Parkcare Homes (No.2) Limited

Georgina House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service in January 2016 and rated the home as 'Good' overall. When we inspected the service on 11 July 2018 we rated the service as Inadequate overall. This is the first time Georgina House has been rated as Inadequate overall. This inspection was announced the day before we visited. This was to ensure a member of staff would be present to let us into the home.

Georgina House 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.

Georgina House provides personal care and accommodation for people who have a range of learning disabilities. Georgina House can provide care for up to four adults. At the time of the inspection three people were living at the home. Georgina House comprises of accommodation over two floors.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy

There was not a registered manager in place when we inspected 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. An application had been submitted to the CQC by the current manager at the home.

The leadership and the provider of the service were not taking timely action to ensure people were safe. Insufficient action was taken to respond to the health needs of a person who had become unwell early this year. No meaningful review had been completed to improve the person's wellbeing. We needed to discuss these concerns further with the provider after our inspection.

We found issues with staff practice which had the potential to put people at risk of harm. These included poor infection control practices. One person's bathroom had mould growing in their shower and a dirty extractor fan. We also observed unsafe staff practices when administering people their medicines and with the storage of people's prescribed creams.

Staff recruitment checks were not thoroughly completed to ensure people were safe around staff. The provider and leadership of the service were not monitoring or checking the competency of staff. The provider did not have strong assurances that staff were effective in their work. Staff had not received suitable support and leadership from the management of the home.

People were not being supported to have real choice with what they ate. People were not always being involved in planning what they ate or the preparation of their food. Healthy alternatives were not being promoted at the home. The meal time was not a social experience. People's cultural dietary needs were not being met by staff.

People's health needs were not always being responded to in a timely way. People's rights and interests in this area were not being promoted and championed by the service.

The service was not compliant with the Mental Capacity Act 2005 (MCA). This provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. People's relatives and professionals were not being consulted with when people could not make certain decisions themselves.

When people's freedom of movement was restricted, there was no checking if these met the requirements of the Deprivation of Liberty Safeguards (DoLS).

People were not always treated in a kind, caring and respectful way. We observed people being spoken at times in a dictatorial and authoritarian tone.

The leadership of the home and the provider were not ensuring that people received person centred care. People's rooms were not always personalised and the parts of the home that people shared were also not personalised. There were some social activities taking place. However, plans regarding some social events and activities were not always being made, with actions taken. People's social day to day needs were not being met at the home. People's cultural needs were also not being met by the service.

Some people could not communicate with others in ways which they could understand. No timely and meaningful work had been completed in this area so that the service understood people's wishes and requests better.

There was a lack of leadership and a poor culture at the home. We identified institutionalised practices which were in place to benefit staff. Provider and internal audits were either not taking place or they were ineffective. Incidents were not responded to and the provider was not supporting the service to improve. The provider lacked insight into the issues which we had identified.

Risk assessments were taking place but these were not always updated. There was no evidence to show staff looked at these documents and were aware of people's needs.

People's confidential information was not being stored in a way which ensured it was secure.
Some of these issues constituted breaches in the legal requirements of the law. There were eight breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures. 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The Service was not safe.

A person's health needs were not responded to fully or in a timely way when they were unwell or showed signs that they could be unwell.

We found poor infection control practices at the home.

Safe staff recruitment checks were not always completed.

People did not receive their medicines in a safe way. Some people's medicines were not always stored in a safe way.

Some people did not have good risk assessments and plans in place to help keep them safe.

Is the service effective?

Requires Improvement

The Service was not always effective.

Staff competency was not being monitored and assessed. Staff practice issues were identified at the inspection.

Staff were not receiving supervisions. Staff training was not checked to see if it was effective.

Meal times were not social events. People's cultural needs in relation to their diet were not promoted. The service did not promote healthy food options.

People's health needs were not always responded to and promoted.

The service was not compliant with MCA and DoLS.

