Astra Investments Ltd

St George's Residential Care Home

Inspection report

Abbey Hey Lane
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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**

Overall summary

This inspection took place on 8 December 2015 and was unannounced. That means that St George's Residential Care Home (St George's) did not know in advance that we were coming.

The previous inspection had been on 12 September 2014 when we had found the service was not meeting regulations in three areas: premises, staffing levels and aspects of quality monitoring. We requested the provider to submit an action plan, which they did on 5 December 2014. At this inspection we checked to see whether these regulations were now being met. We found that action had been taken in those three areas to meet the regulations. Our findings are set out in our full report.

Summary of findings

St George's is situated in Gorton in north east Manchester. It is a former rectory converted to provide accommodation for up to 10 people. At the date of this inspection there were six people using the service, one of whom was temporarily in hospital.

There are six bedrooms on the first floor, with access via a staircase or lift. Each bedroom has a washbasin. There are bathroom and toilet facilities on both floors used by people living in the home. The ground floor has four more bedrooms, a lounge and separate dining room. A kitchen and laundry are also located on the ground floor.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had taken over the service from the former provider in August 2015. Up to that point the former provider's representative had carried out most of the management functions. The registered manager and other staff had remained in post when the current provider took over.

We found five breaches of regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to staff recruitment and lack of staff supervision, medication management, deprivation of liberty safeguards, and assessing the quality of the service. There was also a breach of a regulation in the Care Quality Commission (Registration) Regulations 2009, relating to not reporting an allegation of abuse. You can see what action we have told the provider to take at the end of the full version of the report.

People told us they felt safe at St George's.

We checked on the recruitment processes for staff. We found that one person had been working for six months without the proper checks having been done, which was a breach of the relevant regulation.

We spoke with staff who administered medication. The system for storing controlled drugs did not meet the requirements of legislation. This was a breach of the regulation relating to the safe and proper handling of medicines.

Fire prevention and detection systems were maintained. However, St George's did not have individual evacuation plans, which created an additional risk. This was a breach of the regulation relating to reducing risks.

St George's did not have a cook or a cleaner at the time of our inspection. Care staff prepared meals and did the cleaning. We found there were sufficient staff to meet the needs of residents.

The home was clean although some recommendations made in an infection control report still needed to be implemented.

Staff had received training during 2015 about health-related issues. However, the training in mandatory topics including safeguarding, food hygiene and medication was sporadic. Staff were uncertain whether supervisions had taken place, and we found no evidence of appraisals. This all meant that staff were not being fully supported in their role, which was a breach of the relevant regulation.

Staff had recently received training about the Deprivation of Liberty Safeguards (DoLS). Staff at St George's had not yet applied for any authorisations under DoLS but were planning to do so. Mental capacity assessments had not been used, but were now needed at least for one person.

We saw people enjoying the food. People's dietary needs were catered for. The provider was planning refurbishment of the building and as part of that we recommended that they should improve the environment for people living with dementia.

People told us they were well looked after, and the home was warm and comfortable. We observed that staff knew people well and were respectful, kind and attentive.

One person was in bed and the staff were turning them regularly to avoid pressure sores developing, although there was no chart in use to record this.

Staff had received training in end of life care and people were able where possible to stay in St George's to the end of their lives.

We looked at care files which did not contain enough personal information about people. However, the small number of residents meant that staff were able to know each of them well and meet their personal needs.

Summary of findings

Assessment procedures for potential new admissions had changed since the new provider took over.

A new system of recording daily notes on a grid sheet had been introduced. This might make it more difficult for medical professionals to keep track of people's health.

We saw that care plan reviews were being done regularly.

There were no activities on the day of our visit. We found records showing that some activities did take place. We recommended that the provider should consider introducing a greater range of activities.

There had not been meetings for residents or their relatives, but people told us they could always discuss matters with the registered manager. There was a complaints policy. There had not been any formal complaints recorded since 2013, although we knew some verbal complaints had been made in the previous winter.

The registered manager was aware of the requirement to notify certain events to the CQC. We were informed about an allegation of abuse which had been made in October 2015 and had not been reported to the CQC. This was a breach of the relevant regulation regarding notification of events.

Residents and staff commented that the atmosphere at St George's was calmer since the new provider had taken over. This had a positive impact on the care for residents. The new provider had promised refurbishment and development.

The provider was not involved in managing the quality of the care being delivered or other aspects of the management. The registered manager conducted some audits but there was scope for improving the range of audits. We found this was a breach of the regulation relating to assessing and improving the quality of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

Not all the required checks were in place before staff started working at St George's.

The storage of controlled drugs did not meet requirements.

