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?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
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 provides nursing and residential care and support for up to 62 people. At the time of the inspection there were 48 people using the service. The home is a grade 2 listed building in spacious grounds and close to a wide range of community resources. 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.

We carried out this unannounced comprehensive inspection on 14 and 15 September 2016. This inspection was undertaken to ensure that improvements that were needed to meet legal requirements had been implemented by the service following our last inspection on 16, 18 and 20 November 2015. At the previous inspection the home was found to have eight breaches of Regulations in relation to the safe management of medicines, infection control, supporting staff, staff training, premises maintenance, meeting peoples' needs, assessing monitoring and mitigating risks, and keeping contemporaneous records.

At this inspection on 14 and 15 September 2016 we found that improvements had been made to meet the relevant requirements previously identified at the inspection on 16, 18 and 20 November 2015. However we found three continuing breaches of regulations in relation to the safe handling of medicines, assessing, monitoring and improving the quality and safety of the services provided and maintaining complete and contemporaneous records for each person. You can see what action we told the provider to take at the back of the full version of this report.

At the time of the inspection there was no registered manager at the home. Following the inspection visit, we received confirmation that the registered manager application forms had been submitted to CQC.

Staff understood the principles of safeguarding and there was a safeguarding and whistleblowing policy in place.

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

During this inspection, we found improvements had been made to meet the requirements of regulations in relation to infection control practices. However, a recent audit conducted by Healthwatch Wigan made a small number of recommendations that had not been implemented on the day of the inspection, for example upgrading the sluice room.

The home was clean and we noted no malodours were evident on any of the three floors throughout the course of the day. We saw toilets and bathrooms contained hand hygiene guidance, paper towels and foot operated pedal bins. We checked all hand gel dispensers and saw these were stocked and working correctly.

We saw hoists had been checked and serviced and passed as being safe. We also saw that the slings used

with the hoists had been checked, all were in good condition and deemed fit for purpose. Cleaning schedules were also in place for blood pressure cuffs.

There was evidence of robust recruitment practices and each member of staff had a Disclosure and Baring Service (DBS) check in place.

During this inspection, we found improvements had been made to meet the requirements of regulations in relation to premises management. Gas and electricity safety certificates were in place and up to date; all hoists, the alarm call system and fire equipment were serviced yearly with records evidencing this. The testing of portable electrical appliances (PAT) was completed yearly and an up to date certificate was in place. There was a plan in place for on-going maintenance.

All pedal bins had been replaced since the date of the last inspection and were now foot operated with lids.

People had specific care plans in place with regards to their skin and Waterlow assessments which were carried out monthly. We saw that body maps were in place to identify the locations of any pressure sores or areas of redness.

Accidents and incidents were recorded and audited monthly by the manager. However some incidents that had resulted in minor grazes/bruises/cuts did not have an associated body map in place to correctly identify and monitor the specific site of the injury.

We looked at how the service managed people's medicines. At the last inspection on 16, 18 and 20 November 2015 we had concerns regarding the suitable management of people's medicines and this was a breach of Regulation 12(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found continuing breaches regarding medicines management.

Daily audits (checks) were not always completed by staff. Although we could see evidence that many issues had been identified, action had not always been taken to address them and prevent them from recurring.

Medicines in current use were generally stored securely, but medicines requiring cold storage were not always kept at the correct temperature.

We saw creams that needed to be kept in cool conditions were in people's rooms. The rooms were very hot even with the windows open and fans in operation.

Waste medicines were not disposed of and stored securely as recommended in the current guidance 'Managing Medicines in Social Care' (NICE 2014).

The medication storage cupboards were disorganised and untidy. We found blood testing equipment and infusion sets that were out of date. We also saw three oxygen cylinders that were not stored securely and chained to the wall.

Where medicines could be audited, we found eight examples where medicines had been signed for but not administered and a further five examples where medicines were missing and unaccounted for. Records for the use of creams and other external preparations were incomplete and unclear.

We found that people did not always get their medicines when they needed them. We saw that two people were not always offered regular pain relief and three people had missed being given some of their medicines

as no stock was available.

Some people had difficulty taking their medicines and best Interest decisions had been taken to give them their medicines covertly.

Many people were prescribed creams and medicines, for example painkillers, laxatives and medicines for anxiety that could be given at different doses or used when required. We found that care plans were generally in place for the use of these medicines, but there was not enough information available to enable nurses and care workers to use the medicines safely.

These issues meant there was a continuing breach of Regulation 12 of 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 this report.

At the last inspection on 16, 18 and 20 November 2015 we had concerns regarding staff supervision and appraisal and this was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw that a staff supervision matrix was now in place with dates identified for the year and we found records of supervisions within the staff personnel files we looked at.

