seat cushion placed on the floor. This was a potential infection risk.

We saw that one member of staff had a latex allergy/ sensitivity but no risk assessment or provision of an alternative has been made. We also found that there was no anti-bacterial hand gel available in the lower ground floor of the building.

Following the inspection we spoke with the Local Authority Infection Control Team who offered to provide support and training to staff at the home.

These issues meant that there was a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the service had failed to operate systems to assess, detect, prevent and control spread of infections.

During the inspection we looked around the premises. St George's is a large home on three floors and we found the general environment to be unclean. Radiators contained dust and grime, there were dirty armchairs in the basement lounge, open rubbish bins throughout the building and dirty toilet brushes. We saw that the drainage holes in the wet rooms all looked very dirty and staff did not know whether or how they were being cleaned. However at the time of the inspection the wet rooms were not being used and building work was on-going.

We observed there was a small hand-washing sink but no domestic sized sink in the first floor dining room. Cutlery was soaking in an old plastic jam container, which contained detergent. As we were leaving the dining room we saw a person attempting to pick up the container and the staff member had to move it. We also noticed two dirty dishcloths by the sink which the staff member told us was used by them to wash spilt food and drinks off the tables. We saw open bins were in the dining room and there was a dirty floor brush in this area.

We spoke with the domestic staff who told us that a second cleaner was off work that day. Staff told us that the night staff carry out some cleaning duties to include chairs, hoists, wheelchairs and commodes. However the book that was signed by staff to show that they had done the cleaning identified a gap for six days up to 12 November 2015.

There was an on-going programme of refurbishment being undertaken at the service, which included bedrooms, a walk-in wet room, decorating, lighting and electrical works. The majority of the renovation work was being carried out in a protected area away from people who used the service. However, despite efforts to secure the area, there was a pervasive taste of cement dust in several areas of the home. Prior to undertaking any work we saw that the contractors were required to sign a form to acknowledge receipt of the 'Home Risk Assessment' in relation to having contractors on site as well as several of the relevant policies such as health and safety, fire policy and evacuation plan, accidents/incidents, COSHH, security, first aid and untoward events. This meant that the contractor was aware of the need to adhere to the homes policies whilst carrying out the refurbishment work.

We looked at records regarding the maintenance of the premises and equipment and spoke with the staff member who was responsible for carrying out these checks. We checked all bedrooms and found that all the rooms had television wires that were loosely hanging down from the television units which presented a risk of ligature and trips. We spoke to the provider about this and the wires were subsequently made safe. Some bedrooms had old taps with no indicating marker that would identify if it was hot

or cold water. Some wardrobes had glass-fronted doors which were cracked presenting a risk to people's safety and visual difficulties for some people living with a dementia. Some bedrooms did not have lampshades or toilet seats. The provider told us that a questionnaire had been sent out to people who used the service and their relatives on how they would like their room to be decorated but at the time of the inspection the responses had not all been returned. Additionally some rooms had window restrictors that were broken or loose which presented a falls risk. We raised our concerns about the window restrictors, and these were repaired immediately. We checked these again and found the issue had been rectified.

This is a breach of Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the service had failed to ensure that the premises used by the service were clean, secure, properly maintained and suitable for the purposes for which they were being used.

A relative of a person who used the service said: "I visit every day and I definitely feel (my relative) is safe". We saw that one person had a pressure mat under their bed for night time use and this person had told (their relative) that it is not put in place and that they get up to go to the toilet without staff knowing. The relative told us that there often does not seem to be enough staff and they have to wait for the call bell to be answered.

During the inspection we looked at the way the service protected people against abuse. There was an up to date safeguarding policy in place, which referenced current legislation and local protocols. We spoke with four care staff who demonstrated an awareness of safeguarding and were able to describe how they would make a safeguarding referral.

The home had a whistleblowing policy in place. This told staff what action to take if they had any concerns or if they had concerns about the manager, and included contact details for the local authority and CQC. Staff we spoke with had a good understanding of the actions to take if they had any concerns.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service. We looked at the staff rotas for October and November 2015 and these consistently demonstrated that there were sufficient care staff on duty to meet the needs of people using the service. The rotas identified both nursing and care staff and we saw that a copy of the staff rota was displayed on the wall of the ground floor. There was also a display board with pictures of all the staff, including their names and job role. This would assist people using the service and their relatives to recognise different staff members.