There were sufficient staff. There was no cleaner but the staff kept the home clean.

Is the service effective?

Requires improvement

The service was not always effective.

Staff had received training in health-related issues but not all mandatory refresher training was up to date. The system of supervision for staff needed improvement.

The registered manager was aware of the Mental Capacity Act 2005 but had not yet applied it.

The food was good and people's dietary needs were met. The physical environment needed improvement.

Is the service caring?

Good

The service was caring.

Staff knew people well and supported them respectfully.

Staff were trained to care for people towards the end of their lives and people were supported to stay in the home.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care records were not sufficiently person-centred, although staff knew the residents very well. People's wishes not to be resuscitated were not recorded on their care files.

Some activities took place but there could be more activities suited to people's specific needs.

Complaints made verbally had previously not always been recorded.

Is the service well-led?

Requires improvement

The service was not consistently well led.

Not all incidents had been reported to the CQC as required.

Summary of findings

The atmosphere and morale in St George's had improved since the new provider took over and this had a beneficial impact on residents.

Some audits were being done, but they were not always effective and there was no oversight of the home by the provider.

St George's Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 December 2015 and was unannounced.

The inspection was carried out by two adult social care inspectors.

Before the inspection we reviewed all the information we had, including notifications from the service, and issues raised with us by social workers and healthcare professionals. The former provider had submitted a Provider Information Return (PIR) on 17 June 2015. This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We contacted the contract officer of Manchester City Council for information about the council's recent monitoring visits. We considered an infection control report by Council officers after a visit in September 2015.

We talked with three of the five people living in the home who were present in St George's on the day of our visit. We met three family members who were visiting their relatives. We interviewed the registered manager, the deputy manager and four other members of staff. We carried out observations at mealtimes and in the lounge.

We reviewed a range of records about people's care and how the home was managed. These included the care records for all six people who used the service, staff training and supervision records, four staff personnel records, and documents relating to maintenance of the building and equipment.

After the inspection we spoke with a Macmillan Clinical Nurse Educator who had been delivering a series of training sessions to staff at St George's.

Requires improvement

Is the service safe?

Our findings

We talked with people living in St George's and asked them if they felt safe. They all replied that they did feel safe. One person told us, "Yes I've always felt very safe here – we do get very well looked after."

We checked four personnel files to ensure that the correct checks had been made at recruitment. The files included the application form and the interview questions. Two forms of identification, including photo identification, were present. On three of the files were two written references and a Disclosure and Barring Service (DBS) certificate number. The DBS keeps a record of criminal convictions and cautions, which helps employers make safer recruitment decisions and is intended to prevent unsuitable people from working with vulnerable groups.

One of the files we saw did not contain any references, and did not have the DBS certificate number. The only relevant document was a Criminal Records Bureau (CRB) certificate obtained by a former employer in April 2010. (The CRB was the predecessor of the DBS). This file related to a member of staff who had been working at St George's for six months. We asked the registered manager about this. She explained that the member of staff had started under the former provider, and the request for a DBS check had not been sent. She told us on discovering this she had applied for the DBS check to be completed, Pending the DBS certificate, the registered manager told us the member of staff only worked alongside herself or the deputy manager. The staffing rota confirmed this was the case.

We noted that in recent years two other employees had started work a few weeks before receipt of their DBS certificate. The registered manager assured us that when this happened the member of staff always worked under close supervision. However, if there were only two staff on duty it would not be possible for them always to be in sight of each other.

Ordinarily a care home should only allow staff to start work after their DBS certificate has been obtained. It is acknowledged that DBS certificates can take six weeks or more to be returned. The DBS allows care homes, in exceptional circumstances, to apply for an Adult First check, which is normally returned after two days. If the Adult First check is clear, a person is permitted to start work with adults before a DBS Certificate has been obtained.

The regulations require that prescribed information about job applicants should be confirmed before they are employed. This was a breach of Regulation 19(1) and 19(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from the training matrix that only four out of nine staff had received specialised training in safeguarding while at St George's, and three of those in 2012 or 2013. Although all staff had qualifications which include training in safeguarding, refresher training would be of benefit to all staff. Staff told us they understood about safeguarding and would know how to report it if they witnessed or suspected abuse of any kind. There was a safeguarding policy which staff said they had read. Staff told us they had not seen any signs of abuse while working at St George's.

Accidents were recorded on individual care files. We saw that body maps were used to record bruises or other injuries sustained.

We looked at the ordering, storage and administration of medicines to determine whether they were safe. The registered manager, deputy manager, and the two senior carers were the only staff involved in administering medication.

Medicines were all supplied from the same chemist. They came with a pre-printed Medicine Administration Record (MAR), listing the medicines to be given and the quantity and time. It included a picture of the resident and pictures of each tablet that was to be administered. These details made it less likely that errors would take place.

