Delphine Homecare Limited

St George's Nursing Home

Inspection report

1 Court Close, Pastures Avenue
St Georges
Weston Super Mare
Avon
BS22 7AA

Tel: 01934524598

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12 December 2018

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

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

The purpose-built home is registered to provide accommodation for up to 60 older people who require nursing and personal care. At the time of the inspection 26 people were living at the service.

The inspection took place on 12 December 2018 and was unannounced.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. The registered manager was on leave during the inspection; however, the deputy manager, clinical lead and head of human resources and administration made themselves available to us throughout the inspection.

At the previous inspection on 5 June 2016 the service was rated as Good. At this inspection we rated the service Requires Improvement because the provider's quality assurance processes were not robust. We found shortfalls in relation to environmental checks, infection control, care planning and statutory notifications. Although the provider told us after the inspection that they had rectified the issues, there was a risk that the provider's auditing processes were not adequate.

People and their relatives told us they felt safe. Staff had been trained to keep people safe from avoidable harm. Care plans contained risk assessments and care plans provided clear guidance for staff on how to reduce the risks.

Incidents and accidents were reported and analysed to identify trends. There was evidence that lessons were learned when incidents happened.

Medicines managed safely.

Staff were trained to undertake their roles. Staff had regular supervisions with a supervisor.

People were supported to have enough to eat and drink.

People using the service spoke highly of the staff and all were happy with the support they received. We observed positive interactions between staff and people. People were asked regularly for their feedback.

Care plans were not always person centred and some of the plans we looked at did not provide clear

guidance for staff on how to meet people's needs.

Complaints were logged and investigations and outcomes documented.

All the staff told us the service was well managed. People using the service and their relatives gave positive feedback about the management team.

We found one breach of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Environmental checks had not been carried out as required.

Staff had been trained to keep people safe from harm.

Medicines were managed safely.

Incidents and accidents were reported and analysed.

Is the service effective?

Good

The service was effective.

Staff had been trained to carry out their roles and had regular supervisions.

People were supported to have enough to eat and drink.

People had access to ongoing health care.

The service followed the principles of the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring.

Staff treated people with dignity and respect.

Staff provided privacy and support when required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not consistently person centred and lacked clear guidance for staff on how to meet people's needs.

Staff knew people well and understood their needs.

There was a range of activities available.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality monitoring did not identify shortfalls in environmental safety checks, medicines, infection control and care planning.

Statutory notifications had not always been sent to the Care Quality Commission in a timely manner.

People, their relatives and staff spoke highly of the registered manager.

St George's Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, 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 December 2018 and was unannounced. The inspection team consisted of one adult social care inspector, one expert-by-experience and one specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed other information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us. We also looked at information in the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with nine people and four visitors. We also spoke with eight members of staff, including nurses, care staff, a chef and the management team. Prior to the inspection we sought feedback from three professionals who work with the service. We reviewed four people's care plans and five staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Requires Improvement

Is the service safe?

Our findings

Safety reviews and regular servicing of utilities such as electrical checks, regular fire alarm testing and drills were carried out. However, there was no record of any legionella testing in place and no record of safety checks to ensure the electricity supply was safe. Following the inspection, the service informed us that they had arranged for legionella and electrical testing to be carried out. Further detail can be found in the Well-led section of this report.

Staff were trained to reduce the spread of infection and personal protective equipment (PPE) including gloves and aprons were available for staff to use. However, the service had not consistently reduced the risks. People with urinary catheters in place had their catheter bags resting on the floor, rather than a stand or tray. This meant there was a significant risk of infection for people with catheters in situ. Fall mattresses were ripped which meant it would be difficult to maintain the cleanliness and prevent the spread of infection. Neither of these areas were monitored through the providers infection control audits. After the inspection, the service informed us that metal trays had been ordered to keep catheter bags off the floor and that all ripped mats had been thrown away and new ones ordered.

Care plans contained risk assessments for areas such as falls, mobility, skin integrity and malnutrition. When risks had been identified the plans provided clear guidance for staff on how to reduce the risks. For example, one person had been assessed as having a high risk of falling. The plan guided staff to, "Check [person] regularly, crash mat and sensor mat, low bed, wheelchair for transport." When staff needed to use equipment to move people safely, hoist and sling details were written. Plans for people who were at risk of developing pressure sores, specified how often staff needed to support them to change position. However, position change charts did not always reflect care plan guidance. For example, one person's care plan guided staff to support them to change position every four hours, but there were large recording gaps; on 7 December there was a gap of 14 hours where nothing had been documented and a gap of 17.5 hours on 8 December. Additionally, staff had not always written which position they had supported people from or into. Instead, they had written "repo." This meant there was a risk people had not always had their positions changed as often as required. The provider wrote to us after the inspection to inform us they had discussed this issue with care staff and emphasised the importance of maintaining accurate position change charts.