The manager told us that if there was an unforeseen shortage of staff, the home initially contacted existing staff and as a last resort would use agency staff. When agency staff were used, or when a new member of staff started, they undertook a day of induction and orientation and were assisted by a more experienced member of staff. Following the induction staff were required to sign the 'induction and orientation' form to identify that they had been provided with the required information to enable them to carry out their job role safely.

The service did not use a formal dependency level tool to determine staffing levels but the manager told us that each day the service looked at the information in people's daily notes and shift handover information, and any changes that may indicate the need for additional staff are responded to. The manager said that in the past the provider had responded to requests for additional staff positively.

We looked at four staff personnel files and there was evidence of robust recruitment procedures. The files included application forms, proof of identity and references. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people.

Requires improvement

Is the service effective?

Our findings

We looked at staff training, staff supervision and appraisal information and saw there was a staff training matrix in place. All care and nursing staff had recently completed training in safeguarding. Care staff had also undertaken training in challenging behaviour, COSHH, equality and diversity, infection control, fire training, dementia and DOLS, food hygiene, and manual handling. Half of care staff had completed training in bed rails and thirty percent of care staff had completed training in person-centred care. Eighty percent of care staff held an NVQ level 2 or 3 qualification in care. One staff member told us that they were doing training updates and said: "Things change all the time". We also spoke with another carer who said they felt well supported and that they received good training.

We found that Infection Prevention and Control training was being offered by the Trust and three staff members had signed up to this training. We saw from the information that was on a notice board that it was up to the staff members to opt-in to this training rather than the managers nominating people to go. The clinical lead told us that they hoped that all staff would have IPC training.

We could not find any evidence of a staff supervision matrix and the manager told us that these meetings had not been happening, but that in future they intended to ensure these happened every three months at a minimum in addition to an annual appraisal. We asked a member of staff about supervisions and they said that they had not been happening but thought they would be useful. Another member of staff told us they 'thought that nurses did supervisions but they had not had one recently although the nurses do observe practice.' The manager showed us a supervision bulletin that had recently been circulated to all care staff indicating that annual appraisals would be starting at the end of November 2015. This meant that staff had not been provided with the required support to enable carry out their duties and did not have the opportunity for discussions with managers about work related issues such as performance, training, competency, skills and knowledge.

This is a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because persons employed by the service had failed to receive appropriate supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

We asked the manager about medication competency checks for staff that administered medication and they explained that these had not been carried out.

We asked the clinical manager for a copy of the staff training records in relation to PEG care and found that only 14% of staff who delivered care to a person between the period 13 November 2015 and 16 November 2015 had done this training. This meant that staff may not understand how to ensure the safe delivery of PEG care. We looked at the training records for tissue viability training and saw that there was a tissue viability nurse in post. We asked the clinical lead about this and they told us: "(The tissue viability link nurse) attends the link nurse meetings with the community tissue viability nurse." We looked for records of these meetings and were only able to determine that they had attended two meetings.

These issues meant there was a breach of Regulation 12 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service had failed to ensure that persons providing care or treatment to service users have the qualifications, competence and skills to do so safely.

We asked people if the food at the home was good. The relative of a person who used the service said: "I think the food is top class. I have eaten here every week and it's very nutritious. The relative of another person told us: "(My relative) doesn't go short of food".

There was a four week seasonal menu in use and this was displayed on the wall in the dining room. The dining tables were sparsely laid with no table clothes, no other form of table decorations, and very few available condiments . This meant that the dining room did not feel homely or welcoming. Kitchen staff told us that meals were ordered the day before and the list was sent to the kitchen. If people changed their mind they were able to order an alternative using a 'daily meal choice' form.

We checked the food stocks in the kitchen and found that there was an adequate supply of fresh and dry goods and the freezers were well stocked. Fridge temperatures were recorded daily and a daily and weekly cleaning schedule was in place but had not been fully completed for some

Is the service effective?

weeks. In the kitchen we saw old sticky tape on some of the walls and there was a large bench type tin opener that was old and very chipped which presented an infection control risk. The environmental health officer Food Hygiene Rating Score (FHRS) was Four. Food preparation facilities are given an FHRS rating from zero to five, zero being the worst and five being the best.