We did observe that confusion could arise when someone woke up late and did not have their morning medicines at the set time. We saw this happened on the day of our visit. A note was added to the back of the MAR to say they had received them at 10.30am. However, three of the medicines were not signed as given on the front of the MAR. This could lead to uncertainty as to whether the person had had those medicines or not. During the afternoon the deputy manager confirmed to us that they had been given at 10.30am and signed the front of the MAR in our presence. We acknowledged that our presence conducting the inspection had probably contributed to the oversight.

Medicines were stored in a locked trolley which was secured to the wall of the dining room by a chain attached to a bracket. At one point in the morning we saw the key was left in the lock while the trolley was unattended. We

Requires improvement

Is the service safe?

informed the registered manager that the bracket itself was fixed to the wall by small screws and was not particularly secure. Also, there was no cabinet to store controlled drugs, as is required by legislation. Controlled drugs by their nature are required to be kept more securely than others. At the time of our inspection there was only one controlled drug in use, which was kept in the same trolley as regular medicines. However, St George's had in the recent past kept a stock of 'anticipatory' drugs, which are used for someone approaching the end of life, and was likely to do so again. We acknowledged there were space limitations as to where a controlled drugs cabinet could be placed, as it needs to be securely fixed to a permanent wall or the floor. However, The Misuse of Drugs (Safe Custody) Regulations 1973 require such a cabinet. Not having one was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to 12(2)(g) which relates to the proper and safe management of medicines.

There was a controlled drugs record book which had an accurate record of when the medicine had been given and the stock remaining. This helped ensure that people received the medications that they had been prescribed and reduced the risk of misuse.

We checked that fire prevention and detection systems were in use and regularly maintained. A fire risk assessment had been carried out in July 2015, and actions resulting from that carried out. Fire doors were clearly marked with instructions that they should be kept closed. The nature of the building, a former Victorian rectory, meant that fire prevention and response needed to be a high priority. There was a fire and emergency evacuation policy which carried the instruction that all staff should familiarise themselves with it. There were no personal emergency evacuation plans (PEEPs) which are documents to assist the emergency services in the event of a fire, by describing each person's ability to mobilise and any equipment that might be needed to help evacuate them. The lack of PEEPs created a risk that people might not be evacuated safely in the event of a fire or other emergency. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with reference to 12(2)(b).

We saw evidence of safety and maintenance checks on the lift, gas appliances and electrical appliances. In the previous winter there had been some problems with the boiler and hot water system but these had been rectified and the heating was working well on our visit. A radiator in the lounge had been replaced and that room was comfortably warm. We also saw that hoists and wheelchairs were routinely maintained to ensure their safety. In our previous report we found defects in the heating and hot water system, and the poor maintenance of hoists, were a breach of the regulation in relation to premises and equipment. These defects had been rectified.

At the date of our visit there were only five people residing in St George's (a sixth person was temporarily in hospital). There were two staff on duty throughout the day, and also two staff at night, one of whom stayed awake. One resident told us: "There's always two carers on and there's not many people here so I think that's okay." One person stayed in bed; others were able to walk independently and did not have complex needs. This meant that two staff were sufficient, unless there was an emergency. In those circumstances, we were told, either the registered manager or the deputy manager could come in at short notice to help out. The deputy manager told us, "Since we were taken over there haven't been any problems with staffing – as more people come in we will increase the number of carers." One visitor said to us, "Each time we come in, and we come in a lot, there always seem to be enough carers on duty." We therefore found that the breach in regard to staffing levels identified at the previous inspection had been remedied and we were satisfied sufficient numbers of staff were available to support people properly.

There was no cleaner or cook employed at St George's at the date of our inspection. There had been a cook, who had left about six weeks earlier. Care staff needed to cook meals during their shift. The kitchen was adjacent to the dining area, through an open doorway, so the person doing the cooking was available to be called easily if needed. They also told us, "We do the hoovering." These tasks took staff away from their primary role as carers. The registered manager assured us she was actively recruiting a new cook.

The registered manager told us that St George's never used agency staff. If ever anyone was off sick she was able to ask another member of staff to do an extra shift. At the date of inspection there was a total complement of nine staff available, including the registered manager and deputy manager. This meant there were enough staff to cover foreseeable absences.

Requires improvement

Is the service safe?

