Georgian House (Torquay) Limited

Georgian House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 8, 9 and 10 August 2017, following concerns about the management of the home. We last inspected this service in April 2016 when it was rated as 'Good' overall.

Georgian House is registered to provide personal care and accommodation for up to 43 people who may have a physical and/or mental health needs. At the time of the inspection, there were 41 people living at the home. Georgian House is also registered to provide personal care to people in their own homes. This was referred to as 'the step down service' during the inspection.

At the time of the inspection, the provider confirmed the step down service was providing support to two people. However, neither was receiving personal care therefore, this part of service was not included in this inspection. This was because we only inspect services where personal care is being provided.

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

People were not always protected from the risk of abuse. Georgian House did have in place a policy and procedures to follow if staff suspected someone was at risk of abuse or harm and staff had received training in safeguarding adults. Upon reviewing people's records, we identified two incidents of alleged abuse and one of abusive practice, which had not been reported to the local authority safeguarding team. For example, one person's records showed staff had documented on the 1 June 2017, during an altercation between two people living at the home, that one had punched and pushed the other. Records for another person showed on the 4th July 2017, staff had stopped a person's cigarettes due to their violent behaviour. Staff had not recognised these incidents as abuse or matters they needed to refer to the local authorities safeguarding team.

During the inspection, we made three safeguarding referrals to the local authority and asked the provider to make another, which they did.

Some risks to people health and wellbeing were not always managed safely. Where staff had been provided with guidance by health and social care professionals, this was not always followed.

People were not always supported to have sufficient to eat and drink, and to maintain a healthy weight. For example, where some people had been identified as being at risk of malnutrition, food and fluid charts were not always completed. Records we saw did not demonstrate that some people did not receive their nutritional supplements as prescribed.

People received most of their prescribed medicines on time and in a safe way. However, some

improvements were needed in the storage arrangements for people medicines as well as the management of topical applications.

Systems in place had not identified that the home was not always taking appropriate action to protect people's rights. For example, where the home held or managed one person's monies and/or bankcards, there were no mental capacity assessments to show that people did not have capacity to manage their own finances. There were no records to show the rational for these decisions, or whether this was being carried out in their best interests.

Whilst some premises checks had been completed, risks to people's health, safety, and wellbeing had not always been identified, assessed, or mitigated. We noticed two windows on the first floor were not properly restricted or had safety film applied to the glazing to protect people from accidental injury if the glass were to be broken. In one of the first floor bathrooms, the casing to a waterproof electrical supply box was cracked. We brought this to the attention for the provider they took immediate action and arranged to have this replaced.

We reviewed the home's fire safety precautions. Records showed that routine checks on fire and premises safety had been completed. The provider did have in place a Fire Risk Assessment, which is a legal requirement under The Fire Safety Order.

People were not always supported by staff who had the necessary skills and knowledge to meet their needs. Records showed that staff inductions, supervisions, and annual appraisals were poorly documented. Whilst we did see some positive interactions between staff and people living at the home, staff were focused on the task they were completing and did not always engage people in conversation.

Some of the people we spoke with told us they were happy living at Georgian House. One person told us that staff were, "wonderful." Another person said, "The staff are very nice." However, one person told us they did not feel cared for at all, and another told us, they were deeply unhappy about having to share their room with another person living at the home. Although staff told us they knew this person was unhappy with the room sharing arrangements we found this had not been recorded within this person's daily observations.

People told us they were encouraged to share their views and were able to speak to the registered manager or provider when they needed to. We saw quality control feedback form which had been submitted by visiting professionals over the last six months had rated the home as being 'good' in relation to the professionalism of staff and the level of care they provided.

The home maintained a high standard of cleanliness and steps had been taken to minimise the spread of infection. We saw the premises and equipment were clean and staff had been provided with aprons and gloves. Equipment used within the home was regularly serviced to help ensure it remained safe to use.

The home's quality assurance and governance systems had not identified a number of concerns we found at this inspection, and there was a lack of management oversight.

During the inspection, we identified a number of concerns about the care, safety and welfare of people who lived at Georgian House. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The home was not always safe.

People were not always protected from the risks of potential abuse, as staff were not always aware of their roles and responsibilities or fully aware of how to recognise abusive practice.

Medicines were not stored safely and people could not be assured they would receive their topical medicines as prescribed by their doctor.

Risks to people health, safety and well-being were not being effective assessed, managed or mitigated.

There was no systematic approach to ensuring there were enough staff on duty to meet the needs of people using the service.

People were not protected from receiving care from staff who may not be suitable to work in the care profession. Safe recruitment practices and relevant checks were not always followed before staff commenced work.

Premises safety was not being managed in an effective way.

Is the service effective?

Inadequate

The home was not effective.

People's rights had not been protected. Staff had not followed the Mental Capacity Act 2005 for people who lacked capacity to make particular decisions with regard to potentially restrictive practices.

The principles of the Mental Capacity Act 2005 had not been followed in relation to best interest decisions.

The provider had not ensured staff received appropriate support that promoted their professional development or reviewed their performance to support them to ensure people's needs were met.

People were referred to healthcare services and professionals were involved in the regular monitoring of their health.

Is the service caring?

Requires Improvement

The home was not always caring

People's dignity was not always supported and staff did not always treat people with respect.

People were not always supported to help them maintain their independence.