There was a food hygiene policy and we saw that staff had completed training in food hygiene.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. There were appropriate records relating to the people who were currently subject to DoLS. There was documentation of techniques used to ensure restrictions were as minimal as possible. There were appropriate MCA assessments in place, which were linked to screening tools and restrictive practice tools which outlined the issues and concerns. There were applications for DoLS where the indication was that this was required and these were up to date and reviewed regularly.

Consent documentation was contained within people's care records. We found for one person this had not been completed. We saw that this person had an Independent Mental Capacity Advocate (IMCA). IMCA is a type of statutory advocacy introduced by the Mental Capacity Act 2005 (the Act). The Act gives some people who lack capacity a right to receive support from an IMCA and is used when a person is unable to communicate their views. A pre-admission assessment was in the person's the file, but no capacity assessment had been undertaken by the home as part of the pre-admission assessment, although there was a note stating 'unable to understand'. On the day of the inspection, no evidence relating to consent to share a room was on file at the home. A blank consent form was held within a hard copy file in the person's room. There was also no consent form around care planning.

The information highlighted the IMCA was identified as having been present when a Continuing Healthcare (CHC) Assessment was undertaken on 2 July 2015. We asked the manager if the IMCA had ever attended St George's and they said: "Not that I am aware of." The clinical lead told us they thought a best interests meeting would have been held at the hospital but they hadn't attended. We asked for evidence outlining the outcome of this meeting, and that the decision for (the person) to reside in a shared room had been discussed. The clinical lead said they should have it, but were unable to locate the information. This information, dated 3 August 2015, was supplied to us shortly after the date of the inspection and we saw that it identified discussions regarding the use of shared room and support requirements around PEG care.

Throughout the course of the inspection we heard staff seeking verbal consent from people prior to providing support to them. This ensured that people gave their consent to the care being offered before it was provided.

People's health needs were recorded in their files and this included evidence of professional involvement, for example GPs, podiatrists or opticians where appropriate. Relatives we spoke with told us they were kept informed of all events and incidents and that professionals were called when required.

The home had a dementia café, providing a safe environment for people who used the service to socialise with each other and members of the local community. This was situated on the lower ground floor, which was open to the community one day each month. There was a memory lane reminiscence room decorated with items to stimulate people's memories and facilitate conversation.

People were able to personalise their bedrooms with individual items such as family photographs and personal objects. We looked at the double bedrooms which had recently been renovated. Each bedroom had access to a wet room with toilet and hand basin. In each double bedroom there was a permanent divider between the beds. Some of these dividers came halfway down the middle of the room and some a third of the way down which allowed

Requires improvement

Is the service effective?

more light to the first bed but did not give much privacy if the person was receiving care and very little natural light for the person nearest to the door. Each newly refurbished room had en-suite facilities but the construction of the wet room and the partition reduced the size of the bedrooms.

There were few armchairs in the bedrooms for people to sit in their own rooms or for visitors to sit with them. Rooms had been decorated in magnolia and white, the curtains and duvet covers were very plain and there were very few pictures on the walls.

Some people had placed personal photographs on the window ledge but there were no shelves to place personal items on, overall the rooms felt very 'clinical'.

There was one television in each shared room mounted on the wall opposite the beds, therefore both people sharing the room needed to agree to watch the same programme.

There were wardrobes in some rooms with a mirror on the external side, which may present problems and cause confusion to some people living with a dementia.

We found there were people living at St. George's who were living with dementia. We saw staff responded and supported people with dementia care needs appropriately. However, there were few adaptations to the environment to make it dementia friendly or that would support these people to retain independence within their home. We saw people's bedroom doors did not have their photograph on it, which could make it difficult for people to find their room.

Although adaptations had been made to the bathrooms and toilets to assist people with limited mobility, there were few adaptations such as contrasting handrails, directional signage or themed areas that would have assisted people living with dementia to mobilise round the building or understand where they were if assisted by staff. We found that some doors, including those leading to bedrooms did not have anything visual to identify where that door led. This would make it hard for some people living with dementia to find their bedrooms.

We recommend that the service reviews current best practice guidance on developing dementia friendly environments.

Requires improvement

Is the service caring?

Our findings

The relative of a person using the service told us: "The staff are all my friends". Another relative said: "Staff are well-mannered when speaking to (my relative)".