The registered manager was the infection control lead. This meant it was her responsibility to ensure that the risks of infection spreading were minimised. We had received an audit report by Manchester City Council's infection control team following a visit on 10 September 2015. This had identified a number of necessary improvements. In particular the report suggested having a dedicated sluice room (for the disposal of bodily fluids). This had not been achieved by the date of our inspection but should be considered as part of the refurbishment and extension being planned by the new provider. The report also suggested that hand washing facilities for staff be made available in all bedrooms and in the laundry. We saw that there was now soap and paper towels available, except that paper towels had run out in the downstairs toilet. No hand washing instructions were displayed which would have provided a useful reminder of the required hand washing procedure.

Because there was no cleaner employed the cleaning was done by care staff when they had an opportunity. There was a cleaning schedule. We found all parts of the home including bedrooms, bathrooms and toilets, appeared clean, with no unpleasant odours. Staff wore protective clothing when preparing and serving meals.

Requires improvement

Is the service effective?

Our findings

We asked staff about the training they had received while working at St George's. A member of staff told us, "I had an induction and shadowed another staff member when I started." We saw induction handbooks on one recent starter's file but not on the file of a member of staff who had started six months earlier. Induction training covered emergency and safeguarding procedures, and moving and handling.

Staff should receive ongoing training in mandatory areas. We received a copy of the training matrix which was a record of training received. We noted some gaps in mandatory areas. For example, no staff had received training in food hygiene, even though staff were expected to cook meals while on shift. The deputy manager and only one other member of staff had received training in first aid. Two staff had missed the training dates in health and safety in November 2014, and moving and handling in February 2015.

According to the deputy manager the four staff who administered medicines had done medication training. This was in contradiction to the training matrix which showed that only one of those staff, a senior carer, was recorded as having had training in medication and that was in April 2012. It is essential for the staff concerned in administering medication to have regular refresher training. We asked a senior carer about this who told us there had been some training from the pharmacist, but they had missed it. They added, "I could do with an update. I have been looking to find a course myself."

We noted that the information in the training matrix did not match the information sent to us by the former provider in June 2015. For example that document stated that four people had received training in food hygiene/handling in the last 24 months, and eight people in safeguarding. We only received the training matrix after the date of the inspection, so did not discuss the discrepancies with the registered manager. However, we had to rely on the training matrix as being the most recent record supplied to us.

The registered manager told us that training had been delivered during 2015 by a Macmillan Clinical Nurse Educator. We contacted this person who explained that St George's had participated in a project to increase awareness in care home staff of illnesses and long term health conditions. They had delivered a series of hour long training sessions in alternate weeks covering altogether 14 different health related issues.

The Macmillan Clinical Nurse Educator stated that the staff at St George's had been very enthusiastic about these sessions: "The home staff were most engaged and interested in learning for the care to improve." They stressed, however, that the project did not extend to mandatory learning topics, such as moving and handling or food hygiene. Training in these areas still needed to be sourced and provided by the home.

Further training in the Six Steps was planned for February 2016. This is a programme which assists care homes to support people nearing the end of life.

The registered manager told us that supervisions of staff were held every eight to ten weeks. We did not find any evidence of these on staff files, and some staff told us they had not been happening recently. One member of staff said they had received supervisions, but another told us, "I can't remember the last supervision I had and we should be having them – we need to start." We asked the registered manager what form a supervision took. She told us it involved a conversation with the member of staff while they were working, near the end of their shift. It was possible that what she considered a supervision the staff interpreted as an informal chat. The registered manager told us she completed a checklist. We looked for these on staff files but the latest one we found dated from 2011. Supervisions should be a reasonably formal opportunity for the member of staff and their manager to discuss how work is going, and individual issues and training needs. There was no record they were being done in this way. We also found no evidence that annual appraisals were taking place.

The training offered by the Macmillan Clinical Nurse Educator project was due to cease at the end of 2015. It had evidently been of benefit to the staff at St George's, but it was not intended to be a substitute for ongoing mandatory training. The gaps in that area, especially in safeguarding and medication and food hygiene, together with the lack of formal supervision and appraisal, were a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

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. Mental capacity assessments should take place to assess a person's capacity for each individual decision.

People can only be deprived of their liberty in order 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.

We saw that consent forms for care and treatment, and release of records, were completed and retained on care files. In three of the care files the person had signed their consent form, on a fourth it was recorded that the person had given verbal consent. We heard staff asking for consent before providing support, for example when helping with meals. One person had signed a form to indicate that they wanted their bedroom door kept open at night.

There were no mental capacity assessments in people's care records. We would have expected an assessment to have been completed to help ensure their rights were being respected if they were unable to make their own decisions. St George's had not submitted any notifications about DoLS authorisations at any time since registration with the CQC. We asked the registered manager about her and her staff's understanding of MCA and DoLS. She stated that the staff had received training in this area the week before our inspection from the Macmillan Clinical Nurse Educator. This was recorded on the training matrix (except for one member of staff who had missed it) and staff confirmed they had received this training and found it helpful.