Is the service caring?

Requires Improvement

The Service was not always caring.

We observed some unkind and disrespectful practice from staff towards some of the people at the home.

Practical action was not always taken to support people.

Information was not given to people in ways they could always understand.

People's confidential information was not fully protected.

Is the service responsive?

Requires Improvement

The Service was not always responsive

People's communication needs were not being met

The cultural needs of people were not always being promoted.

People's care records were not complete.

People did not have meaningful reviews of their care.

People's social needs were not being fully promoted

Is the service well-led?

Inadequate

The Service was not well led.

People's safety was not always being checked and promoted.

Incidents were not being followed up.

There was an uncaring culture. There was lack of leadership day to day and to support improvements at the home.

Audits were not being completed or were ineffective.

Georgina House

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection site visit took place on 11 July 2018. We gave the service 19 hours' notice because the home was small and people could be out during the day. So, we wanted to ensure a member of staff would be present to let us in.

The inspection team consisted of one inspector.

Before the inspection we made contact with the local authorities' contracts team and safeguarding team. We asked them for their views on the service and we took these into account when we inspected the service. We looked at the notifications that the previous registered manager and managers had sent us over the last two years. Notifications are about important events that the provider must send us by law.

During the inspection we spoke with one person who lived at the home. The other two people who lived at Georgina House could not communicate with us in ways which we could understand. We spoke with two members of care staff, and the manager. We looked at the care records of two people, one more in depth than the other. The medicines records of two people and the recruitment records for three members of staff. During our visit we completed observations of staff practice and interactions between people at the home and the staff. We also reviewed the audits and, safety records completed at the home.

We received a Provider Information Return report. This is information we require the provider to send us at least once annually to give some key information about the service. What the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in the report.

Inadequate

Is the service safe?

Our findings

We inspected Georgina House in January 2016 and found the service was providing safe care. However, when we visited in July 2018 we identified issues which led to this rating of inadequate.

A person had become ill in March 2018 due to a long-term health condition. After being seen by emergency services, no thorough and timely action had been taken to check that this person was safe. When the new manager started at the home two months after this incident, they had identified that staff did not have adequate training about this person's particular health need. They arranged for this training to take place. However, action had not been taken to promote this person's safety by responding to this need in a robust way. We wrote to the provider to seek assurances that action was now being taken to promote this person's safety.

We later received written assurances from the provider that certain actions had been taken to respond to this event. However, when we spoke with the manager action had not fully been taken. The service had not advocated on this person's behalf to ensure timely professional input. This person's care plan was revised, but it still contained guidance for staff which could have put them at risk. No professional had been consulted with in creating this guidance for staff. We needed to speak with the provider again about the fact the service was not fully promoting this person's safety. We later received confirmation from the manager about the action they had taken.

We also identified that the person hit themselves. This person could not communicate in ways which others could understand. Staff told us that this behaviour was a relatively recent change but no action had been taken to find out why this person hit themselves. No action was also taken to check if they were hurting themselves through this action. Or to see if they were trying to tell people something. We needed to speak with the manager and the provider for a health professional to be consulted about regarding this matter. Despite this happening the service still had not considered if they needed to take other action regarding this matter to advocate on the person's behalf or make observations to establish what might trigger this behaviour.

When we visited the home, we went into the kitchen. We found a knife drawer which contained sharp knives was open. There was a key in the drawer but it was not locked. A member of staff was not in the process of using this drawer. This had the potential to put people at risk. We spoke with a member of staff about this who told us that they only locked the drawer if a new person moved into the home. When we raised this with the manager, they told us this is not correct. The drawer should be always locked, in order to ensure staff supervision with these knives, but this was not the case.

There were two domestic cleaning detergents left by the side of the kitchen sink. We asked a member of staff about this, they said they had just used them to wash up. However, this was not the case. These should have been removed straight away. We told them that this could put some people at risk. They took no action. We were shown the laundry room. There was a large bottle of washing detergent on the floor. This room was not secured. We spoke with the manager about these issues and they said these items should

have been removed, as people lacked capacity and this was a potential risk to their health.