People were supported to maintain relationships with family and friends.

Is the service responsive?

Requires Improvement

The home was not responsive.

People and their relatives were not always involved in developing care plans. Changes to people's needs were not always reflected and acted on by staff.

People were supported to participate in a range of activities;

People were able to express their views and were given information how to raise their concerns or make a complaint. However we found these were not always recorded.

Is the service well-led?

Inadequate

The home was not well-led.

People's care records were not accurate or kept up to date.

Although quality assurance systems were in place, they were not being used effectively or undertaken robustly enough to identify the issues seen during the inspection. As a result, people could not be assured they would receive safe and responsive care and support.

Staff told us the manager was approachable and they felt supported in their role.

People, relatives, and healthcare professional were given the

opportunity to give feedback on the service. It was not clear how this was used to improve the service.

Georgian 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 was 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 the 8, 9 and 10 August 2017: the first day was unannounced. This responsive inspection was undertaken following concerns raised in relation to people's care and welfare at another home owned and managed by the same provider and registered manager. We wanted to see if people were receiving safe and responsive care and support. Two adult social care inspectors carried out the inspection.

Prior to the inspection, we reviewed the information held about the home. This included previous inspection reports and statutory notifications we had received. A statutory notification is information about important events, which the home is required to tell us about by law.

At the time of the inspection, 41 people were living at the home. We used a range of different methods to help us understand people's experience. We looked at care records for 15 people to check they were receiving their care as planned. We looked at how the service managed people's medicines, the quality of care provided, as well as records relating to the management of the service. These included eight staff personnel files, staff training records, duty rotas, and quality assurance audits. We spoke with 14 people who received support at the home, 12 care, and support staff, the registered manager, provider, and a management consultant from a care consultancy service who had recently been appointed to support the provider's management team. We also spoke with two visiting healthcare professionals during the inspection.

Following the inspection, we received feedback from the local authority's quality team and two health care professionals. Because of our inspection findings, we made three safeguarding referrals and asked the provider and management consultant to make one safeguarding referral.

Inadequate

Is the service safe?

Our findings

People were not always safe or protected from the risk of abuse or avoidable harm. We found some risks to people's health; safety and wellbeing were not always being assessed or managed. Safeguarding concerns were not managed appropriately. Some risks such as those associated with people's complex care needs, the environment, recruitment processes and the storage of medication had not been identified or action taken to mitigate these risks.

Some people were not protected from the risk of abuse. We found Georgian House did have in place a policy and procedures to follow if staff suspected someone was at risk of abuse or harm and staff had received training in safeguarding adults. Once prompted, staff were able to tell us the correct action to take if they suspected people were at risk of harm or abuse. However, after reviewing people's records and speaking with staff we identified two incidents of alleged abuse and one of abusive practice, which had not been reported to the local authority safeguarding team. For example, one person's records showed staff had documented on the 1 June 2017, during an altercation between two people living at the home one had punched and pushed the other. This had been witnessed and reported to staff by another person living at the home. Records for another person showed on the 4th July 2017, staff had stopped a person's cigarettes due to their violent behaviour as a form of punishment. Staff had not recognised either of these incidents as abuse or matters they needed to refer to the local authorities safeguarding team.

When asked, the registered manager told us they were unaware of the incidents that had been recorded. During the inspection, we made safeguarding referrals for three people to the local authority and asked the provider to make another, which they did.

People were not always protected from the risk of harm. We found risks associated with some people's behaviours had not always been identified or guidance provided to staff to mitigate these risks. For example, one person's daily observations showed they regularly displayed aggressive behaviour towards staff and intimidated other people living at the home. There were no risk assessments relating to this behaviour and the person's care plan did not contain guidance for staff on how to manage or mitigate these risks. Following the inspection, we were provided with some additional information, which showed the risks to some people were managed.

Risks to people health and wellbeing were not always managed safely. For example, where some people had been identified as being at risk of malnutrition, food and fluid charts were not always completed. Staff told us they recorded people's food and fluid intake as part of their daily observations within the computerised care management systems. However, we saw people's food and fluid intake were not always recorded in sufficient detail, recorded correctly, totalled, or analysed. There was a lack of oversight by senior staff to ensure appropriate action was taken where people were not having sufficient quantities to eat and drink.

For example, records for one person showed they had been admitted to the home in January 2017 following

a period of self-neglect, which had led to them becoming severely malnourished. We noted they had consistently lost weight since their admission. Records indicated staff had noted this weight loss, and made an appropriate referral to the speech and language team (SALT). A nutritional supplement had been prescribed to be taken twice a day. Staff had only documented that this had been given to the person once a day. There were no records to show staff were monitoring this person's food and fluid intake in order to reduce the risks of malnutrition and dehydration. There was a lack of oversight by senior staff to ensure appropriate action was taken if people were not having sufficient quantities to eat and drink or to ensure they received their nutritional supplement as prescribed.

Another person's records showed a weight loss of seven kilograms from February 2017 to May 2017. They had not been weighed during the months of June and July 2017. Their dietary needs care plan had been reviewed in July 2017, and did not indicate that this weight loss had been noted or any action had been taken in response to the weight loss.

We spoke with the chef who confirmed care staff had provided them with information about people's dietary needs, including who was taking supplements and which people were to have high calorie foods. However, we found one person who had lost a significant amount of weight and had been prescribed a dietary supplement was not included on the list in the kitchen of people who required a daily supplement. Staff were not recording this person's food and fluid intake.