One person said to us, "I would like more say in what I do. I can't have a drink in my bedroom." We checked this person's care file and saw that the Speech and Language Therapist (SALT) had recommended a few days earlier (on 4 December 2015) that the person should not have drinks in their bedroom. The registered manager told us that this had been explained to the resident. However, there was no mental capacity assessment to determine whether or not the resident had mental capacity to consent to this restriction. If they did not, then the service ought to be considering applying for authorisation under DoLS. We noted however that the instruction from the SALT had been made only four days before our inspection. The same person also told us that they weren't allowed to keep certain pain relief creams in their bedroom. Again we were told the valid reasons for this, but consideration should be given as to whether this was a deprivation of liberty.

The registered manager told us that following the training she was planning to make a DoLS application in relation to someone who often refused to take medication and according to their GP was putting their health at risk. The GP had suggested it might be necessary to give the medicines covertly, which means disguised with food or drink. The registered manager understood that this would involve a mental capacity assessment, and if the person did lack capacity to decide for themselves a best interests decision to determine whether being given medicines covertly was in that person's best interests. Then a DoLS application would become necessary. The registered manager understood this process so although up to this point no DoLS applications had been made, we considered that the service was working within the principles of the MCA.

In the past concerns had been raised by family members and by visiting professionals about the quality of food at St George's. We learnt that this had improved. The deputy manager told us, "Since the new owner came in I now get a weekly budget and I buy all fresh food now." One resident said, "The food has got much better." Another person said, "The meals are fine and if you don't want something you just say and they will do something else for you." The change was confirmed by a visitor who said, "No doubt there has been a big improvement in all areas,…food – it really is good now." Another family member said, "[my relative] has got a great appetite and eats everything they bring in for them – they enjoy it."

The staff were currently preparing and cooking meals during each shift, but the registered manager was recruiting a new cook. People could eat either in the dining room, the lounge or in their bedrooms. We saw staff

Requires improvement

Is the service effective?

providing encouragement and assistance as needed to people eating. A choice of food was offered, along with hot and cold drinks. Only two people had lunch in the dining room during our visit, and they sat at different tables not facing each other. We asked staff the reason for this, as it appeared institutional and unsociable, but we were told there were good reasons because of previous incidents, and this was what the residents themselves preferred.

In one person's care plan, it was stated that they should be observed while eating because of a possible choking problem. Staff members were present during lunch time and were observing this person unobtrusively. The service could cater for people's specific dietary needs. One person required a special diet as they were diabetic. A SALT had given advice that one person should eat a 'fork mashable' diet, which means food with a soft consistency.

People's weights had been regularly recorded on weight monitoring charts in care plans up until August 2015. We asked why weight monitoring had ceased. We were told a new system had been introduced which allowed weights to be recorded on the reverse of daily monitoring sheets. This made it more difficult to observe trends or gradual changes in people's weight. One person had been identified as being overweight and consequently, we expected their weight would have been recorded regularly. However, the last weight recording within their care plan was on 11 August 2015. We saw that there was space to record weights on new daily record sheets.

We saw evidence on care plans of access to healthcare. Records were kept on care files of visiting healthcare professionals including the district nursing team, opticians, GPs, chiropodists, the mental health team, and dieticians. People also went regularly to the dentist. One person told us, "I went to the dentist a month ago. I am waiting to have my teeth out." Another person said, "I'm going to hospital today and the staff arranged it all – if we need a doctor then they ring one for us."

The physical environment in St George's was in need of refurbishment. The registered manager told us that the new owner had plans to begin work at the start of 2016. These plans included adding an extension. At the moment the outdoor space was not usable as a garden. Indoors, there were no signs to assist people living with dementia, for example on bedroom doors, bathroom or toilet doors. There were no pictorial menus to help people living with dementia to recognise food or express their preferences. At the time of our visit there was one person with a diagnosis of Alzheimers and other people who would benefit from these and other developments.

We recommend that the provider should research and apply the latest guidance on providing a suitable environment for people living with dementia.

Good

Is the service caring?

Our findings

We asked residents and their visitors how well they were looked after. One person told us, "They are all great – can`t remember having a problem with any of the carers." Another person said, "Some of the carers have been here longer than me so they know us all – they will do anything for us." Relatives were also positive about the care and support given at St George's. One told us, "I have got to give the girls their due – they really take care of [my relative]." Another said, "We are so lucky to have a place to come to like this – it's so homely and warm." When we visited the home was festooned with Christmas decorations and felt very comfortable. St George's had two cats which brought pleasure to at least one resident who we saw stroking one of them. Both staff and some residents commented that it seemed quiet because there were only five people living there at the time.