During the inspection we reviewed the administration of people's medicines. We observed a member of staff go to the medicine cupboard and take a person's tablets out of the dossett packet. They then placed these medicines into a cup and left the room. We and the manager prompted the use of the Medication Administration Record (MAR) but they said that they did not need it. Safe practice would have been to check what the person had been prescribed and then administer their medicines. The manager told us that later this was explained to this member of staff.

We looked at people's MARs and found that a person had been prescribed some medicines daily but they had not been having these daily. Following a discussion with a member of staff it was discovered that these medicines had changed from a daily dose to a 'as required' dose. However, this person's MAR chart had not been updated. This had not been identified by the service for several months, despite the fact this person had a medication review six months ago. This should have also been identified by the member of staff checking in people's medicines when they were delivered to the home. No other member of staff had raised this issue despite supporting this person with their medicines daily.

The service was supporting people to have prescribed creams. These were not being stored correctly. These products needed to be stored at certain temperatures. If they are stored above certain temperatures this could undermine the effectiveness of these prescribed products. The service was not monitoring the temperatures of these products when they were not in use. They were monitoring these items when they were in use. However, often the temperature of this cupboard had got close and over the recommended temperature. In July 2018 on three consecutive days the temperature recording was above the recommended 25 degrees. No action had been taken. We spoke with a member of staff who said it was often difficult to keep the cupboard and the room it was in, cool. No action had been taken to address this issue and solve this problem despite it being known.

We visited people's rooms, we noted that in one person's en-suite there was an open bag with used incontinence products in it. There were also several used incontinence items in this bag. This meant that staff were simply filling this open bag, rather than safely removing each used item. The person whose room it belonged to was also in their bedroom alone at the time we found this bag with the used incontinence items in it. The manager agreed this could be a risk to this person's health. We also found used gloves disposed of in wastepaper and tissue bins in the main bathroom and in this person's en-suite. This is not a safe way to dispose of these items. Also in this person's en-suite their shower had black mould in the corners of the shower cubicle. No action had been taken to address this issue. Two radiator covers had rust on them, a toilet brush was sitting in water, an extractor fan in a bathroom was dirty. These are potential infection control risks which could cause people to become unwell. These issues had also not been identified before our inspection.

The above issues constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff recruitment checks. We could see that all three staff personnel records we looked at had Disclosure and Baring Service (DBS) checks in place. However, staff's references were not being verified to check they were from the people the member of staff said they were from, for example their former employer. One member of staff's two references were on printed letters. These had no signatures on them. There was nothing to confirm that these were from the people this member of staff said they were from.

During this process of looking at staff safety checks we identified two gaps in staff employment histories.

Staff's application forms did not ask for a full employment history. The manager called the provider's Human Resources team and they confirmed they seek two to three years employment history. Full employment histories are an important check, among others to check that staff are suitable for their roles. However, the provider was not doing this.

The above issues constituted a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff about their knowledge about how to protect people from experiencing harm or abuse. Staff could tell us what abuse could potentially look like. They told us that they would speak with the manager if they had concerns. Staff were also aware of the local authority which they could report concerns to and of the provider's 'whistle blowing' telephone number. However, there was some shortfalls in staff knowledge of this area. When we asked one member of staff about how they would make contact with the local authority safeguarding team. They said they would google it, but we later saw that this number was on the notice board in the office. Another member of staff said if they identified potential harm their first action would be to contact an advocate for this person. They said they had 72 hours before they had to report a safeguarding event. This is not correct. Action should be taken in a timely way if staff have concerns. Staff should be clear about these processes to ensure people are protected from potential harm. The provider was not adequately checking this issue.