A number of 'thank you' cards from people who had previously used the service were displayed on a notice board in the entrance area. One card read: "May I say a very big thank you to you all for everything you have done for me during my stay with you. Your kindness and cheerful attitude has helped me feel so much better." Another card read: "Your kindness, helpfulness and consideration at all times was appreciated. You all made me feel so at home and comfortable."

We saw that interactions between people who used the service and staff members were warm, conversations were of a friendly nature and there was a caring atmosphere. Staff attitude to people was polite and respectful using their names and people responded well to staff. For example at the lunch time meal we saw a staff member gently assisting one person to eat their meal, encouraging the involvement of the person and providing reassuring assistance whilst maximising the person's independence and recognising what they could do for them self.

We heard positive chatter between staff and people during the course of the inspection.

The staff we spoke with demonstrated an understanding of the people they supported, their care needs and their wishes. They were able to tell us about people's preferences and how they endeavoured to ensure care and support provided was tailored to each person's individual needs.

Staff spoken with could give examples of how privacy and dignity was respected, for example by knocking on doors, covering up people whilst providing personal care, asking permission before carrying out any assistance and explaining reasons for interventions.

The home had a Service User Guide and this was given to each person who used the service. The guide contained information on how to make a complaint but the contact details were out of date. The guide also identified that the home had an open visiting policy which meant that relatives of people who used the service could visit at any time, though visiting at meal times was discouraged in order to ensure people were not interrupted whilst eating their meals.

We saw there was a 'privacy and dignity' policy, which was up to date and recently reviewed. There was also an up to date 'resident's rights' policy and a 'philosophy of care' policy which helped staff to understand how to respond to people's different needs. Staff were aware of these policies and how to follow them.

We saw that prior to any new admission a pre-assessment was carried out with the person and their relative(s) where appropriate. We verified this by looking at care records. At the time of the inspection no-one was receiving end of life (EOL) care.

We saw that one person was sitting on a dirty cushion on a bench seat and partially undressed. A member of staff immediately assisted the person in a dignified manner, gently talking to the person whilst assisting them to their room. The seat cushion was immediately removed.

Prior to the commencement of the refurbishment work, the home had informed people using the service and their relatives about what would happen at different stages. Following the completion of the refurbishment work it was the intention of the provider to consult with people regarding their choice of furnishings and décor.

We saw that surveillance cameras were in place in the corridors throughout the home. People who used the service and their relatives had been informed about the use of these cameras but there was no evidence to identify that they had been involved in any prior, meaningful engagement that supported the decision to install them.

Requires improvement

Is the service responsive?

Our findings

We looked at the care planning records for people using the service. The home used both an electronic and paper copy care plan system, which was accessible by several staff at the same time who had an individual log-in password. On the first day of the inspection, we found that the electronic care planning system had not been working for the previous three days and this was attributed to external cabling having been degraded by wildlife. We asked the provider about this who demonstrated that they had been trying to resolve the issue with the IT provider. We asked if there was a contingency plan for when the electronic care system went down. The provider told us that there wasn't a plan and said: "but it has never happened before." The manager highlighted that there were hard copy files in people's bedrooms but when we checked the care plans, not all files contained the latest information due to it being stored electronically, which meant that staff did not always have access to the latest care planning information.

We carried out pathway tracking for one person who was subject to a Percutaneous Endoscopic Gastrostomy (PEG). This is a procedure that allows nutritional support for people who cannot take food orally. We asked to view the records for this person to deliver care relating to their PEG, that staff had access to over the previous three days when the electronic system was not working. Three hard-copy files were provided. We saw that initial records were in place that had been provided by the hospital. However, none of the files contained a copy of the person's care plan relating to their PEG. We were informed by the manager that the record should be in paper copy form but would also be on the electronic system.

We asked the clinical lead how staff would know how to provide care to this person and they said they would log onto the electronic system and if it was an agency nurse they logged on under an agency password. Due to the lack of records in the paper copy file, staff were unable to access the up to date care plan for this person during the time the electronic system was not working.

The remaining hard copy records were disorganised and difficult to follow. The person was unable to take food orally and was identified as 'nil by mouth' but this information was not clearly present with the care file documents being used to record PEG. This was confirmed by the clinical lead who agreed to place a paper copy file of a PEG care plan in the person's records immediately.