We asked staff how they felt about working at St George's. One said, "The atmosphere is much calmer than it used to be. I see the people here as my family. In fact my grandad was here a few years ago; I would be happy to bring a family member here."

We saw that privacy was respected. Staff knocked and waited for an answer before going into a bedroom. A member of staff told us, "I always knock before I go into anyone's room and ask if they need anything – I am here for them." We observed that staff responded swiftly to call bells used in people's bedrooms.

We saw there was a small and close-knit staff team who knew the residents well, and treated them respectfully and in a kind manner. There were keyworkers for each individual who took a particular responsibility for ensuring that each person's needs were met and their care maintained. We saw that people looked well cared for. People were dressed in clean, well-fitting clothes and their hair had been brushed or combed. Staff were attentive to people's needs, offering drinks throughout the day.

During our visit the registered manager (who had come in on her day off for that purpose) accompanied one resident to hospital for tests. This demonstrated a caring approach and willingness to support residents with their health needs.

There was one person who stayed in bed all day due to their health. The registered manager told us this person was regularly turned, to help prevent pressure sores developing or deteriorating. However, there was no chart to record when these turns took place. This increased the risk of long gaps between turns and pressure areas developing. We understood that tissue viability nurses were already involved in this person's care. The registered manager told us that because it was a small staff team they communicated well with each other and would ensure that information about when the person had last been turned was passed on at handovers between shifts. Nevertheless, a turning chart would help to ensure regular turns and also provide evidence of when they had been done for medical professionals.

We saw evidence that one person chose to sleep with their bedroom door open at night. This showed that people were encouraged to express their preferences. One person told us that staff provided help when they needed a bath or a shower. They said staff were always willing to help, but sometimes they had to wait a little while if the staff were busy with someone else.

One person who had no family members had an advocate recorded on their care file. The advocate had been involved in a best interests decision when the person had come to live in St George's. However, we did not see any evidence that the advocate had been to visit recently.

The deputy manager and two senior care staff had received training in end of life care, in 2012 and 2013, and this area had formed part of one of the training sessions delivered by the Macmillan Clinical Nurse Educator. The home had not yet taken part in the Six Steps programme for end of life care. However, we knew from notifications received that St George's was able to cater for the needs of people at the end of life. One resident had passed away in St George's earlier in the year. The district nursing team were involved, and anticipatory drugs and related equipment had been obtained. These are drugs that are used for example to control pain and help with breathing. In the event those drugs had not been needed and the person had passed away peacefully. This showed that St George's was able to care for people up to the end of their lives.

Requires improvement

Is the service responsive?

Our findings

We looked at the care records for all six residents (including the person in hospital). There was limited information about each person's history and background. This meant the files were not person-centred, in that they did not give individual information about each person. There was some information about their health conditions and their needs. Each file contained a sheet headed 'Likes and dislikes' but these related primarily to food.

Staff did tell us, however, and we accepted that with few residents they got to know them all personally very well. They could also discuss people's history and preferences with family members. As agency staff were never used, there was less need to record details about each person formally in writing. The registered manager also told us that much more information about each person had previously been kept on the files, but they had been advised to remove this by "someone from the council".

We saw on the care files that information was gathered about potential residents before they moved in, and an assessment made as to whether St George's was a suitable placement for them. We knew from professionals involved in one person's care that their needs had not been met at St George's in October 2015 and it had been necessary to find somewhere else for them to live. The registered manager explained that this had been a tense and difficult time for the home. She explained that the person had previously stayed at the home for a short period of respite care. She added that the placement had been arranged under the former provider, and that different assessment procedures were now in use. These were intended to ensure full assessment before a person moved into St George's.

Within one person's care plan, we saw a requirement for staff to observe them doing leg exercises, which had been recommended following a hospital visit. However, the person told us that they completed the exercises regularly in their bedroom, but staff were never present to observe. This meant that the staff were not fulfilling the instructions in the care plan. However, in this instance the exercises were simple and there was no need for constant observation.

We saw that daily notes were no longer kept on each person's care file. Since November 2015 a sheet had been introduced instead. This was in the form of a grid, with boxes to tick or initial under a series of daily activities. These began with "Assist out of bed" and finished with "Activities". If anything required more description there were lines on the reverse of the sheet for staff to record details. The registered manager explained that this system had been introduced to make it easier for staff to record daily events, without the need to write the same details every day.

We looked at completed sheets and saw that the boxes had been ticked or initialled, but very few of the sheets had any detail recorded on the reverse. This meant that the notes were of less value, for example to medical professionals, if they wanted to gain a picture of a person's health or changes over time.