Where staff had been provided with guidance by health and social care professionals, this was not always followed. For example, one person had risks associated with the management of their epilepsy. Their support plan contained guidance and protocols for staff to follow when the person experienced a seizure, such as recording and monitoring the seizure activity. However, records showed this person's seizure diary had not been completed since October 2016 despite having seizures during this time. This meant it was not possible to identify how frequently the person was experiencing seizures, the nature of the seizure. Staff did have a clear understanding of the condition, and what support the person needed.

People's medicines were not stored safely or administered as prescribed. Medicines were stored securely in a locked medicines cupboard, accessible to appropriately trained staff. However, we found improvements were required because whilst medicines were securely stored, the provider did not accurately monitor the temperature of the medicines storage areas. We found the temperature within the first floor medication room was 29 degrees Celsius, which could affect their efficacy. Medicines should be stored within a temperature range of 16 to 25 degrees centigrade. We brought this to the attention of the senior member of staff on duty who took immediate action to remove all medication from the first floor storage area. All senior staff we spoke with told us they were aware of the concerns regarding the temperature of the upper medication room and this had been raised with the registered manager prior to the inspection. We spoke with the registered manager who told us they were aware of the concerns regarding the storage of people medicines and had reported this to one of the directors, but accepted that sufficient action had not be taken.

Some people were prescribed topical applications, such as creams, ointments, and gels. Medication Administration Records (MARs) stated that prescribed creams were to be applied by the carers. Body maps contained detailed information on where to apply these and why they had been prescribed. Charts were available for staff to record when they had applied the appropriate topical medicine. However, we found staff were not always completing these in full.

People were not protected from the risk of harm as they were living in an environment that was not always safe. One person's bedroom window and a bathroom window on the first floor were not properly restricted.

A number of windows had safety film applied to the top half of the glazing to protect people from accidental injury if the glass were to be broken. In one of the first floor bathrooms the casing to a waterproof electrical supply box was cracked and a telephone supply box was broken and in need of repair. We brought this to the attention of the registered manager and provider who were unaware of the concerns relating to the environment. They immediately arranged for an electrician to complete the repairs to the electrical supply box and instructed the care consultant service (who they have engaged to support them) to carry out a review of home's environment and provide an action plan detailing the work that need to be completed with timescales. Following the inspection the provider confirmed the telephone supply box was redundant and did not contain any live wires.

Records showed the homes maintenance team carried out monthly checks to help ensure all fire doors were in a good state of repair and free from obstruction. During a tour of the home, we noted a number of fire doors did not close properly when tested. Four people's bedrooms doors were propped open with make shift wedges. A fire door on the second floor was defective which would significantly reduce its resistance to the effects of fire or smoke as its integrity had been compromised. Where the home had carried out remedial works, this had left holes in walls and cavities. These had not been filled with a suitable fire resistant material and as such would not reduce the spread of smoke. Following the inspection, the provider wrote to us and confirmed that any holes in walls and cavities following any remedial works had now been filled with a suitable fire resistant material.

We reviewed the home's fire safety precautions. Records showed that routine checks on fire and premises safety had been completed. The provider had in place a Fire Risk Assessment, which is a legal requirement under The Fire Safety Order. Upon reviewing this document, we found it did not identify or reflect all the risks associated with the environment, or potential sources of ignition. This meant the provider did not have in place systems to ensure they had identified all fire hazards, reduce the risks of those hazards causing harm. Following this inspection the registered manager confirmed they had arranged for a Fire Risk Assessment to be completed by an external contractor.

We raised these concerns with the registered manager and with Devon and Somerset Fire Service. A fire officer visited the home during the inspection and advised the registered manager on the immediate action they needed take to ensure people were safe in the event of a fire and arranged to carry out an inspection of the premises. Following that inspection, the fire office wrote to the Commission to inform us the provider was not fully complying with 'The Regulatory Reform (Fire Safety) Order 2005'. This regulation requires the provider to 'continuously monitor and review where necessary the effectiveness of their fire risk assessment.

The fire officer found the homes fire warning system was inadequate for the type and use of premises. Some escape routes and exits could not be used quickly and as safely as possible. Several fire doors did not meet current standard for fire resisting doors. Where serves pass through compartment wall or floor, ceiling all gaps must be filled to achieve the same fire resistance as the existing wall, floor or ceiling. Gas pipe located in protected stairway and corridor in the lower ground floor to be enclosed in appropriate fire resistance materials affording 30 minutes fire resistance. Battery powered mobility scooters must only be charged or stored in areas that do not obstruct occupant's means of escape and appropriate evacuation procedures. Fire safety drills to be followed in the event of serious and imminent danger are not established. Following the inspection the provider sent us information which confirmed that fire drills had taken place regularly.

We discussed these findings with one of the homes directors and asked them what action they were taking to mitigate these risks and ensure people safety. They assured us they had taken immediate action to ensure people safety and mitigate the risks identified by the Fire officer, and agreed to send to the

Commission an action plan setting out the action they had taken and schedule of the works to be carried out with timescale.

Following the inspection the provider wrote to the Commission to confirm they had taken action to address the fire management issues

We discussed the actions the provider had taken with the fire officer who confirmed the provider had now taken sufficient action to mitigate the risks associated with fire.