Medicines were managed safely. All medicines were stored safely and regular stock checks were carried out. The temperature of the clinical room and medicines fridge were monitored and records showed medicines were stored within manufacturer guidelines. Medicines that were no longer required were safely disposed of.

People told us they received their medicines on time. One person said, "I get my medication all of the time, on time. I never have to ask, they bring it to me." Some people were prescribed additional medicines on an as required (PRN) basis. In these instances, PRN protocols were in place; however, they did not always detail how people who were unable to communicate might indicate they were in pain. Some people were prescribed topical medicines such as creams and lotions. There were topical administration charts in place, and these had been signed by staff. However, it was unclear how staff knew when and where to apply the creams because the instructions were limited to "as directed" or "as required."

We recommend the provider reviews PRN protocols in order to reflect people's communication needs.

The environment was visibly clean and free of odours. One person told us, "The home is always kept clean and tidy. If you make a mess they will always offer to clean up for you." When we asked, people confirmed that staff used PPE when providing personal care. One person said, "The staff are always washing their hands and they wear aprons and gloves."

People and their relatives told us they felt safe. Two people told us, "We like it in here. We feel warm and cosy and safe as houses." Another person said, "Yes, I feel safe here, the staff do what they can for me, keeping an eye on me all the time, even at night. I've got nothing to worry about here."

Staff had been trained and understood their responsibilities to keep people safe. One member of staff said, "If I noticed someone had bruises, I'd show the nurse in charge, take pictures, document it, and ask how it happened." Staff were familiar with the term whistleblowing and said they felt confident to challenge and report poor care. One member of staff said, "I would report it to [registered manager], or go higher. I would use the whistleblowing policy."

The provider had procedures in place to ensure staff had checks undertaken before commencing their employment. These included inviting them for a formal interview and carrying out pre-employment checks. Within these checks the provider asked for a full employment history, references from previous employers, proof of staff's identity and a satisfactory Disclosure and Barring Service clearance (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with adults.

There was enough staff on duty to meet people's needs. The provider used a dependency tool to calculate staffing levels and we saw that staff numbers were generally maintained. The service used agency staff to cover staff vacancies and we were told that where possible the same agency staff were used to maintain continuity of care. People told us they felt there was usually enough staff available. One person said, "Plenty of staff around here, you see them around the place all of the time." Another person told us, "Visually, there is plenty of staff around; sometimes it gets very tight, then they get agency staff in." Most staff said they felt there was enough of them on duty as long as staff did not call in sick. One member of staff said, "I think we're a bit short [staffed] in my opinion. I wish I had more time to talk with people, getting to know them better. People are more relaxed and seem to enjoy talking. That's the difference; when we're in a hurry, we don't have time." During the inspection we saw that call bells were answered swiftly and staff were visible and available when people needed them.

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Good

Is the service effective?

Our findings

Staff were trained to carry out their roles. There was a training plan in place which showed which training staff had completed and when refresher training was due. New staff completed an induction programme. One new staff member said, "I had some training and shadowed another member of staff." One person told us, "The staff know what they are doing here. I feel safe in their hands."

Staff had regular supervision sessions with their line manager. This meant there was an opportunity for staff to discuss their performance, their training needs and access support in their roles. Regular staff meetings took place and annual appraisals were also undertaken. Most staff we spoke with said they felt supported in their role.

People were supported to have enough to eat and drink. People's weights were monitored and when people lost weight, advice was sought. The chef told us, "I've got a sheet that is updated on what people like to eat, any special diets etc. Anything specific, staff will tell me." We saw staff regularly offering drinks and snacks to people throughout the day. The chef told us, "The trolley goes around the home. We offer biscuits, crisps and chocolate bars in the morning. The afternoon trolley will have scones, doughnuts, pork pies or crumpets. It's all about helping people to gain a bit of weight." People spoke highly of the food. One person said, "I am given a lot of choices regarding my food. I asked for a full English breakfast and I got it. The next day I asked for a bacon and sausage sandwich, I got this as well and on the third day I asked for a bacon sandwich. They brought me this and a plate of sausages just in case, which was a nice touch."