Other records that had previously been kept had also stopped and been incorporated into the new daily sheets. For example one person had a bowel movement record which had been kept from April 2015 until September 2015. This was related to the person's health needs. On the new grid was a box for bowel movement but there was no space for anything other than a tick. The member of staff would need to record details on the reverse of the sheet. Medical professionals would have to look at a sequence of daily sheets in order to understand any changes. This system would make it more difficult to identify issues over time than a single purpose record and would not facilitate monitoring on a daily basis for the home to identify when to refer to medical professionals.

Some members of staff told us that they preferred the former system of writing daily notes. The registered manager told us she would monitor the daily sheets and consider whether or not to keep using them.

There was an inconsistency in one person's care plan. Within one assessment, it stated the person could be "aggressive with staff" while within a further risk assessment it stated that they "actively co-operated". This inconsistency raised a question about how thoroughly this care plan had been reviewed.

The care plans had been reviewed on a monthly basis. The review was recorded on a care plan review sheet and we saw that notes were made to indicate where updates or improvements were needed. Reviews were completed by each person's keyworker. Although we saw some inconsistencies within care plans, the review process was a

Requires improvement

Is the service responsive?

meaningful attempt to keep them updated and relevant to the person's current needs. This meant that people were more likely to receive the care they needed. However, the inconsistencies we identified indicated that the system of care plan reviews required improvement.

During our visit there were five people in St George's. One person stayed in bed, another went to hospital for the whole afternoon. We did not see any activities arranged for the other three people, other than the television in the living room. One member of staff told us, "We should have more activities but we are such a small home and to be honest, we do ask residents to go out but they say 'no'." Another member of staff mentioned that young people from the Prince's Trust used to come in to play bingo, but this had stopped now.

We found an activities file which recorded people's activities. For one person the record started on 6 August 2015 and finished three weeks later. The only activity recorded was "watching TV". It was not clear why the record had stopped. We did not find activities recorded on their care file or anywhere else. For someone else activities were recorded between 27 August and 8 October 2015 when the record ceased. The only activities recorded, at weekly or fortnightly intervals, were "chatting with residents and staff", "singalong CDs", "nails cut and painted" and "played bingo". A third person's record showed they had refused activities. This person told us that games of bingo did take place, although they personally did not take part. They added, "I just want to be quiet. But I would like to go out more." They said they had gone out more in the past (under the former provider). There was an activities board in the hallway advertising that a hairdresser would be coming in on the day of our visit, but they did not turn up.

We considered that the staff were clearly aware of the need to arrange activities and to encourage people to participate, if they wanted. But there was not a great deal of variety on offer and there was scope to offer more entertainment and physical activity.

We recommend that the provider researches suitable activities and considers introducing a greater variety of appropriate activities.

We asked residents whether there were ever any meetings where they could discuss items with the registered manager. One person said, "We see the manager every day so if we need to talk to her we can – she always talks to us anyway." The registered manager confirmed that formal residents' meetings did not take place, but stated that the staff knew people very well and so knew what they wanted.

On one care plan we found a completed questionnaire for families and residents, showing that they had been asked for their views of the service. One family member told us, "I remember filling out a survey a while back but it's not something I have been asked to do a lot." There had not been any meetings for relatives, but the registered manager stated that because she had an open door policy and relatives could come in and discuss things with her at any time, she felt there was less need to hold regular meetings. A relative confirmed this: "I don't worry about anything – if there was a problem I know someone would ring me."

Staff told us that staff meetings had recently restarted. They had met with the new provider on several occasions who had outlined his plans for developing the service. There were no minutes of these meetings available.

A complaints policy was displayed on the wall in the hallway and a copy was also kept in people's care plans. The complaints policy stated it was "intended to ensure that complaints are acted upon quickly, properly and efficiently so that a positive outcome can be reached promptly." It added that residents' opinions and complaints would be listened to attentively. We asked to see the record of complaints but were told no written complaints had been received since 2013. However, a complaint does not necessarily have to be in writing. One family member had made several verbal complaints during the previous winter about the heating in their relative's room and the intermittent hot water supply. We knew this because the family member had also contacted CQC and we had been in contact with the former provider's representative. These verbal complaints were serious enough that they should have been recorded as a formal complaint. This suggested that the recording of complaints was not completely effective.

One person living in St George's told us, "I have never had to complain – I would just speak to [my keyworker] or the manager if I had a problem."

Requires improvement

Is the service well-led?

Our findings

The registered manager confirmed she knew the requirements to notify CQC of certain events. We had received a death notification in October 2015 which had no details of the circumstances of the death as the box had been left blank. It had provided basic information about the time of death but no additional information. We mentioned this to the registered manager who understood that more information was required.