At this inspection we also asked staff about their understanding of how to protect people from discrimination. We needed to explain to one member of staff how certain people are more vulnerable to experiencing discrimination than others. Even though the service was supporting people with learning disabilities and who were from different cultural backgrounds. The service had no information in relation to prompting staff about what discrimination could look like or what a hate crime or hate incident was. The manager told us that this was not covered in staff training.

We looked at staffing levels and we concluded that there were sufficient numbers of staff to support people's needs.

People had risk assessments in place. These did explore the risks which people faced. There were also plans in place to respond to these risks. Although we identified that one person's particular plan was not complete, nor had the service checked the guidance in the plan would promote this person's safety.

We identified that staff knowledge about people's needs was not always complete. The provider had not routinely asked staff if they were aware of what people's needs were. We asked one member of staff to tell us about one person's needs. They said they could not do this as they had not been involved in the writing of this person's care plan. The service was supporting three people when we inspected. All staff should have a good understanding of the risks which people faced and what they must do to reduce these risks. We spoke with the manager about this.

Various fire safety checks were taking place. Drills were taking place on a regular basis which involved the people living at the home and staff. Fire related equipment was also checked. People had emergency evacuation plans which contained important information about them and their photographs. There had been a recent fire service inspection at the home. One issue was identified in relation to a fire safety issue in a person's bedroom. The manager told us what action was being taken to rectify this issue.

There was an emergency contingency plan for the service. This did contain some practical information for staff to follow. Emergency contact numbers for utility suppliers and maintenance services were included.

However, in relation to the risk of a loss of staff there was no practical information to ensure staff availability. There was reference to the use of agencies but their contact numbers and names were not supplied. There was no list of local staff who could or would be prepared to work at the service at short notice. There was no evidence to say that this plan was regularly being reviewed and shared with staff. To ensure staff knew where the plan was located and what they needed to do in certain emergencies.

Requires Improvement

Is the service effective?

Our findings

When we visited Georgina House in January 2016 we found that staff provided effective care to people. However, when we visited in July 2018 we found there were areas which required improvements to be made.

During this inspection we found that staff did not have the skills and knowledge to do their jobs well and provide people with effective care. We observed poor practice with infection control practices, keeping people safe, and how they communicated and interacted with people.

Staff did speak positively about their training and their inductions. When we asked staff why this training was positive, they were unable to tell us. Staff received training in some areas relevant to their work. However, some training relevant to people's health conditions had not been delivered in a timely way. Staff also did not receive training about how to best meet people's cultural needs. We found this put people at risk of not receiving effective care.

Staff were not always being supported to develop a good knowledge and understanding about people's needs. When we looked at people's care assessments and care plans, we noted that these records were too long. This made it difficult for staff to have the time required to thoroughly read through these and fully understand people's support needs. We spoke with the manager about this who agreed with us that further work was required in this area.

The service operated a 'sleep in service.' This meant that staff would be sleeping and not working during the night time. Often staff would work a shift before they 'slept in' and then work the next day until the afternoon. We were told that it was hard for staff to sleep because it was an unfamiliar environment for them to sleep in. We were also told that it was hard to sleep as staff were conscious that someone may need them. We were also told that the room in which staff slept in was a '"Bright and warm room", making it difficult for them to sleep. Consequently, staff working after not resting enough had the potential to have an impact on the effectiveness of staff practice. These issues were not being monitored or checked by the manager or the provider.

The manager and provider were not completing competency checks on all staff. This would be to check they had understood and retained the training, and they were putting this training into practice. Therefore, the leadership of the service could not tell us what assurances they had that staff were effective in their work. Staff who administered people their medicines did receive three competency checks to ensure they were effective in this role. We looked at these documents. They did not show how or why the assessor had reached their conclusion that an individual member of staff was competent in this area. The assessor's conclusions were not evidenced with detailed examples.