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. However, we could not locate copies of two people's best interest assessments.

We saw people had appropriate nutritional care plans and risks assessments in place. The dining rooms were nicely decorated and laid with table clothes, place mats and table decorations.

We saw that the management recognised good staff practice through an 'employee of the month' programme.

We saw that all the toilet seats and grab handles in the refurbished rooms were white, the same colour as the toilet, which may make it difficult for some people living with a diagnosis of dementia to use these facilities independently.

In some of the shared rooms, there was very little space for the person who had their bed near to the door to have a chair and/or create an intimate/private space.

The people we spoke with told us they liked living at St George's and were happy with the care they received.

We observed polite and appropriate interactions between staff and people who used the service. We saw that interactions between people who used the service and staff members were warm and engaging.

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

At the last inspection on 16, 18 and 20 November 2015 we had concerns regarding the quality of care

planning and recording and this was a breach of Regulation 17(2)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found continuing concerns in this area and the service was still not meeting the requirements of this regulation.

We noted that of the five care plans looked at, only one had been discussed with a family member and none with the person themselves. We also saw that there were some inconsistencies within the care records contained on the electronic system.

There was a 'complaints, suggestions and compliments' policy and procedure in place. However the organisation of some of the complaints information was such that it was difficult to follow the actions taken regarding the complaint from the initial referral stage to final completion.

Some care plans had missing information, information that had not been updated, and actions that had not been carried out.

These issues meant there was a continuing 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. You can see what action we told the provider to take at the back of the full version of this report.

The home employed an activities coordinator and the activities on offer were displayed on a notice board in the entrance area.

We observed the manager was visible within the home. They supported the staff and provided advice and support throughout the inspection. The service was transparent about the last inspection rating and identified areas of improvement.

We saw that the home had comprehensive policy and procedure files in place; these had been purchased from a company which specialises in this area.

At the last inspection we had concerns about the safety of the environment. During this inspection, we found that although improvements had been made regarding environmental issues we previously found, further improvements were still needed to meet the requirements of this regulation.

We found audits had not been effective in identifying and rectifying some of the issues we found during this inspection. This meant there was a continuing 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. You can see what action we told the provider to take at the back of the full version of this report.

The service worked in partnership with Healthwatch Wigan, the fire service, the local authority contracts monitoring team and the clinical commissioning group (CCG) .

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.

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 consistently safe.

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

Staff supervisions were not being carried out in line with the organisations policy.

Records of best interest assessments were missing from some care files.

Is the service caring?

Good

The service was caring.

People who used the service told us they felt the staff were caring.

Staff attitude to people was polite and respectful using their names and we saw people responded well to staff.

Staff spoken with could give examples of how privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some care plans did not identify if the person or their relative had been involved.

Some care plans had missing information or had not been updated to reflect the current position.

Is the service well-led?

Requires Improvement

The service was not consistently well-led and there was no registered manager at the home.

Audits had been carried out in a number of areas but these did not identify some of the issues we found during the inspection.

The manager was visible within the home, supported the staff group and provided advice and support throughout the inspection.

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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.

The inspection was undertaken by two adult social care inspectors and a pharmacist inspector from the Care Quality Commission (CQC). Before the inspection we did not request a Provider Information Return (PIR). 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 reviewed statutory notifications and safeguarding referrals.

We also liaised with external professionals including the local authority contracts monitoring team. We reviewed the action taken by the provider following our previous inspection. We looked at records held by the service, including five care files and 10 staff personnel files. We undertook pathway tracking of five care records, which involves cross referencing care records via the home's documentation. We looked at the medication records for all people living at St. George's.

We observed care within the home throughout the day. During the inspection we spoke with the manager, the managing director, six care staff, administrative staff, five people who used the service and two nurses.

Requires Improvement

Is the service safe?

Our findings

The people we spoke with at St George's told us they felt safe. One person told us, "Yes, I feel safe here." Another person did not verbally respond but nodded and gave a thumbs up in response to being asked if they felt safe."

During the inspection we looked at the way the service protected people against abuse. We found the service had an internal safeguarding policy in place. The Wigan Safeguarding Adults Board Multi-Agency Policy was also in place with guidance on the Independent Safeguarding Authority and multi-agency procedure. We saw that safeguarding information was displayed in the staff toilet and throughout the building relating to how to raise a safeguarding concern.