During our inspection we learned there had been an allegation of financial abuse of a resident in October 2015. The registered manager had contacted a social worker and the safeguarding team, and the police became involved. The incident was unresolved at the time of the inspection. We checked the details on the person's care file. The incident should have been reported to the CQC as an allegation of abuse and also as one in which the police were involved. Failure to report it was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

One resident said to us, "I know there was a change a few months back, not sure what, but to me everything's always been fine." A member of staff said, "Things have improved so much it's hard to explain – but it's a pleasure coming into work now."

The change of ownership of St George's completed in August 2015 had made a significant impact on the morale of staff. Under the former provider there had been a series of complaints raised about matters such as the heating and lack of hot water, and the quality of the food provided. There had also been a number of safeguarding concerns raised by district nurses and relatives. Although the registered manager had been in post throughout this period, responsibility had been shared with the provider's representative, who had made many of the decisions. This had created tension and uncertainty as to who was actually in charge. This tension had affected other staff.

After the sale of St George's to the new provider the registered manager had taken full responsibility, supported by the deputy manager. Our visit was only four months after this change had taken effect, so it was still quite early days, but we noted a much calmer atmosphere and the staff united behind the leadership. The registered manager told us that the new provider was willing to supply resources when needed, for example giving an adequate budget to purchase fresh food. She also told us about the provider's plans to refurbish the building and to build an extension and increase the size of the home. The refurbishment indoors would include new windows, replastering and decoration, new carpets and beds. The kitchen would be renovated. Outdoors the extension would lead eventually to a properly landscaped garden area for the use of residents in the summer. We found that the major concerns regarding quality of the building which had led to a breach of the regulation in this area in our last report were now being addressed.

The staff we spoke with all agreed that the atmosphere had greatly improved and that this meant the residents were receiving a better standard of care and attention. Family members expressed the same view. One said, "Without a doubt there's been a massive improvement all around – the decoration needs some work but other than that it's all good." Staff said the registered manager was "approachable and easy to talk to." Many of the staff had worked at St George's for many years and they formed a team which supported each other as well as the residents. We saw there was a friendly relationship between the registered manager, deputy manager and staff. Nevertheless, staff we spoke with were aware of the whistleblowing policy and procedure and told us they would use it if necessary.

The new provider visited approximately once a fortnight and had met the staff and residents several times. The registered manager said it was always possible to contact them on the telephone. We spoke with the contract officer from Manchester City Council who had met the new provider and been informed of their plans.

The provider was not involved in the day to day running of the home or in quality management. This meant it was the registered manager's responsibility to conduct audits and monitor the quality of the service.

There was a list on the notice board in the dining room to record when care plan reviews were due. Keyworkers conducted the review on their resident's file, then signed the list to show that it had been done. The registered manager then checked to ensure the reviews had been done. She audited the files periodically to ensure the reviews were of a high standard.

Requires improvement

Is the service well-led?

The registered manager was one of the staff who administered medication but she also was responsible for medication audits. This could potentially lead to a lack of objectivity. The pharmacy or a suitable qualified person might be invited to conduct an audit.

As was mentioned earlier, accidents were recorded on individual care files. We were not shown an accident book or other record which might help identify any trends or risks.

The registered manager had a checklist to complete regarding building maintenance issues. For reasons mentioned earlier, the building had been neglected in recent years, but there was now a planned programme of improvement.

St George's was part of the Manchester Care Home Managers Meeting Forum, a group of local care homes. This enabled it to work in partnership with other care providers to share experiences, knowledge, training, and best practice.

We were concerned that there was no external scrutiny or quality management of the home by the provider. The system of audits was incomplete. Those audits that did take place were not always effective. For example, the care plan audits had not picked up the issues with care plans identified on this inspection. The registered manager needed to take responsibility for ensuring that safe care was delivered. Even though St George's was a small home, a stronger system of quality control was needed. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to 17(2)(b).

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The required information was not available about each person employed** Regulation 19(1) and 19(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **There was no cabinet for the safe storage of controlled drugs** Regulation 12(1) with reference to 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People were not protected against the risks of fire or other untoward events because individual emergency evacuation plans had not been written.** Regulation 12(1) with reference to 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Insufficient training and supervision was provided to enable staff to carry out their duties.** Regulation 18(2)(a)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents An allegation of abuse which had been investigated by police had not been reported to the CQC Regulation 18(1) with reference to 18(2)(e) and (f)
	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were insufficient systems and processes to enable the provider to assess, monitor and improve the quality and safety of the service Regulation 17(1) with reference to 17(2)(b)