We observed lunch. Some people ate in the dining room, others chose to eat in their bedrooms. The tables were laid and people were offered a choice of drink to accompany the lunch. One person had a glass of wine and another had a can of beer. People had chosen their meal earlier in the day; however, before serving the meal people were asked if they would like to change their minds. The meal was well presented and smelt appetising. People told us they enjoyed their food. One person said, "Very good, I enjoyed that, I always do." Although none of the people had any specific cultural needs in relation to their diet, the chef said they could provide this if required. They said, "I try to adapt the food to suit diabetics too."

Some people were having their food and fluid intake monitored. Daily fluid intake targets had not always been documented on fluid charts; however, this information had been recorded in care plans. Food and fluid charts had not always been completed in full; this was an area that staff were aware they needed to improve. One member of the management team said, "We know documentation is sometimes a problem. But, I've been able to discontinue food and fluid chart because people have put weight on. That's a reflection of the time and support that staff are putting in." Despite charts not always being completed, from what we saw and from what people and their relatives told us, we were assured that people had enough to eat and drink. For example, we saw staff supporting people with meals. This was done sensitively; staff sat alongside people, told them what the food was, asked if they were enjoying it and did not rush them. People told us they were always offered a drink and snack before bedtime. One person told us, "At night, just before bedtime, the night staff ask me if I want a snack and they often bring me a sandwich ."

People had access to ongoing healthcare. Records showed people were seen by the GP, physiotherapist and speech and language therapist (SALT). When provided, advice had been included within people's care plans. For example, SALT recommendations about people's specific dietary needs.

The environment was light and spacious. There were several small seating areas as well as larger communal areas and a secure patio garden laid with borders and a water feature which people could enjoy during warmer weather. There was a digital display screen in the main corridor; this had current information clearly displayed such as, the days menu, the staff on duty, and the activity schedule.

Consent to care and treatment was sought in line with legislation and guidance. People were assessed for their capacity to consent to their care and when people lacked capacity best interest decisions had been made. These were documented and showed that less restrictive options had been considered. Staff remained knowledgeable about the Mental Capacity Act and could explain how they applied it when supporting people to make decisions. One member of staff said, "I always offer people a choice. If people can speak, we show them by holding up clothing options or ask them. I always ask if people want to get up or not. If people refuse that's their right." One person said, "They [staff] will never do anything without checking first and then asking if it is okay."

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). 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). The provider was meeting the requirements.

Good

Is the service caring?

Our findings

People and their relatives all spoke highly of the staff. Comments included, "The staff are wonderful here, they put you first and always listen to what I have to say" and "The staff are wonderful here and so kind. They listen to me and give me time." One person's relative said, "The staff are very patient and caring. My [relative] has dementia. Staff never rush [relative]; they give [them] all of the time in the world."

We observed many positive interactions between staff and people. On one occasion we saw one person walking along the corridor. A member of staff asked if they'd had a cup of tea or did they want one or some chocolate. The person shook their head and leant into the member of staff, who said, "Oh you want a cuddle? I'm happy to do that." The staff member then hugged the person, and asked if their back was hurting and said, "Shall I check with the nurse to see if you're due any pain killers?"

People were treated with kindness and compassion. Staff spoke positively about their roles. One staff member said, "Care is good here, it's person centred. We treat people like individuals, they have care as they want it. If they want a bath, they can have it. We have a bond here with residents and families; we feel like we're all in it together." Another member of staff said, "I know if I can get a resident to sing and laugh with me when I'm singing, then I know I've made a difference." One person told us, "The staff appear very kind and caring and take time to listen to me, I asked for a note to be put on my wall detailing what help I need with walking, just in case. See, it's up there [pointing to the note]." One of the nurses told us, "This is one of the happiest homes I've worked in. The home just has a lovely feel. I wouldn't stay somewhere if I didn't feel the care was really good."

Staff understood how to maintain people's privacy and dignity. We saw that red cards were hung on people's bedroom doors to indicate that personal care was taking place and to inform others not to enter. One member of staff said, "I always keep people covered up during personal care, put the red sign on the door and close curtains. One lady always asks me why I close the curtains even when she's just going to toilet. But it's about dignity, isn't it?"