We looked at people's personal emergency evacuation plans (PEEP). The purpose of a PEEP is to ensure staff know how to assist each person to leave the building safely in the event of an emergency. We found these lacked detail and did not give staff clear instructions and guidance about the support people required to evacuate the building in an emergency.

Accidents and incidents were recorded, however the provider did not have a systematic approach to ensure this information was collated and analysed to look for any trends or identified measures minimise the risk of further occurrences.

The provider failed to take sufficient action to ensure care and treatment was provided in a safe way, and that risks arising from people's care needs and the environment were being mitigated or managed. This is a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

People were not always protected by safe recruitment procedures. We looked at the recruitment files for eight staff. These contained checks on each staff member's identification, references and completed application forms, but these did not always include details of each staff member's full employment history or the reasons for any gaps in their employment. References provided by staff were not always from the employers listed in the employment history they had provided, but this had not been followed up by the provider for clarification. These issues meant the provider could not be assured they had taken sufficient action to ensure staff were of good character.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were sufficient staff to meet their needs. One person said, "They [staff] are here when I need them." Another person told us, "I'm self-caring and can manage a lot of things on my own, but staff are on hand if I need help." However, staff told us there were not always enough care staff to meet people's needs. One staff member said people often have to wait for care and they were not able to spend quality time with people, to just sit, and chat. They said, "[name] rings the bell quite a lot, I think it's company she wants but we just haven't got much time."

There were 41 people living at Georgian House who were supported by five care staff and six support staff. Care staff were responsible for meeting the day-to-day personal care needs of people. Support staff provided individual support for example by providing support and assistance enable people to attend external appointments or take part in things they enjoyed, as well as providing a range of group activities for people living at the home. Support staff also provided individual support to people who had additional 1:1 funded support.

Care and support staff were supported by, two senior staff members who also provided personal care, and by the registered manger. A number of ancillary staff such as maintenance, kitchen and cleaning staff were also on duty. There were also several office staff responsible for managing accounts and payroll and supported the running of the home. In addition, two directors who were based at the home supported on a daily basis.

We discussed these staffing levels with the provider and registered manager who told us they felt there were enough staff on duty to meet people's needs. However, they did not have a system for determining how many care staff were needed in relation to the number of people who lived in the home and their level of dependency.

We recommend the provider uses a suitable tool to determine people's level of dependency to ensure that staffing levels are sufficient to meet people's assessed needs.

People told us they felt safe living at the home. One person said, "I feel quite safe here; I know the staff are looking after me." Another person told us, "I do feel safe here, it's a secure environment."
People received their oral medicines when they needed them and in a safe way. Staff told us they had received training in the safe administration of medicines and records confirmed this. Medicine administration records (MARs) showed people received their medicines as prescribed. We checked the quantities of a sample of medicines against the records and found them to be correct. Where people were prescribed medicines to be given "as needed," such as for the management of pain or anxiety, guidance had been provided for staff as to when this should be used.

Other risks were managed. We saw were the provider had used assistive technology (GPS watch) to the managed and mitigate the risks associated with one person's safety as due to their complex needs they were known to wander off which could have had a significant impact on their safety and wellbeing.

The home was clean with no unpleasant odours. Staff were aware of infection control procedures, and had access to personal protective equipment (PPE) to reduce the risk of cross contamination and the spread of infection. Training records showed that staff had received training in infection control.

We reviewed the home's annual "safeguarding and building and services audit" completed in June 2017 by one of the directors, and the homes planned maintenance schedule. Regular checks were undertaken in relation to general maintenance of the environment and safety of equipment. The home employ three maintenance staff who carry out regular maintenance on the building

Records showed that safety checks had been undertaken of the electrical and gas installations. The home had fire extinguishers, fire protection equipment and clearly signposted fire exits to assist people in the event of a fire. The home employed an accredited company to monitor, inspect and test all firefighting equipment on a regular basis.

Inadequate

Is the service effective?

Our findings

Most of the people who lived at Georgian House had needs relating to their mental health, which affected their ability to make some decisions. We checked whether the home was working within the principles of The Mental Capacity Act 2005 (MCA) and found the home was not taking appropriate action to protect people's rights.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Records showed some mental capacity assessments had correctly assessed the person's ability to understand, retain, weigh up the information, and communicate their decision. However, not all records we saw reflected a good understanding of the MCA in practice, or contained the same level of detail.

For example, where the home held or managed one person's monies and/or bankcards. Staff told us this was because this person did not have the capacity to understand their money and how much they were spending. There were no mental capacity assessments to show that people did not have capacity to manage their own finances. There were no records to show the rational for these decisions, or whether this was being carried out in their best interests. Records for one person showed the home was limiting/restricting the amount they could smoke by managing their tobacco. There were no records to show the rationale for this decision, no mental capacity assessment to show the person did not have capacity to manage their own tobacco or why this was being carried out in their best interests.