Staff had not been having regular supervisions and staff meetings, to check how staff were getting on in their roles, or to see if staff needed further support or training. We looked at the supervision templates and we saw that supervisions were not being used as a learning opportunity to check staff knowledge in certain areas. We asked the manager why staff had only had a supervision recently. The manager told us that they

had been advised these supervisions were taking place before they started at the home, but these records could not be located. Staff were not clear when supervisions took place.

The above issues constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 make 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 so that they can 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.

We identified one person who the service said lacked capacity to make decisions about their health and wellbeing. This person had been ill this year. Action was taken following our inspection in relation to their health needs. Their records stated that the local authority had legal responsibilities and powers in terms of their care. The local authority had not been consulted with about this person's health needs and the planned actions that the service was taking. We had confirmation after our inspection that the actions taken in relation to this person's health needs took place via a 'best interest' process.

People who lived at the home had been placed under a DoLS. However, one person's authorisation had expired and the previous manager or provider had not identified this. The current manager told us that they applied for a review by the local authority shortly after starting at the home. We saw records which confirmed this. However, we noted that one person's movements were being restricted in a certain way. We spoke with the manager about this. From looking at this person's recent authorisation from the local authority it was unclear if the assessor had included this restriction as part of their assessment. The manager said they would speak with the local authority about this. However, this demonstrated that there were no checking processes, to see if the service was adhering to these restrictions and that the assessor was aware of all the restrictions.

The above issues constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with told us how they promoted choice and supported people to make their own decisions with the care they received. The staff we spoke with also had a good understanding about what capacity meant.

When we spoke with staff about their understanding about DoLS, they understood that it was about restricting people's movements.

People were not being fully involved in decisions about what they wanted to eat and drink. There was a menu board in the kitchen with pictorial guides. Some of the people who lived at the home could not communicate in ways we could understand. The service had not considered ways to involve people with the planning of their food and drinks. We spoke with one member of staff who told us that the weekly menu had

not changed since they started at the service last year.

We observed a member of staff asking two people what they wanted to eat. However, we saw that people were not given the time to explore the food options with staff. One person could not communicate with others in ways which they could understand. Extra time was not given to this person to check what they had chosen is what they wanted. We saw this was a quick process with the member of staff speaking in a raised tone to the person, while they started to prepare the other person's lunch.

We were also told about the food likes of one person. Staff told us that they liked a particular dish related to their cultural background. We were told that sometimes staff purchase a take away for this person. Considering this person had lived at the home for several years, staff had not been supported to learn how to cook the particular types of dishes and food that this person liked. We spoke with the manager about this, who agreed this should
have happened.

Some people had a cultural background which meant that their food needed to be prepared in a certain way. This was not happening. There was an assumption made that given the person's level of capacity, they would not follow their cultural and religious traditions. However, staff had no way of knowing this. The manager later told us what action had been taken to rectify this issue.

The staff did not promote healthy foods and alternatives with people. For example, two people had sandwiches with white processed bread. Staff did not suggest ways to make this meal healthier. We noted there was a bowl of fruit in a cupboard high on the wall. Staff did not ask people if they wanted any fruit, this bowl of fruit was not accessible by people. People were not offered snacks during the day.

The meal experience was rushed. There was no social element to it. We observed two people have their lunch and staff did not sit with them. They did not engage with them to make this a social experience. While people were still having their lunch, a member of staff started to wash up in the kitchen just next to the dining room. There was a lot of banging and crashing, and they gave no consideration to people's dining experience.

After these two people had their sandwiches and crisps they left the table. Staff then individually made their lunches and sat at the table. The meals that staff had were heartier and healthier than the food the two people who lived at the home had. At one point a member of staff ate their lunch with their back to the room. One of the people living at the home, looked on at this member of staff. There was no attempt to engage with this person.