People were asked for their feedback. Regular resident and relative meetings took place. One person said, "Yes, I go to the meetings. We suggest things." We saw a 'You said, we did' poster in the dining room which indicated changes made within the home following suggestions made at meetings. We saw the compliments folder. Examples of compliments received included, "[Relative] felt loved and safe and never yearned for home. For that we are eternally grateful. [They] had love, affection, cuddles, banter, and all of this was vital to [their] well-being, you all gave [them] this. We cannot say how much we appreciate you all." Another compliment read, "We cannot thank you enough for the wonderful care and attention you gave my sister. I visited daily, where I always had a warm welcome. It's such a happy, friendly place."

During the inspection relatives of people who had previously lived and passed away at the home visited. One of these visitors told us, "My [relative] had very different cultural needs to the other residents. The staff went out of their way to find out what was needed to meet [their] ethnicity needs and they did it. For example [relative's] skin required a lot of coconut butter applied to it every day and staff asked me to show

them how to do it and how to style [relative's] hair. The staff without exception were kind and caring. I was worried that staff would not be able to meet [relative's] cultural needs, but they did. What a surprise that was, wonderful".

Requires Improvement

Is the service responsive?

Our findings

Care plans in relation to people's health needs were limited. Some people had urinary catheters in place, but the care plans did not inform staff how to care for these. There was no information on how to ensure the catheter was kept clean, the signs and symptoms of infection that staff needed to be aware of, or how much fluid the person should drink. Plans for people with diabetes did not inform staff of the signs and symptoms of hypo or hyperglycaemia and did not detail the actions staff needed to take in these instances.

Two people required daily exercises as part of their health recovery. In both people's plans there was a document with some pictures, showing the exercises the person needed to undertake. However, there was no written information for staff on how often they needed to support people to do these, other than "regular" in one person's plan. When we asked one person if staff supported them to do the exercises the sheet, they said staff rarely encouraged or supported [them] to do so. When we asked staff how often they should support people to undertake any required exercises, staff were unable to tell us.

Care plans were person centred in places but this was not seen consistently. For example, in one person's care plan the information for staff on how the person preferred to be supported to have their hygiene needs met, was detailed. Staff had documented the person preferred to wear makeup and jewellery and how their personal grooming needs were met. In other plans we looked at, this level of detail was missing. Some people had 'this is me' documents in place. These documents provide information for staff on the person's cultural and family background; events, people and places from their lives; preferences, routines and their personality. Some of the forms we looked at provided comprehensive information for staff; but some did not. For example, in one person's file it was documented the person "liked watching TV" but the person's preferred programmes were not listed.

When care plans do not contain the necessary detail there is a risk that people may receive inappropriate or unsafe care particularly when this information is not available for new or agency staff. The provider wrote to us after the inspection to say they had rewritten plans where information was missing.

Despite the lack of information in some plans, staff were able to discuss people and their needs with us. Staff told us they had access to the care plans and that there was also a folder in the staff room which contained details about people's support needs. The handover sheet staff were provided with was very detailed. One member of staff said, "I've read the care plans, but I keep learning about people every day. For example, [person's name], only likes their bedroom door half open."

People's communication needs were met. One member of staff told us that one person communicated with them using a picture board. They said, "If it's not on the board, we point at what we think it might be." They took us to meet the person and showed us the communication board. As we left, the staff member asked the person "Do you want the light on?" whilst pointing to the light. The person smiled in response and so the light was switched on. The staff member checked this was correct and when the person then shook their head, the light was turned off. The staff member did a 'thumbs up' and the person smiled to indicate this was the response they wanted.

Advanced plans were in place. These are plans that provide staff with information on people's choices and any special wishes they may have when they are approaching the end of their life. Some of the plans contained details such as whether people wanted to be visited by a member of the church and other special wishes. Other plans lacked detail. For example, in one person's plan, staff had documented, "Staff to obtain [person's] wishes from family" but there was no other information available. Despite this, staff spoke highly of the end of life care they provided and told us they had good links with the local hospice. One member of staff said, "I'm really proud of our end of life care. Because of the love we feel for our residents, we give a lot of love and compassion. Someone who died here, wanted their funeral procession to start from here and we made that happen." Another member of staff said, "Personally, I thought it was so good here, that my relative came here for [their] end of life care. I felt so confident about the care [relative] would receive. My family still talk about the home and the staff." Staff told us they continued to have a good relationship with relatives of people who had died at the service. We saw this as a group of relatives of people who had passed away visited the home during the inspection.