Records in relation to decisions made on behalf of people were incomplete, inaccurate or had not been reviewed. For example, we spoke with one person who told they were deeply unhappy about having to share their room with another person living at the home. Records showed that both people were fully involved in the process and had consented to the room sharing arrangements and that following the move the provider had reviewed these arrangements. However when we spoke with the person and asked them if they liked sharing their room, they replied, "No I hate it and I hate [person's name], [person name] is always shouting and causing trouble, I just can't cope with it". This person then went on to describe how terrible it was sharing a room because the other person was constantly shouting at her and others. They went on to say "I like to be on my own, I don't want to share with [person name,] they just put her here". Although staff told us they knew this person was unhappy with the room sharing arrangements we found this had not been recorded within this person's daily observations.

We raised these concerns with the registered provider and manager who told us they were not aware the person was unhappy with the arrangements or that the other person was constantly raising their voice. They explained this was only meant to be a temporary arrangement and they would take immediate action to address the person's concerns. We raised this as a safeguarding referral with the local authority's safeguarding team during the inspection.

During the inspection process one person's care manager made us aware they had also had cause to challenge the provider in relation to the process they had followed and decision that had been reached which had let to [person name] sharing a room with someone they did not know and did not have an existing relationship with. The provider had not consulted the person's independent advocate or themselves in the best interest process before making a decision. This has since been resolved. However, during August permission was requested for another person to temporarily share a bedroom for a period of two or three weeks. The home were advised by the local authority that it would not be their best interests to share with someone they did not have a pre exiting relationship with. During a welfare visit to the home after this contact, they found their advice had been disregarded and the person was found to be sharing a bedroom with another person who had lived at the home for many years.

The provider used CCTV in the majority of communal areas around the building and at the time of the inspection was in the process of upgrading the equipment and installing additional cameras. The use of CCTV was identified in the Service User Guide which we were told was provided to people prior to or at the time of their admission. However, none of the records we saw identified the use of CCTV had been discussed with people or their consent obtained for its use.

We raised our concerns with the registered manager and provider who agreed that people's records did not contain sufficient information to demonstrate the home was working within the principals of the MCA. The registered manager assured us they would take immediate action to address this.

Failure to gain consent from people, or where people were unable to give consent, involve relevant health or social care professionals in best interest decisions is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the inspection, we heard people being offered choices by care staff, and being asked for their consent in relation to day-to-day decisions. For example, we saw people were shown different meals at mealtime to help them make an informed choice.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest 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 saw the registered manager had made a number of applications to the local authority for authorisation to deprive people of their liberty. As some people were not free to leave the home if they wished, due to safety considerations or because they were under constant supervision by staff.

At the time of the inspection, 13 applications had been made to the local authority, eight applications had been approved, and five were waiting approval. A system was in place to monitor the status of DoLS authorisations and DoLS applications that were in progress. Individual care plans referred to the person being subject to a DoLS authorisation.

We looked at supervision records for eight staff. Staff files did contain an induction tick sheet, which identified that new staff had been familiarised with the home. However, there were no induction records to show that new staff had undertaken an induction, which met with nationally recognised induction standards. Only one of the staff files we reviewed contained any evidence that staff had their competencies checked during their probationary period of employment.

Staff told us they completed an induction when starting work at the home. This included a period of orientation at the home; time spent reviewing policies and procedures; shadowing colleagues who were

more experienced, and developing their understanding of the individual support people required. However, one staff member told us when they started at the home they were not provided with any mandatory training nor were they asked to produce their training certificates relating to training from a previous employment, as they should have been. Another said that they had sustained an injury, as they had not been made aware that the person might try to harm them whilst carrying out personal care.

Supervisions and appraisals are an opportunity for staff to discuss concerns, their work performance or training and development needs. Records showed that out of the eight staff files we looked at only three had any form of supervision or annual appraisal documented. Records showed that staff inductions, supervisions, and annual appraisals were poorly documented. There was not an effective system in place to ensure staff were provided with the necessary induction or support to meet the needs of the people they supported.

Failure to provide staff with the support, and supervision necessary for them to undertake their role is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional needs were not always being met. Records showed people's dietary needs had been assessed and specific care records had been developed following guidance and support from health care professionals, for instance speech and language therapists (SALT). Some people's care plan's and body mass index (BMI) indicated they were at risk of malnutrition. The body mass index (BMI) is a measure that uses your height and weight to work out if your weight is healthy. Nutritional screening was being undertaken using a Malnutrition Universal Screening Tool (MUST) to identify people who were at risk from dehydration or poor nutrition. We found this was not being used effectively and in some cases not at all. For example, one person's diet needed to be monitored to ensure their food and fluid intake was sufficient to maintain their health and well-being. There were no records kept relating to this person's food and fluid intake. Records for this person indicated they had lost six kilograms in weight from January 2017 to March 2017 and had not been weighed since.

People told us they enjoyed the food at Georgian House. Comments included, "The food is good and I enjoy it", "The cook is really good. They give us what we like" and "The food is very good. I enjoyed my lunch and get a choice."

We observed the lunchtime meal people were offered a choice of food and drink and staff were present to ensure people received the support they required. For example, one person was finding it difficult to cut up their food. A staff member recognised this and offered to assistance the person in a sensitive way.

We spoke with the chef who clearly knew what people liked to eat and we saw that they developed menus based on this, which changed on a daily basis. Menus had a number of different options but the chef was also able to prepare something specific for people if they did not like choices that day. Where necessary, they provided people with soft or pureed meals, which were presented in an attractive way to ensure people still had an enjoyable mealtime. People were offered regular drinks throughout the day and staff told us people had access to drinks and snacks at any time during the day or night.