The staff members we spoke with were able to explain the correct procedure for referring safeguarding concerns to the local authority. One staff member said, "I have done safeguarding training earlier this year; if I was concerned I would tell my senior, write down what I had seen and complete any other documents like a body map if I had seen an injury. If I was concerned about the manager I would go to the owner, the local authority or CQC." Another staff member told us, "Safeguarding is about ensuring people are treated properly and they get what they need; we have to make sure all aspects of care are good. If I was concerned I would go to my manager, but I can also go to CQC, the local authority or the owner of the business as well."

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 September 2016 and these consistently demonstrated that there were sufficient care staff on duty to meet the needs of people
using the service. The people we spoke with felt that there were enough staff employed to meet their needs. One person told us, "Yes, there's definitely enough staff, I get to go out each week on a one-to-one." We saw that the service was now using a formal 'dependency' tool which identified low, medium and high dependency levels and this assisted with identifying the number of staff required to safely provide the service.

The rotas identified both nursing and care staff. There was also a display board in the entrance hallway with photographs of all staff members, including their names and job role. Also displayed were pictures of the different types of uniforms that staff wore, and what job role was associated with each uniform. This would assist people using the service and their relatives to recognise different staff members and their job roles.

At the last inspection on 16, 18 and 20 November 2015 we found the service had failed to operate systems to assess, detect, prevent and control the spread of infections. This was in breach of was a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the provider was instructed to take action to improve infection control practices. During this inspection, we

found improvements had been made to meet the requirements of regulations.

The home had an 'Infection Control' policy and procedure in place which had last been amended on 16 December 2015. We observed that the service followed appropriate infection control and prevention practice, for example using personal protection equipment (PPE) when providing support to people and at meal times. A recent audit had been carried out by Healthwatch Wigan on 18 August 2016. Healthwatch England is the national consumer champion in health and social care and part of the local Healthwatch programme is to carry out enter and view visits. We saw that the audit had achieved positive results and recognised improvements that had been made since the date of the last inspection. However a small number of recommendations had been made that had not been implemented on the day of the inspection, for example the upgrading of the sluice room.

Upon arrival at the home, we completed a walk round of the building to look at the systems in place to ensure safe infection control practices were maintained. We noted that no malodours were evident on any of the three floors throughout the course of the day. We observed domestic staff completing cleaning duties. We saw that any soiled items had been placed in red bags, as per infection control guidelines. We checked the cleaning products located on the cleaning trolley against the home's Control of Substances Hazardous to Health (COSHH) file and saw that the necessary safety data sheets were in place. There were also cleaning schedules in use that had been updated since the last inspection, and signed when completed.

We saw toilets and bathrooms contained hand hygiene guidance, paper towels and foot operated pedal bins. We checked all hand gel dispensers and saw that these were stocked and working correctly. We checked the three toilets located on the ground floor and saw that two of these did not have a working lock in place, meaning that people's privacy could not be maintained. We also noted that in both of these toilets, there were large holes in the plaster, caused by the door handle hitting the wall when opened. In one of the toilets, a door stopper had been fitted to prevent this from re-occurring, but the damage had not been repaired. In the third toilet, we saw that some tiles were missing from the wall and the floor upon entering was uneven, which could be a trip hazard.

On the lower ground floor, we saw that the lounge and dining areas were clean; however we noted that some walls were stained. It was apparent that these marks could not be wiped away and that the areas required redecoration. We also looked in several bedrooms and communal areas and found these to be clean and tidy.

We looked at what systems were in place to manage people's laundry. We looked at the homes laundry room, which is located on the lower ground floor. We saw that the laundry room was small, cramped and cluttered. We noted that the laundry had two washing machines and one dryer to cater for the needs of up to 62 people. We saw that due to only having one dryer, duvets which had been washed due to being soiled, had been draped over the washing machines to begin the drying process. We noted that clothes rails for hanging up people's clothing were located in the corridor outside the laundry room as there was not adequate space inside.

We spoke to the laundry assistant who told us that there were three laundry staff in total; two worked during the day on alternating shifts to cover the week and a third worked three nights per week. We were told that either the carers or the domestic staff would bag up any soiled clothing or bedding and this was then collected and washed by the laundry assistants. We noted that despite the cramped environment, soiled and clean items were kept separate and the appropriate coloured laundry bags were being used.

We checked the moving and handling equipment being used by the home. We saw that all four hoists had

been checked and serviced in July 2016 and passed as being safe. We also saw that the slings used with the hoists had been checked, all were in good condition and deemed fit for purpose. Cleaning schedules were also in place for blood pressure cuffs.