Given there were two people at the home and two members of staff this dining experience could have been more meaningful. We asked a member of staff why they had not sat with people at lunch time. They told us that they normally did but they needed to record what one person was having for lunch. Given this related to one person we believed that this could have taken place after lunch. This action and others at this time did not put people first, it put the staff first.

There was no use of technology in the home as an aid to support people and meet their needs. Two people were unable to communicate with others in ways others could understand. The use of technology had not been considered.

We were shown records which demonstrated that one person had received their 12 month GP check-up. We could also see other records where people had seen other professionals such as opticians and dentists.

However, given the lack of timely action in relation to a person becoming ill in March this year, we could not be confident that people's health needs were always responded to appropriately and in a timely way. One person was expressing behaviour which could be an indicator of distress or pain. No action had been considered about this issue. We later checked on this after the inspection. Again, we needed to prompt this.

There was no consideration given to the design, and decoration of the building, as a way of meeting people's needs. There was access into the back garden, but there was nothing for people to do or enjoy in this area.

Requires Improvement

Is the service caring?

Our findings

When we inspected Georgina House in January 2016 we found that the service was caring. However, when we visited in July 2018 we found there were areas which required improvements to be made.

One person did not like their lunch. It took time for staff to respond to this. They did not try to engage with the person. One member of staff appeared frustrated about this. Another member of staff went to get the person a bag of crisps which the person had clearly indicated that they wanted. One member of staff said, "I'll get him some crisps." The other member of staff said, "No, he can have his sandwiches first." They said this in a loud voice from the kitchen. This is not respectful, or kind. The other member of staff said, "Oh". They did not challenge this.

We later heard a member of staff call this person over to the kitchen. They just stated their name in a loud voice. We saw this member of staff wipe this person's face with a rough looking hand paper towel. They did not try to explain to the person what they were going to do. When this member of staff wiped this person's face it was not done in a gentle way. We spoke with the manager about this. They later told us what they were doing in response to these observations.

Staff did not promote respectful and compassionate behaviour within the staff team. People were referred to as "Him" and "He" by the staff team in front of people. People's first names were not used by staff when they referred to people. These poor practice issues were also not challenged by the rest of the staff team, the manager was not informed of these events by a member of staff.

The above issues constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with one person who we could potentially understand but it was unclear if they had always understood what we had asked them. We asked them about the staff. They indicated that they liked their key worker. We noted that during our visit, they presented as at ease with this member of staff. However, two people did not always present at ease or familiar with another member of staff who had worked at the home for a long time.

All the people who lived at the home had communication challenges. Two people were unable to communicate in ways others could understand. These people had lived at the home for a long time. No real action had been taken to improve staff's understanding about how to communicate with these people. We spoke with the manager who told us that they had identified this when they recently started working at the home. They told us what action they had taken to start to address this issue. Although this is positive, meaningful work had not been undertaken by the provider. This questioned how the provider's values, promoted and championed people's rights at the home.

We observed how the staff interacted and supported the people at the home. There were some occasions when a member of staff spoke with two people in a soft and gentle way. However, another member of staff

consistently spoke with people in a sharp way, often raising their voice. People were called to the kitchen to collect their lunches in a dictatorial tone.

The service was giving staff the time to support people but they were not checking if staff were actually responding to people's needs. They were not testing or checking this.

One person was periodically slapping their stomach. This created a loud sound and sounded at times, like a hard slap. We asked a member of staff if they could explain this to us. They could not. We spoke with the manager about this and checked the person's records. No action was being taken to investigate this further.

People's private information was stored in the main office which had a lock to it. However, this room was not locked when staff were not in it. People's care records were placed on a shelf, they were not in locked cabinet. Although the front door was locked, further action could have been taken to protect people's confidential information.

There were times when people would complete certain tasks independently. However, staff did not always promote this during the inspection.

The staff we spoke with were able to give examples of how they promoted people's privacy and dignity when they supported people with personal care. We saw staff knock on people's doors before entering their rooms. However, no work had been completed to see if people understood what this meant. No time was given before the member of staff actually opened their doors after knocking on them.