People were supported by staff who had the necessary skills and knowledge to meet their needs. Staff told us they felt they had received adequate training to meet people's care needs. Records showed that staff had received training in variety of core subjects, which included managing challenging behaviour, health and safety, safeguarding, infection control, manual handling, food hygiene, first aid, equity and diversity and

mental capacity. In addition, staff received training specific to support the complex needs of those people living at Georgian House. For example, some staff had received specific training in managing or supporting people with their Autism, Asperger's, Epilepsy, and Huntington's disease.

People were referred to a range of other health and social care professionals, including GP's, social workers, opticians and dentists. Multi-disciplinary meetings were held when necessary to help ensure all aspects of people's needs were taken into consideration when planning care. Healthcare professionals told us the registered manager and staff worked well with them. Comments included, "They respond to everything we ask them to do" and "I have always found them very accommodating and they try to reach a solution to any issues. For example, one person's catheter was blocking because of their reluctance to drink. The staff went out of their way to try different drinks to encourage them to drink more. This worked and we haven't had a problem since."

Care records showed that if people's needs had changed, staff obtained guidance or advice from the person's doctor or other healthcare professionals. Outcomes of people's visits to healthcare professionals were recorded in their care records. People were provided with specialist equipment such as sensor mats, wheelchairs, walking frames, hoists, specialist beds or bathing aids to assist and support people overcome everyday difficulties caused by their disability or illness.

Requires Improvement

Is the service caring?

Our findings

Some of the people we spoke with told us they were happy living at Georgian House and people's feedback about the staff was mostly positive. One person told us that staff were, "wonderful." Another person said, "The staff are very nice." However, one person told us they did not feel cared for at all, and another said, "They just don't care, It is just a job to them."

Staff told us they had built positive relationships with people living at the home. One staff member said, "I love working here; it's a great job and we are like a family." A second member of staff commented, "It's a very good place to work and we work well as a team." However, we found the relationships between staff and people receiving care and support did not always demonstrate that people were treated with dignity and respect. For example, we heard one member of staff repeatedly telling one person to "stop it," "be quite" and to "go away" when they became anxious or raised their voice. This language was accepted within the staff team, as colleagues and senior staff present did not challenge this.

Whilst we did see some positive interactions between staff and people living at the home, staff were focused on the task they were completing and did not always engage people in conversation. For example, on the third day of the inspection, we observed two members of staff attempting to transfer and weigh one person with the use of equipment, This took place in the main entrance hall of the home in full view of other residents, staff, and visitors. Both staff were engaged in conversations with other residents and staff, whilst ignoring the person they were assisting.

When we spoke with staff about people needs, some staff spoke in a disrespectful manner about the people they supported. For example, one staff member referred to people as "feeders" meaning people that needed help or assistance from staff to eat their meals and maintained a balanced health diet. Another staff member referred to people, as being "doubles" referring to people that required the assistance of two carers to safely move or change position.

Some information staff had recorded did not show that they respected the people they were providing care for. For example, one person was meant to be encouraged and supported to maintain their independence with personal hygiene and develop their independent living skills in relation to keeping their own environment (bedroom) clean and tidy. Records showed one member of staff had written in this person daily observations, "At lunch time [person name] was still unwashed and he had not done anything in his smelly room." Records showed staff had written in another person records who needed support and assistance to manage their continence "[Person name] was walking around the home covered in faeces and making others feel uncomfortable with the smell."

Failure to treat people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was able to support people's care at the end of their lives, and records showed that staff had been provided with specialist training to support people during this time. However, none of the care files we

looked at contained sufficient information about people's preferences in relation to their end of life care. For example, one person had returned from hospital for care at the end of their life. They did not have an end of life care plan; staff did not have any information about the person's personal wishes or preferences. This meant that people could not be assured they would receive end of life care in line with their wishes.

Failure to provide care and treatment in a person centred way was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It was not always clear how staff supported people's independence; Some people living at the home were capable of being independent with some aspects of daily living with support. For example, by making some meals and doing their own washing and were able to do more for themselves. We saw that some people were not supported to engage in these activities as much as they could be. For example staff did people's laundry, they tidied their rooms and they served people drinks without involving them. Staff did things for people rather than with people and did not actively encourage people to get involved. However, this was not same for everyone living at the home. Following the inspection, the provider wrote to us and gave us many examples of how people were supported and encouraged to maintain their independence. For example, one person had their own kitchen and cook their own meals. Others had tea and coffee facilities within their rooms whilst others people were supported to use the homes kitchen to prepare drinks and snacks.

Other staff we spoke with were kind and caring. For example, a senior member of staff became upset when we spoke about a person's needs and how they were not being met. They told us how worried they were for the person, as they knew they were unhappy and their needs were not being met. We discussed what we had been told with the registered manager and provider, who assured us they would speak to the person and address any concerns they might have. We referred these concerns to with the local safeguarding team during the inspection.

There were occasions where staff treated people in a caring way and respected people's dignity. We observed staff knocked on people's bedroom doors and waited for an answer before entering. Staff ensured personal care was carried out in areas where people's privacy could be maintained.