We looked at 10 staff files to check if safe recruitment procedures were in place and there was evidence of robust recruitment practices. Each member of staff had a Disclosure and Baring Service (DBS) check in place; a DBS check helps a service to ensure the applicant's suitability to work with vulnerable people. All staff also had two references on file as well as a full work history and completed application form. Staff we spoke with confirmed they had been subject to a period of induction at the start of their employment and this included 'shadowing' other colleagues prior to being assessed as competent to work independently.

We looked at records regarding the maintenance of the premises and equipment. At the last inspection on 16, 18 and 20 November 2015 we had concerns regarding the suitable management of the premises. This was a breach of Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the provider was instructed to take action to improve practices in relation to premises maintenance. During this inspection, we found improvements had been made to meet the requirements of regulations.

We looked at the home's safety documentation, to ensure the property was appropriately maintained and safe for people who lived there. Gas and electricity safety certificates were in place and up to date; all hoists, the alarm call system and fire equipment were serviced yearly with records evidencing this. Call points, emergency lighting, fire doors and fire extinguishers were all checked regularly to ensure they were in working order.

The testing of portable electrical appliances (PAT) was completed yearly and an up to date certificate was in place. The passenger lift had been serviced in July 2016 and the associated safety certificate was in place. Water tests (for legionella) had been completed in October 2015 and the results were clear. The kitchen extraction unit had been deep-cleaned on 4 August 2016 by an external contractor and appropriate certification was in place.

There was a plan in place for on-going maintenance which was checked and signed by the manager. A daily walk-around of the building was completed by the manager and this process was used as a spot check.

All pedal bins had been replaced since the date of the last inspection and were now foot operated with lids. The kitchen in one lounge had also been replaced with a hand washing sink and a domestic sink, and there were new worktops and cupboards. The area was clean and free from clutter. Staff told us the new kitchen was a big improvement and allowed night staff to prepare snacks and drinks for people without having to go to the main kitchen on the lower ground floor.

We looked at how the home cared for people with pressure sores. We noted that people had specific care plans in place with regards to their skin and saw that Waterlow assessments were carried out monthly, to identify if people were deemed at risk or to assess if their level of risk had changed. We saw that airflow mattresses and pressure relieving cushions were in place for those identified as being at risk.

We saw that body maps were in place to identify the locations of any pressure sores or areas of redness. However we noted that on the electronic care planning system called Everyday Care System (ECS) it was only possible to document one pressure sore on the computerised body map, as the system would not let the user add another. We saw that one person had three areas which needed documenting, however the body map on their electronic care plan only identified one. The manager told us that a new electronic care

planning system was being sourced and a demonstration of this system had already taken place.

We saw that were concerns about possible or actual pressure areas had been identified, the home had made appropriate referrals to a tissue viability nurse (TVN) and had implemented care plans following assessments and provision of wound care plans.

Accidents and incidents were recorded and audited monthly by the manager. However some incidents that had resulted in minor grazes/bruises/cuts did not have an associated body map in place to correctly identify the specific site of the injury. In addition some records did not identify the action to be taken to reduce the potential for further injury in the future.

We looked at how the service managed people's medicines. At the last inspection on 16, 18 and 20 November 2015 we had concerns regarding the suitable management and this was a breach of Regulation 12(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found continuing breaches regarding medicines management.

Daily audits (checks) were not always completed by staff, for example a twice daily audit of Controlled Drugs had only been completed 30 times out of a possible 88 times since 1 August 2016. A member of the management team had completed monthly audits of the medicines management system and the home had also received support from the local CCG medicines management unit in order to improve the way the service managed medicines. Although we could see evidence that many issues had been identified, action had not always been taken to address them and prevent them from recurring.

We looked at medication records, medicines and other records of care (both planned and received) for 17 people who were living in the home. We spoke with the manager and two nurses on duty about medicines management within the home

Medicines in current use were generally stored securely, but medicines requiring cold storage were not always kept at the correct temperature. Since 1st July 2016, the temperature of the medication fridge had only been recorded on 42 out of a possible 74 days. Records showed that the temperature was outside the recommended safe range of 2-8C on 38 of those 42 occasions. There was no evidence that any action had been taken to ensure that the medicines were still safe to use. We saw creams that needed to be kept in cool conditions were in people's rooms. The rooms were very hot even with the windows open and fans in operation. Medicines may spoil and become unfit for use if they are not stored correctly.

Waste medicines were not disposed of and stored securely as recommended in the current guidance 'Managing Medicines in Social Care' (NICE 2014). We found supplies of prescribed painkillers and laxatives that had been kept for use as 'homely remedies' (simple medicines that can be given to people without prescription) instead of being disposed of safely. This is illegal. Medication cannot be taken or given to anyone other than the person for whom it was originally prescribed.