People knew they had a care plan and told us they had been involved in writing and reviewing them. One person said, "I have been involved every step of the way with regard to completing my care plan."

People had access to a range of activities. These included visits from the British Legion and the local PAT dogs. Male residents had a 'gents club' and staff told us they sat and chatted together and drank beer. The activities co-ordinator said the local BBC radio station had been into the home and broadcast live a few weeks earlier. They told us, "It was really good." People told us they plenty to keep them occupied. Comments included, "The activities here happen every week day in the morning and afternoon. I am never bored here; we go out to different places and people come in to entertain us" and "I know that activities happen in the lounge but I don't go, so they come into my room. I never feel left out."

People were supported to maintain relationships. People we spoke with all confirmed that they had visitors, who were free to visit at any time.

There was a complaints procedure in place. Complaints had been recorded, investigated and resolved appropriately. People told us they knew how to make a complaint. One person said, "Nothing to complain about here, everything is fine. I know how to complain; I have a copy of the complaints form." Another person said, "I don't have any complaints but if I did I would raise them straight away, you can be sure of that."

Requires Improvement

Is the service well-led?

Our findings

The service was not always well-led.

Quality assurance processes were in place; these included audits of food and drink monitoring, infection control, care plans, medicines and the environment. When issues were noted, action plans were in place and we saw actions had been completed. However, the quality monitoring was not robust because the audits had not identified the issues we noted. Legionella testing and electrical safety checks had not been undertaken and this had not been identified during health and safety audits. The risks of the spread of infection due to catheter bags being left resting on the floor and ripped crash mats had not been identified during infection control audits. Statutory notifications had not always been sent to us in a timely manner. For example, of two serious injury notifications, one had been sent fifteen days after the event and the other, seven days after the event. Notifications are information about specific important events the service is legally required to send to us. Delayed notifications meant we were not aware of incidents that had occurred and so were unable to request further information if required. Care plans audits had not identified that plans were not consistently person centred and on some occasions lacked enough detail to inform staff of the support people needed. Medication audits had not identified issues in relation to lack of detail in PRN protocols, or the lack of instructions for the administration of topical administrations. Although the service told us after the inspection that they had rectified the issues noted above, there was a risk that the provider's auditing processes were not effective.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

Staff told us morale was generally good and that they felt well supported by the management team. Comments included, "[Registered manager] is lovely. [They] come around regularly, check up on us, talk to us. I feel happy to bring things up with [them]" and "[Registered manager] is calm, and has told me, any problem I can speak up. [Registered manager], the deputy manager and the clinical lead; they've all said I can speak up any time I need more support. I feel confident to speak to them."

People and their relatives spoke highly of the management of the service. One person said, "The manager is called [name]. They are very open and transparent and go out of their way to make sure you're alright." Another person said, "The home is very pleasant. Everyone does their best and everyone is approachable from the top down."

The management team told us they felt they worked well together. One of the management team said, "We [manager's] complement each other; there's good communication. I'm confident residents get good care

here. They're looked after, cared for, loved and encouraged to do what they can for themselves."

Regular feedback was sought from people using the service, their relatives and staff. Comments from the survey included, "The home does well at everything "and, "No complaints at all. I'm very happy here." One person's relative told us, "I have completed many quality surveys; always very good." A staff survey had been carried out during July 2018 and we saw staff had provided positive feedback.

The service had good links with the local community. This included a team of volunteers who came to talk with people. The deputy manager told us people had attended the local school nativity play and that other local schools were due to come in and sing Christmas carols soon. A local supermarket also donated unsold flowers to the home for the residents to enjoy.

Providers are required to display the ratings from inspections so that people, relatives and visitors are aware of these. The rating from the previous inspection was displayed prominently at the service and on the provider's website.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring was not robust because the audits had not identified the issues we noted. Legionella testing and electrical safety checks had not been undertaken and this had not been identified during health and safety audits. The risks of the spread of infection due to catheter bags being left resting on the floor and ripped crash mats had not been identified during infection control audits . Statutory notifications had not always been sent to us in a timely manner. Care plans audits had not identified that plans were not consistently person centred and on some occasions lacked enough detail to inform staff of the support people needed. Medication audits had not identified issues in relation to lack of detail in PRN protocols, or the lack of instructions for the administration of topical administrations.