Requires Improvement

Is the service responsive?

Our findings

When we inspected Georgina House in January 2016 we found that the service was responsive to people's needs. When we visited in July 2018 we found areas where improvements were required.

The people who lived at the home had communication needs. We could see that some work had been completed to involve people in the planning of their care. However, no real action had been taken to address some people's communication needs. The manager told us how they were addressing this issue now. Referrals had recently been made to specialist health professionals in relation to this issue. The manager told us about plans they had to build on this with these professionals' input. Some initiatives had taken place. Staff were to promote a particular word in sign language daily. There was a visual card of a particular word on display in the lounge at the home. Despite this, staff were not referring to it or using it during our visit. There were no systems in place for the leadership of the service to be checking, reviewing, and investigating this communication issue.

People's care records did not always reflect people's physical needs. One person had been unwell before we inspected the home. This event had not led to a full review of this person's needs, to consider new ways to keep them safe and promote their physical health. This person had also started to hit themselves. No one had looked into this issue. The leadership of the service did not know if this person was trying to communicate something to staff when they did this. Whether it an indicator of distress or pain, staff and the manager did not know.

When we reviewed people's records, we could see work had been completed to identify people's social needs. What they liked to do, their interests, and what they found enjoyable. However, no work had been completed to develop these interests and expand on them. Two people had two particular likes. These people could not communicate with others in ways which they could understand. Given these people's communication needs, no one had tried to expand on these people's known interests. There was no reference to these likes and interests in the rest of the home or in their bedrooms.

Some people had particular cultural needs which had been identified in their care records. However, there was no guidance for staff about how they should be promoting or responding to these. Standard phrases were used in these plans, such as, "Staff are to support [name of person] with their cultural needs. No detail was given about how staff would do this. When we spoke with the manager about this issue they told us that certain conversations had been had with people's relatives. However, this had not been followed up with a plan in place for staff to follow.

When we spoke with staff and the manager about plans to engage people with social opportunities, there was a lack of actual planning taking place. There was no drive to make things happen. One person accessed the garden regularly during our visit. One member of staff said, "He loves being out there (garden)." There had been no attempt and there were no plans made to make this a more personal or attractive space. There was only a shed, grass, and a table, nothing else. The manager agreed this space needed development. One member of staff told us their ideas about supporting people to decorate the fence. However, no action had

been taken. Staff spoke about a "Summer holiday" but despite the fact we inspected in mid-July, there were no plans in place. No attempts had been made to consider options and involve people with this. We saw that in January and February 2018, meetings had been held with people at the home. Staff had identified having a holiday and a summer sports day as some of the activities people could do, but no plans had been made. No action was taken to make these happen.

There were no planned regular social events in the home. We were told about some social trips out, which included shopping, going out for lunch, and bowling. We were shown a photo scrap book which had been created showing some people doing arts and craft work in the home and some outings. As the manager told us, these events could have been completed in one or two days. There was insufficient evidence to show if people had adequate opportunities to access the local area, and be with people that they wanted to be with.

During our visit, there were missed opportunities to engage with people in a socially inclusive way. Staff did not perform activities together with people. There was no attempt made to make the people's time with staff enjoyable. For example, daytime TV was playing Good Morning and Loose Women. These programmes were not about people's interests who lived at the home. We raised these issues with the manager. We heard them speaking with the staff about this. They were told to put music on. However, no one was asked what they wanted to listen to. Staff did not try to tailor this to people's likes.

Only one person's room was personalised and reflected some of their interests. Two people's rooms were decorated in a generic way the same as the rest of the home. The manager could only identify a picture on their wall as something personal to them. These people had lived at the home for a long time. The manager agreed work was needed in this area.

People went to bed at ten in the evening when the 'sleep in' member of staff went to bed. No consideration or flexibility was given if these people wanted to stay up longer.