Most people's care plans were clear about what each person could do for themselves and how staff should provide support. People's preferences were obtained and recorded during their pre-admission assessment and people's care plans contained personalised information about people's backgrounds, significant events as well as information about what was important to them.
One person told us, "Staff know me well and understand my needs." Staff mostly described people in a positive manner and were knowledgeable about people's life histories and important family contacts. Staff demonstrated a knowledge and understanding of people's preferred routines, likes and dislikes and what mattered to them and told said they encouraged people to remain as independent as possible. For instance, staff were able to tell us about people's preferences, what people liked to eat, what they liked to do, when they liked to get up and go to bed.

People's rooms were personalised and furnished with things that were meaningful to them. For instance, photographs of family members, treasured possessions, favourite ornaments, or pieces of furniture. If people wanted, they had a key to their bedroom door to protect their possessions and to prevent other people walking into their room uninvited. People told us they were able to go to their bedrooms whenever they wanted Relatives and visitors were free to visit at any time and told us they were always made to feel welcome.

Requires Improvement

Is the service responsive?

Our findings

Some of the people we spoke with told they were involved in identifying their needs and developing their care and support. Following the inspection, we received feedback from healthcare professionals who told they had been fully involved in supporting people to plan their care. However, records did not always reflect this.

The registered manager and/or a senior member of the team carried out an initial assessment of each person's needs before they moved into the home. This formed the basis of a care plan, which was further developed after the person moved in and staff had got to know the person better. Some people's care plans were personalised and provided staff with detailed guidance about each person's specific needs. For example, the care plan of one person who required assistance from staff with washing and dressing, described in detail how the person wished to be supported and what they liked to wear. Where some people had specific needs relating to their mental health, guidance was provided for staff in how best to support people. For example, one person was known to become distressed and anxious whilst being assisted with personal care. The home had developed a plan for staff to follow to support this person's well-being and minimise the impact this might have during this time.

Not all of the care plans we saw contained the same level of detail. For instance, one person's care plan simply stated they required assistance with washing and dressing and is at risk of self-neglect if left "to their own devices." This person's care plan did not contain any guidance for staff on how to assist this person with their personal care needs or contain any information about what the person could do for themselves.

People's care was not always based on individual's needs. Where some people had specific health care needs, such as living with mental health conditions, epilepsy or dementia these had not been fully taken into account when planning their care or identifying what support they needed. One person's care plan identified they needed support to manage a long-term health condition. We looked at this person's care plan and found staff had not been provided with sufficient information on how to recognise signs and symptoms that would indicate this person was becoming unwell and what action staff should take. We raised this with a senior member of staff and spoke with staff who assured us they were fully aware of people needs, but agreed that this person's care plan lacked detail and assured us this would be addressed. However this was not the case for all people living at the home other people's care plans did contain detailed information in relation to specific health care needs and guided staff as to the action they should take should they have any concerns about people's wellbeing

Some of the people supported by the home could at times become anxious and display behaviours that may place themselves or others at risk of harm. Care and support plans we saw were not detailed or contained insufficient information for staff on recognising the early signs of people's distress. Staff were not guided about situations that might increase people's anxieties or how to support people at these times. For example, one person's care records identified they were prone to violent outbursts and may throw items. Staff were directed to use diversion techniques to distract this person's behaviour, but their care records did not go into any detail about what these were.

When any aspect of care was provided, the staff were able to record this immediately. Daily observation records were completed to record the support provided to each person; however, these were written in a very task orientated way. In most cases, there was little or no information about people's well-being, interactions, activities or mood, providing a picture of the person's day and highlighting any issues. This showed us that although there was up to date information about the support provided, the information was not person centred. The home used computerised care planning and monitoring system. This allowed for information to be colour coded and flagged up where action needed to be taken, for example, if a person's had been involved in an incident or attended a medical appointment. This information was instantly available and flagged as Red, Amber, or Green to all members of the team.

Staff told us people, who were able, were asked to be involved in planning and reviewing their own care. Where people lacked the capacity to make a decision for themselves, staff involved family members or other advocates in the review of their care needs. However, we did not see evidence in people's care plans that people and relatives (where appropriate) were involved in the planning of their care. Senior staff completed monthly reviews of people's care plans and risk assessments. It was not clear that people were involved in this process.

Care and support plan did contain detailed information about people's hobbies, interests, and activities they enjoyed. Some people spoke positively about the level of activities provided by the home and said they had the opportunity to join in if they wanted. We saw people socialising in the home as well as going out to meet with friends and family. Some people were able to come and go as they wished, while others needed support from staff when they went out.

We found there was a lack of engagement and activity, for some people who did not receive additional funding for one to one support. Some people told us they were unhappy living at the home because they had little to occupy their time. One person, who spent time in their room, told us "I'm not happy here. No one comes in for a chat. I've asked someone to take me down to the town. They tell me they will get someone to take me but it's been three months now." Another person said the staff were unable to spend adequate time with them. They said this had an adverse effect on their wellbeing and they became tearful when they were telling us this

Failure to provide care and treatment in a person centred way was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans were maintained on a computerised system. Each staff member had access to a fixed terminal from which any information they needed about each person living at the home was readily available. Senior staff were also able to monitor and access this system remotely.

Alongside these electronic records, there where paper copies, which contained food and fluid charts, body maps and topical medicine administration records. Each section of the care plan covered a different area of the person's care needs, for example, personal care, mobility, physical health, continence and skin care, communication and mental health and emotional support. Important information, such as allergies and health conditions was easily available for staff at the front of the care plan.