Towards the end of the first day of the inspection the electronic care plan system became live again, and the clinical lead was able to access the person's care plan for their PEG on the system. This had last been updated on 11 October 2015. A discharge letter from the Community Stroke Team had been present in the person's hard copy file from 06 November 2015. This referred to advice given on 9 September 2015 to monitor hypergranulation tissue around the person's PEG site, which is an excess of granulation tissue beyond the amount required to replace the tissue deficit incurred as a result of skin injury or wounding. This visit had not been recorded on the electronic system at the time, nor had the receipt of the letter instigated the updating of the person's care plan.

This meant there was a breach of Regulation 17(2)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because the service had failed to maintain securely and accurate, complete and contemporaneous record in respect of each person using the service.

During the inspection, we reviewed people's care plans. Each care plan contained a variety of risk assessments and included areas such as nutrition, mobility, pressure sores, physical health, mental health and pain management. Some of the care plans we looked at did not have a photograph of the person on them. The plans contained a profile of the person concerned including basic personal information such as height, nationality and previous occupation but this was not always completed for every person.

One person using the service required and used specially adapted spectacles. This person's relative told us the carers 'don't like putting them on' and '(the person) was unable to see anything without them or to walk safely with their walking frame.' Their anxieties about (the person) not walking had previously led to a request for a physiotherapist to assess (the person) and advise the carers about how they should be walked with one carer holding from behind and a second carer guiding the frame. The relative told us staff did not always follow these instructions and frequently used a wheelchair. The relative said: "They (the home) need more staff."

Requires improvement

Is the service responsive?

We looked at the care records for another person using the service and saw that care plans were in place from Oct 2014 and the clinical lead had signed to say they had updated them each month until Feb 2015 when their job changed. However they did not ensure that other staff were doing the updates or recording them in the same way. We were unable to check the more recent updates due to the computer system problems. We saw that the tissue viability nurse (TVN) had previously provided advice for the management of a wound on three occasions. The last wound assessment was dated 25 Oct 2015 but was unreliable as the wound had previously been assessed as grade 3 then subsequently grade 2, then grade 4. If (the persons') wound had deteriorated to a grade 4 the TVN should have been asked to review the position but this had not been done, which meant that the person was at risk of further deterioration.

This meant there was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care, because the service had failed to ensure people's care and treatment was appropriate and met their needs.

The home employed an activities coordinator and activities on offer were displayed on a notice in the entrance area which included arts and crafts, relaxation, pamper sessions, and dominoes. The activities coordinator told us how people liked hand massages on a 1-1 basis and information on people's recreational preferences was recorded in their care plans. The activities coordinator told us that they were developing pictorial versions of activities which would help people to understand what was being offered.

Recent events had included a tea party in a local town, a trip to Blackpool, and a 'memory walk' carried out in partnership with a local day centre. Additional regular activities included visits to a local café on a 1-1 basis and coffee mornings in partnership with a large well-known supermarket.

There was a library with large print books in the lower ground floor of the home and a hairdressing salon available for people who did not access the community for this.

There was a 'Supporting Residents Outside the Home' and 'Religious and Cultural Issues' policy in place and we saw that information about personal preferences, social interests and hobbies were recorded in people's care files.

Residents and relatives' meetings were not carried out regularly. We asked for notes of previous meetings and were provided with the record of one meeting that had taken place on 29 January 2015 where discussions included meal times, staffing, care planning, refreshments, the dementia café and fundraising. No other records were provided to us.

There was a 'Residents' Complaints Procedure' in place and we looked at examples where complaints had been raised and responded to in a timely manner.

Shortly after the date of the inspection, the provider wrote to us to inform us that a series of questionnaires had been devised to ensure the service captured the views of people regarding the refurbishment and a meeting had been arranged for the following week. We saw that one questionnaire asked about people's knowledge of what facilities were offered at St. George's and another questionnaire asked about people's views on medicines, personal health, privacy and dignity, care plans, and end of life (EOL) care.

Requires improvement

Is the service well-led?

Our findings

There was no registered manager at the home. 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 the time of the inspection a person was in the process of applying for this position and registering with the CQC.

A member of staff told us: "I would say that the management team has changed too often so there's been no consistency. I'm hoping it'll now settle a bit." Another staff member said: "The manager is approachable and has an open door policy." Another staff member told us: "I feel there has been some improvement recently but I think communication is lacking and overall I think there is room for improvement."