The medication storage cupboards were disorganised and untidy. One nurse told us it was sometimes difficult to find stock because medicines in the cupboard were, 'all over the place' and storage baskets sometimes contained medicines for more than one person. We found blood testing equipment and infusion sets that were out of date. We also saw three oxygen cylinders that were not stored securely and chained to the wall. The nurse on duty told us that no-one in the home was currently prescribed oxygen and was unsure why the cylinders were still present. We also found a large quantity of service user's personal money and jewellery present in the Controlled Drugs cabinet. This cabinet should only be used for the storage of Controlled Drugs (strong medicines that may be misused).

Records showed that the quantities of medicines and nutritional supplements received into the home or carried forward from the previous medicines cycle had not always been recorded. This meant we were sometimes unable to calculate how much stock should be present and therefore determine whether or not these people had been given their medicines and supplements correctly.

Where medicines could be audited, we found eight examples where medicines had been signed for but not administered and a further five examples where medicines were missing and unaccounted for. Records for the use of creams and other external preparations were incomplete and unclear. The nurse on duty told us that care workers were responsible for these. We asked how nurses checked whether these had been used correctly, but were told no formal checks were made. This meant that there was no effective system in place to ensure that external products were used as prescribed in order to protect people's skin.

We found that people did not always get their medicines when they needed them. We saw that two people were not always offered regular pain relief and three people had missed being given some of their medicines as no stock was available. One person had been given one of their tablets twice a day instead of once daily for a week. The manager was informed and told us this error would be investigated. The health and wellbeing of people living in the home was placed at unnecessary risk because they did not always get their medicines as prescribed.

Some people had difficulty taking their medicines and best Interests decisions had been taken to give them their medicines covertly. We looked in detail at records for three out of the six people who were given their medicines covertly and saw in each case that arrangements for the safe administration of covert medicines, as published in the NICE guidance document, had not been fully followed.

Many people were prescribed creams and medicines, for example painkillers, laxatives and medicines for anxiety that could be given at different doses or used when required. We found that care plans were generally in place for the use of these medicines, but there was not enough information available to enable nurses and care workers to use the medicines safely. Some of the plans had conflicting instructions, for example, one person's plan stated that they should be given an extra dose of insulin when their blood glucose levels were high and glucose oral gel should be given if their blood glucose was 'low'. There was no information regarding how low the reading should be before giving the gel and records stated two different figures as to what 'high' meant. This person's plan had not been followed with records showing that over the last 10 days, extra insulin had been administered on two occasions when blood glucose readings were recorded within the normal range and yet on a further occasion the reading was high, but no dose had been given.

These issues meant there was a continuing 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. You can see what action we told the provider to take at the back of the full version of this report.

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 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 saw that 90% of all staff had now completed tissue viability training, 40% of care staff had completed training in bed rails and 25% of care staff had completed training in person-centred care. 80%of care staff had completed an NVQ level 2 or 3 in health and social care. One staff member told us, "I feel that training has improved lately and I've recently done training on site in percutaneous endoscopic gastronomy (PEG)." Another staff member commented, "Training is good here and I've recently done hospice in your care home training." A third staff member said, "I've recently done training in safeguarding, infection control and first aid; I've also recently completed all training needed for the Care Certificate." The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Staff also confirmed they completed an induction at the start of their employment.

At the last inspection on 16, 18 and 20 November 2015 we had concerns regarding staff supervision and appraisal and this was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw that a staff supervision matrix was now in place with dates identified for the year and we found records of supervisions within the staff personnel files we looked at.

However we saw that most staff only had one or two completed supervision records within the files for 2016 and this was in contradiction to the homes' supervision policy which stated that staff must receive at least six supervision meetings each year, although we noted that the full year had not yet ended. We asked the office manager if these could be located anywhere else, and were told that all supervision documentation would be in the personnel files. One staff member told us, "I've had supervisions since starting but I'm not sure how frequent these are, but I get daily informal support from the managers so I don't feel I need any more formal supervisions than I already get."

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.

However in two people's electronic care files, we saw that both had care plans in place in relation to their capacity. The first part of each person's action plan stated; 'Complete the Best Interest Assessment and Capacity Document - These forms to be completed by the RGN and staff who know the person well.' We could not locate copies of these assessments within the electronic care files. We spoke to the deputy nursing manager about this, who said that the assessments were likely to be in the paper based files, however when we checked the paper files we could not find any evidence to support this.

We asked people if the food at the home was good. One person who used the service said, " The food's good here, I would recommend it to anyone, there's lots of choice." Another person told us, "The food is alright, though not always to my own taste but its hot and nicely presented." Whilst speaking with another person we observed that they asked for an extra portion and this was provided.