The home produced a seasonal activities programme, which was displayed within the home. This informed people about upcoming events and offered everyone living at the home the opportunity to take part if they wanted. We saw a range of activities were available which include a friendship group, music club, gardening club, arts and crafts, card games and quizzes. As well as the opportunity develop their life skills or give back

to their local community and environment by helping with the community beach clean.

A team of support staff encouraged and supported people to lead full and active lifestyles, follow their interests, and take part in social activities. They provided one to one support for people who received additional funding to support their participation in social activities. For example supporting people to go swimming, play games or sports, attend college, local church groups, music session, or local places of interest such as Paignton zoo.

People knew how to make a complaint. People told us they did not have any cause to complain but if they did, they were happy to go to the head of care or the manager and they would listen to them. One person said, "I have no reason to complain but if I did [name of head of care] would deal with it."

People and relatives were supported to raise concerns. The home had a policy and procedure in place for dealing with any concerns or complaints, which was made available to people and their families. The procedure was clear in explaining how the complaint should be made and reassured people that any concerns would be responded to appropriately. We saw evidence that were people had raised concerns about or with the service; these had been investigated in line with the homes policy and procedures. However, we noted were people and staff had made us aware of their concerns neither the registered manager or provider seemed to be aware when we asked and these had not been formally recorded. For example in relation to room sharing arrangements or the level of activities being provided to people who did not receive addition one to one funding.

Inadequate

Is the service well-led?

Our findings

We looked at the quality assurance and governance systems to ensure procedures were in place to assess monitor and improve the quality of the services provided at Georgian House.

We found there was insufficient management oversight to ensure people received the care and support they needed, in a respectful and dignified way that promoted their wellbeing and protected them from harm and abuse. Where staff displayed poor practice or spoke in terms of the language they used this was not challenged by senior staff which influenced the culture of the home.

The home's quality assurance and monitoring systems were not effective and had failed to identify a number of concerns we found at this inspection. For instance, quality assurance systems had failed to ensure people's medicines were stored or managed safely. Although senior staff had been advised that medicines were being stored at potentially unsafe temperatures action had not been taken to address staff concerns.

The care plan reviews and audits had not identified that some risks to people had not been assessed or that some risks did not have associated care plans with guidance for staff to follow. The audits had not identified that care plans were not always person centred and did not always have the level of detail staff required to carry out their roles safely and in a way that was person centred.

There was a lack of oversight by senior staff to ensure appropriate action was taken if people were not having sufficient quantities to eat and drink or to ensure they received their nutritional supplement as prescribed.

The home was not working within the principles of The Mental Capacity Act 2005 (MCA) and found the systems in place had not identified that the home was not always taking appropriate action to protect people's rights.

Arrangements for recruiting staff did not adequately protect people. Although, the provider had a recruitment procedure and policy in place, the quality assurance systems had not identified where checks had not been completed. This meant they did not have a robust system in place to ensure all staff recruited were safe to work with people who are vulnerable due to their circumstances.
The home did not have effective systems in place to assess or to monitor staff competence and skills to carry out the role required of them. The lack of supervision and induction meant the home could be assured staff had the necessary skills and knowledge to meet people assessed needs in safe way.

People may not be protected from the risk of harm as they were living in an environment that may not be safe. Whilst some premises checks had been completed, risks to people's health and wellbeing had not always been identified, assessed or mitigated.

Accidents and incidents were recorded, however the provider did not have a systematic approach to ensure

this information was collated and analysed to look for any trends or identified measures minimise the risk of further occurrences

We met with the provider and registered manager following the inspection, and discussed what we had found. They explained there had been a change of deputy manager earlier in the year and recognised they needed to make changes to improve the quality and support being provided at the home.

Failure to ensure systems were effective in assessing, monitoring and improving the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they kept their knowledge of care management and legislation up to date by using the internet and attending training sessions. They were aware of their responsibilities in relation to duty of candour, that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm. However, they had not always notified the Care Quality Commission of significant events, which had occurred in the home in line with their legal responsibilities. This included the notification of safeguarding concerns.

Failure to notify CQC of significant events at the home is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

The management and staff structure provided clear lines of accountability and responsibility. Staff knew who they needed to go to if they required help or support. There were systems in place for staff to communicate any changes in people's health or care needs to staff coming on duty through handover meetings. These meetings facilitated the sharing of information and gave staff the opportunity to discuss specific issues or raise concerns.

Records showed the registered manager and provider held regular staff meetings. Staff meetings were used to discuss and learn from incidents, highlight best practice and identify where any improvements where needed. For instance, we saw from these meetings the registered manager had discussed concerns relating to people care needs, medication, infection control in the environment and activities.

People told us they were encouraged to share their views and were able to speak to the registered manager or provider when they needed to. We saw quality control feedback form which had been submitted by visiting professionals over the last six months had rated the home as being 'good' in relation to the professionalism of staff and the level of care they provided.

People's personal confidential information was held securely and only senior office staff had access to records and personal information relating to people living at the home and staff.

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 Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have robust recruitment procedures in place to ensure people employed were of good character and had the necessary recruitment checks in place. Regulation 19 (1)(a) (2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not notified the CQC of significant events in line with their legal responsibilities. Regulation 18 (2)(e)

The enforcement action we took:

We issued a Fixed Penalty Notice