The above issues constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaint policy in place. This outlined how the complaint should be processed and where people should be directed to if they were unhappy with the outcome of the complaint. There had been no complaints made at the home when we inspected it.

When we looked at people's records to see if people had end of life plans in place. Some consultations had taken place with people's relatives, but this had not been progressed. Attempts had not been made for staff who knew people well to be involved in this planning. Best interest processes had not been put in place regarding this subject. We spoke with the manager about this. They told us that they planned to revisit this area of people's lives and how there should be an ongoing assessment and review of this.

Inadequate

Is the service well-led?

Our findings

When we inspected Georgina House in January 2016 we found the service was well led. At this inspection we found the leadership of the home to be inadequate.

During this inspection we found multiple breaches of the regulations of the Health and Social Carte Act 2008.

Timely action had not been taken to ensure a person was safe following a period of being unwell. This event did not result in a full review of their care needs. Professional advice was not sought. As a result of our concerns after identifying this at the inspection, we requested confirmation that certain actions had been taken quickly to ensure this person was safe and their health needs were met. Information from the manager indicated that insufficient action had been taken to ensure this person was safe and their rights had been promoted. We needed to have further contact with the provider about this issue in order to be satisfied that they were seeking the necessary support to meet this person's needs.

We identified a potentially uncaring culture at the home. Staff were not always kind and thoughtful towards the people they supported. A member of staff had expressed control over a person at the home and did not treat them as an individual and in a respectful way. Staff were not giving people their time and did not try to build relationships with people. Staff were not respecting the fact they were in someone's home. For example, a member of staff was observed sitting watching TV, staff ate their lunch without asking people if this was ok. Staff chose TV programmes and music which they wanted to watch and listen to.

There were examples of institutionalised practice. Some people's rooms were not personalised despite them living at the home for some years. Communal spaces were also not personal to the people who lived at the home. Work had not been completed and there was no focus on trying to support the people at the home to live as a community. Some practices were for the benefit of staff not the people at the home. For example, one person had continence products on display in their bedroom. There was a notice in their en-suite in large red writing reminding staff about infection control practices. The fact this was a person's own space was not promoted at the home.

When we spoke with the manager about some of the issues we had identified about staff practice, they went to speak with the staff. We heard these members of staff raising their voices and being defensive towards the manager. All these factors and a lack of person centred care are indicators of a poor culture at the home.

The service was not promoting people's rights and wishes at the home. Work had not been completed to try and understand how people were communicating with staff. The service was not working with staff about promoting people's rights and what this looked like. The provider was not testing or checking this.

We identified shortfalls in staff practice during our inspection. The provider was not monitoring staff competency. Provider audits had not identified this issue. The audits which did take place were not effective. They did not evidence that staff practice was observed. Staff were not asked questions about their

work. Care records were not being robustly checked. Incidents relating to people's health were not being reviewed. People's experiences were not being monitored in a meaningful way to see if they were living fulfilled lives. Given people's communication needs, there was no monitoring to see if the service could do more for people.

There was a lack of management presence at the home. The leadership and provider were not promoting best practice amongst the staff team. Basic shortfalls had not been identified and addressed. When we visited the home, the new manager had only been appointed for two months. They were also overseeing another home by the same provider which was larger and there were known issues at that home, and the local authority had been involved with that service recently. Given the issues we found, we were not confident that the provider was appropriately supporting the new manager.

The above issues constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was not a registered manager in place when we visited Georgina House. There was a new manager who had recently submitted an application to register with the Care Quality Commission.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that people's social needs and preferences are met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that people are always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment must be provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that care and treatment was provided in a safe way. They had not assessed all risks to people's safety or taken appropriate actions to mitigate these risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured that people's

nutritional and hydration needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to have effective systems and processes in place to monitor and improve the safety and the quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that there are always staff of good character employed at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there are always suitably qualified competent staff at the service.