We looked at how people were supported to eat and drink. We saw people had appropriate nutritional care plans and risks assessments in place which provided staff with information about people's nutritional needs and how best to support them. We also noted that where people needed to be weighed each week or month, there were records showing this was done by staff in the required timescales.

We saw the home was responsive when they had concerns about people's nutritional status. In one instance we saw that following staff concerns, GP involvement had been sought and a referral to the nutrition and dietetic service had been made. This person was also referred to the local Speech and Language Therapy (SALT) service for an assessment and subsequently placed on a soft diet.

We saw that food and fluid charts were in place for all people who used the service, with staff recording the amount of fluid and food taken on a daily basis. Information regarding special diets was available in the kitchen in addition to professional advice on preparing different dietary food. There was a four week seasonal menu in use and this was displayed on the wall in the dining rooms. If people changed their mind they were able to order an alternative.

The dining rooms were nicely decorated and laid with table clothes, place mats and table decorations. There were also smaller dining areas adjacent to the main dining rooms where people could eat in a quieter setting if that was there choice. The dining rooms felt homely and welcoming.

We checked the food stocks in the kitchen and found 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. The kitchen was clean and had stainless steel worktops and splash backs. There was a food hygiene policy and we saw that 90%of all staff had completed training in food hygiene.

We observed staff completing manual handling practices. On two occasions we observed staff using a hoist to transfer a person into their wheelchair. We noted that staff explained to both people what they were going to do and then asked for their consent before commencing the manoeuvre. Staff continued to re-assure the person throughout the process. We did observe on one occasion that in order to position the sling behind the person, staff members moved the person forwards in their seat by getting them to grip their

arms and then leaning backwards.

We observed one person being supported to stand up from sitting, in order to walk to their room. Staff talked the person through the process of using the arms of their chair to push themselves up and then two staff members supported the person on either side, as they walked to their room. This was in adherence to what was described in the person's care plan.

Throughout the inspection we heard staff seeking verbal consent from people prior to providing support. 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.

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.

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. During the course of the inspection we looked at what systems and adaptations the home had put in place to support people living with dementia. Several bedrooms had recently been refurbished to include a modern walk-in shower/toilet room. We saw that all the toilet seats and grab handles in these refurbished rooms were white, the same colour as the toilet, which may make it difficult for some people living with a diagnosis of dementia to use these facilities independently.

We saw the home had some signage in place throughout the building to identify where bathrooms and toilets were located; however these were very small and easy to miss, especially for people with any visual impairment.

In some of the shared rooms, there was very little space for the person who had their bed near the door to have a chair and/or create an intimate/private space. We saw that people had been consulted about the redecoration of their rooms and could choose to have it personalised with regards to bedding/linen, furnishing/decorations/colour schemes and personal photographs for their bedroom doors.

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

Good

Is the service caring?

Our findings

The people we spoke with told us they liked living at St George's and were happy with the care they received. One person told us, "I like it here; the staff are good with me." Another said, 'It's good here, I'm looked after." A third person told us, "The staff are very kind." A fourth person commented, "Staff are very respectful to me and very good in everything they do for me." A number of 'thank you' cards from people who had previously used the service were displayed on a notice board in the entrance area.

All the people living at St. George's had a named nurse and key-worker, who people and their relatives could speak to for information, or to voice any concerns they may have and these were identified on people's bedroom doors.

As part of the inspection we spent time observing the care provided in all areas of the home. We observed polite and appropriate interactions between staff and people who used the service, with staff members regularly asking people if they were okay, if they were comfortable or needed anything. We observed staff members completing regular checks on people who had chosen to stay in their rooms, again making sure they were okay and asking if they needed anything.

We saw a staff member provided positive feedback and encouragement to a person who was completing a painting in the lounge. They took time from what they were doing to initially go over and look at the person's work, before providing validation. This lead to a conversation between the people sat nearby, about drawings and paintings they had done. The staff member then provided positive feedback to others, all of who look pleased with the feedback received.

On one occasion we observed one person who was visibly upset. The staff member also observed this and went to sit next to the person. They asked them if they were okay, what was troubling them and if there was anything they could do to help. The person was unsure why they were upset but thanked the staff member for their concern.

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 attitudes to people were polite and respectful using their names and people responded well to staff. For example we saw one person came into the dining room at breakfast time and a staff member said, "Good morning [person], would you like your breakfast now or do you want a cup of tea first?" This prompted a conversation that was cheery in nature and the staff member explained the purpose of the CQC visit to alleviate any anxiety the person may have regarding our presence.