The relative of a person using the service said: "I've made a record of events every day since (my relative) has been here and I would say less than 1% would be negative. I know the manager and how to make a complaint. When (my relative) has had a problem I have always been informed. The manager told us that continuity of staffing was a problem and that 'the service needed to accept changes and move forward.'

We looked at how the provider audited the quality and safety of the service. Audits were in place in a number of areas. We found audits had not been effective in identifying and rectifying the issues we found during our inspection. For example, a medication audit had been completed for the period June to October 2015. However, this had not been effective as we found a range of medication issues during the inspection.

No infection control audits were in place. We saw that cleaning rotas were in place for the night staff but these were incomplete. We saw that equipment was not being cleaned regularly and there were no records of management checks to identify if this was being done.

We looked at the records held by the person responsible for carrying out equipment and building checks, who told us that they had started to design and implement a regular system of building checks since coming into post two months previously. There were weekly checks for water temperatures, the fire alarm and means of escape. There was a contract file which was all up to date and included a gas safety record, a fire system annual inspection certificate, a hoist examination and service report, a hoist-sling thorough examination report, routine servicing and examination reports for the lift, a pest control certificate, records of washing machine and dryer checks, a legionella report, a hot water boiler check report and COSHH information. However, the service had failed to identify and rectify the environmental issues that we found in people's bedrooms.

This meant there was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because the service had failed to effectively assess, monitor and improve the quality and safety of the services provided.

We found care plan audits had been carried out for the period April to July 2015. There was a document titled 'monitoring form – service user care files' in place which had been completed for the period April to October 2015 and covered the admission process, basic personal information, other professionals involved details, pre-admission assessment, medical conditions and allergies. There was a falls and weights audit completed for the period April to October 2015.

There was a wound care plan audit completed for the period April to October 2015 which covered wound histories, wound care plan, wound and patient assessment, progress and review, advice to staff and pressure sores. There was a kitchen audit completed for the period April to October 2015 and a mealtime audit had been completed in October 2015. A weekly carer's checklist was in place for each floor of the building and this covered various aspects of equipment and information checks.

There was also a complaints audit completed for the period March to October 2015 and we saw that the appropriate people had been involved where applicable and the complaints had all been resolved to the satisfaction of the complainant in a timely way.

There was an accidents and incidents audit completed for the period May to August 2015 and this identified the number of incidents in the previous month, the details of the incidents, if the incident was commonly recurring, the actions required to prevent a reoccurrence, and the

Requires improvement

Is the service well-led?

implications for staff training, resource provision and policy and practice review. We saw that the 'actions required to prevent a reoccurrence' section of the audit had been completed.

There was a contingency planning handbook in place that identified actions to be taken in the event of an unforeseen event such as the loss of utilities supplies, pandemics, flood disruption and lift breakdown. Policies and procedures were all up to date, having been reviewed in August 2015.

Before the date of the last inspection the home had worked alongside Healthwatch Wigan in order to support an 'Enter and View' inspection. Healthwatch Wigan gathers the views of local people and makes sure they are heard and listened to by the organisations that provide, fund and monitor social care services. The service also worked closely with Wigan Council provider market management and development team and regularly accessed a local day centre.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with the spread of infectious diseases because the service had failed to operate systems to assess, detect, prevent and control spread of infections. Regulation 12(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The service had failed to ensure that the premises used by the service were secure, properly maintained and suitable for the purposes for which they were being used. Regulation 15(1)(b)(c)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service had failed to ensure people's care and treatment was appropriate and met their needs. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Persons employed by the service had failed to receive appropriate supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a)

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 People who use services and others were not protected against the risks associated with unsafe or unsuitable management of medicines. Regulation 12 (2)(f) (g) The service had failed to ensure that persons providing care or treatment to service users have the qualifications, competence and skills to do so safely. Regulation 12(2)(c)

The enforcement action we took:
CQC has issued a Warning Notice with conditions to be met by 11 March 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service had failed to maintain securely and accurate, complete and contemporaneous record in respect of each person using the service. Regulation 17(2)(c) The service had failed to assess, monitor, improve and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17(2)(a)(b)

The enforcement action we took:
CQC has issued a Warning Notice with conditions to be met by 11 March 2016.