The staff we spoke with demonstrated an understanding of the people they supported, their care needs and their wishes. They told 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, in addition to a statement of purpose. This contained information on how to make a complaint and identified external agencies such as the local authority, the clinical commissioning group (CCG) and CQC. 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.

We saw there was a 'privacy and dignity' policy, a '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. Other policies in place included 'end of life care', 'equality and diversity', 'privacy' and 'advocacy'.

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.

We saw that staff had been enrolled on 'Hospice in Your Care Home' training, and two staff records we viewed indicated that this had been completed and passed. Seven other members of care staff were also enrolled onto the programme and had completed some but not all of the training modules included. At the time of the inspection no-one living at St George's was receiving end of life (EOL) care.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 16, 18 and 20 November 2015 the electronic care planning system was unavailable due to the degradation of the internet cable and we had concerns regarding the lack of a contingency plan for if the electronic care planning system was in-operational. At this inspection we found that the system was fully functional and the management had now purchased a 'dongle' which is a small device that allows access to the internet independent of any hard wiring that may be in place. This meant that staff were able to access the electronic system at any time.

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 were accessible by several staff at the same time through the use of an individual log-in password. We saw that there were several computers available for staff to do this, situated on each floor of the building.

The manager told us that the existing electronic care planning system and all paper copy records were soon to be replaced by a new electronic care planning system, with the exception of hard copy correspondence for example such as letters for professional appointments (which could also be scanned into the electronic system) and the most up to date records and information were located on the electronic system.

We asked people who used the service if they had been involved in planning their care. One person told us, "[Staff members' name] sorts all that out for me, she's really nice." Another person told us, "I've been involved in this but my wife mainly sorts it out."

At the last inspection on 16, 18 and 20 November 2015 we had concerns regarding the quality of care planning and recording and this was a breach of Regulation 17(2)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found continuing concerns in this area and the service was still not meeting the requirements of this regulation.

We saw that each person's individual care plans indicated if it had been discussed with and approved by the person themselves or a family member. We noted that of the five care plans looked at, only one had been discussed with a family member and none with the person themselves. We saw that each of the five peoples care plans had been reviewed on a monthly basis; however this had been done by a staff member, with no indication that the person and/or their family had been involved in the process.

We saw that there were some inconsistencies within the care records contained on the electronic system. In one person's care file, it stated on their body map page that they had a grade 4 pressure sore, whereas the care plan stated that it was a grade 3. We also saw that one person had been recorded as being admitted in January 2015, but had care plans in place dated 2014. We checked the paper based file for this person, which indicated they had actually been admitted in January 2014.

Within the same persons records, their MUST tool results for the last three months, stated 'high risk, urgent action required.' However there was no indication on the nutritional care plan as to what had been done.

We asked a senior member of staff about this and they were also unable to tell us what had been done or where this information might be.

Another person's latest MUST results also stated 'high risk, urgent action required', however the last entry on their nutritional care plan was dated four months prior and indicated that their weight was stable and there was not an issue. This care plan had been reviewed in August 2016, but not been updated to reflect the current situation.

We saw that another person's care plan indicated that the Beck Depression Inventory, which is a screening tool for depression, should be completed monthly. We found no completed forms either within the electronic or paper based care files.

We observed that everyone had a manual handling care plan within their care file, which identified the level of risk and how many staff were required to support transfers. However we saw that one person, despite requiring the use of hoist for all transfers, did not have a risk assessment or specific care plan in place for manual handling.

These issues meant there was a continuing 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. You can see what action we told the provider to take at the back of the full version of this report.

We saw that each day a care staff member completed a daily care record for each person. This form covered the following areas: if they were assisted to wash, if they were assisted to have a bath or shower, if they have had their hair brushed, combed or washed, oral care, pressure area / skin integrity, whether they have been supported to shave, finger / nail care, use of the toilet, meals taken.

We saw that some people had individual monitoring in place. One person was subject to 15 minute staff observations; we reviewed their notes and saw that this was being carried out consistently.

There was a 'complaints, suggestions and compliments' policy and procedure in place and we looked at examples where complaints had been raised and responded to in a timely manner. However the organisation of some of the complaints information was such that it was difficult to follow the actions taken regarding the complaint from the initial referral stage to final completion.

Complaints were audited monthly and we saw that there had been three complaints from January to August 2016; one was from a staff member and two were from people's relatives.

We saw that people's bedroom doors contained personalised door plaques with their photograph on, which would assist people to identify whose room it was. Some people had chosen to use a recent photograph and others had chosen older pictures, whilst some had used different types of images which had significance to them.

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. Dates and advertisements for future activities were also on display throughout the home and these included a clothing party, a tea party, world's biggest coffee morning and family Sunday lunch. People also enjoyed using the dementia café and reminiscence room, which held a wide variety of historical items that would assist people to remember and reminisce about their past.

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. Following the inspection, the manager confirmed that the registered manager application forms had been submitted to CQC.

A staff member told us, "I think the manager is doing a good job and things have improved recently." Another staff member told us, "I feel that the management team work well together, and it's improving for the better." A third staff member commented, "It's definitely better now since the last inspection.

We observed the manager was visible within the home, supported the staff group and provided advice and support throughout the day of the inspection. The manager told us they operated an 'open door' policy and were available at any time. People we spoke with knew who the manager was. One person said, "Oh yes I see the manager knocking about here and there every day and we're on first name terms." A staff member told us, "The culture is very good and the manager has made a big positive impact since being here; you could knock on the manager's door any time." A second staff member commented, "I definitely now feel valued and supported; the recent changes have been positive and I feel the manager is approachable and would always respect my privacy and confidentiality."

We saw the home had a comprehensive policy and procedure files in place; these had been purchased from a company which specialises in this area. The policies were all dated 2015 and included key policies on medicines, safeguarding, MCA, DoLS, moving and handling and dementia care. Policies and procedures were all up to date.

At the last inspection we had concerns about the safety of the environment and this was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we found that although improvements had been made regarding environmental issues we previously found, some further improvements were still needed.

We looked at how the provider audited the quality and safety of the service. Audits were in place in a number of areas and recorded in a 'managers audit file.' However we found audits had not been effective in identifying and rectifying some of the issues we found during this inspection. For example, although medication audits had been completed for the period January to August 2016, these had not been effective, as we found a range of medication issues during the inspection that had not been identified on the audits.

This meant there was a continuing 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. You can see what action we told the provider to take at the back of the full version of this report.

A mattress audit had been completed on 12 April 2016. We saw that 32 mattresses had failed the audit and were condemned. We spoke with manager about this and they told us 30 new mattresses had been purchased and were in use to replace these. As the home was not at full occupancy, this meant that everyone had a clean and safe mattress.

Monthly bed rail checks were carried out, with distances between rails being measured and recorded to ensure safe guidelines regarding their use were adhered to. Nurse call-bells response times had also been audited and we saw that staff response times were within an acceptable limit, which meant that people did not have to wait a long time for assistance when they requested it via this system.

Wheelchairs had been audited 25 August 2016 and this was done each month, although wheelchairs were checked on a rota basis so that each one was checked bi-monthly at least. There was nowhere on the form used to record whether any action points had been completed. We spoke with the manager about this and a new form was devised and implemented straight away to provide this information.

There was an accidents and incidents audit completed for the period January to August 2016 and this identified the number of incidents in the previous month, the details of the incidents, if the incident was commonly recurring and the actions required to prevent a reoccurrence. For example an audit had identified an increase in falls and as a result the number of care staff had been increased by one person in June 2016.

The service worked in partnership with Healthwatch Wigan, the fire service, the local authority contracts monitoring team and the clinical commissioning group (CCG) regarding medicines management. The CCG had also organised 'Wigan council care home forum' meetings which the service participated in, to discuss for example issues such as pressure ulcer prevention. The service also worked alongside the 'hospice in your care home' team and as a result some staff had undertaken a formal training programme. The manager told us, "We want to be totally transparent in what we do when working alongside others."

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.

There was a monthly staff supervision schedule in operation. A member of staff said, "I get my supervisions about every three months and we get copies of the notes. Another staff member commented, "I get supervisions but I'm not sure how frequent they are; they took a while to get going but I do feel well supported by the manager and my colleagues on a daily basis. It's an open door policy."

There was evidence in minutes of staff team meetings that findings from audits were communicated to staff and actions taken. We saw the management team recognised good staff practice through an 'employee of the month' programme. Staff members could be nominated with the person receiving the most votes, getting the award. We saw that photographs had been put on the notice board showing recent winners. The notice board also contained an employee recognition section, which included validation for staff that had recently completed training courses and acknowledgement of length of service for all staff.

We saw that the last CQC inspection report was highly visible in the entrance hallway of the home and each page had been posted onto a large notice board. Next to these were a series of cards that identified what action had been taken so far to meet the requirements, for example; updating kitchens, decorating, staff training, increase in staff numbers and increase the frequency of residents/family meetings. This showed that the service was transparent about the last inspection rating and identifying areas of improvement.

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 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)

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)(d The service had failed to effectively assess, monitor and improve the quality and safety of the services provided. Regulation 17(2)(a)