St. George's Care Ltd

# St George's Home

## Inspection report

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Date of inspection visit:
27 March 2017

Date of publication:
31 May 2017

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 27 March 2017 and was unannounced.

St George's Home provides personal care and accommodation for up to 29 older people. There were 24 people living at the home at the time of our inspection. This included a number of people living with dementia.

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

During our last inspection on 5 May 2016, the provider was not fully meeting the standards required in relation to the "Safe" "Responsive" and "Well Led" key questions. The registered manager and staff did not have sufficient knowledge of what constituted abuse and referrals were not being made to the Local Authority and notified to us as required. We asked the provider to take action to make the necessary improvements.

During this inspection we found some action had been taken to ensure safeguarding referrals were made to the Local Authority, but there continued to be some that were not reported to us as required. Safeguarding systems and processes remained in need of improvement as they were not sufficiently clear to ensure people were protected from potential abuse. Both the registered manager and staff continued to have gaps in knowledge of what constituted abuse.

Despite safeguarding processes not being clear, people told us they felt safe living at the home and we saw there was enough staff on duty to keep people safe and meet their needs. People received their medicines as prescribed but the procedures for managing prescribed creams were in need of review to ensure these were being managed safely and effectively.

Staff were knowledgeable about the risks associated with people's care and knew people's needs varied according to their abilities and preferred routines. However, risk assessments and management plans for people were was not always clear enough to provide guidance to staff to minimise risks.

People were able to access healthcare professionals when they needed to ensure their healthcare needs were met.

Recruitment checks were carried out prior to staff starting work at the home to make sure they were suitable for employment. New staff received an induction to the home to prepare them for their role and all staff had access to ongoing training to develop their skills and knowledge.

The manager and staff understood their responsibilities under the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). People who lacked capacity were supported in decision making, and where appropriate, applications had been made to authorise any restrictions on their freedom that were in their best interests.

People received a choice of meals and overall people were positive about the food provided. Drinks were regularly made available to people so they had enough to drink.

Some group social activities were arranged and some people were taken out on a one-to-one basis, however, activities were not consistently provided in accordance with people's needs, preferences and wishes.

Staff were kind and patient and showed respect to people. People were encouraged to maintain relationships with people important to them and visitors were welcomed at the home.

A complaints procedure was in place and complaints received had been appropriately investigated. People and their families were positive about the care being provided and they told us they knew who to approach if they had a complaint.

People, their visitors and the staff were positive about the management team and the running of the home. There were processes to monitor the quality and safety of the service provided but some of these were in need of review to ensure the quality of care and services provided were consistent.
We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

People told us they felt safe and there were enough staff to meet their needs. Staff had some understanding of what constituted abuse but safeguarding systems were in need of improvement. People received their medicines as prescribed but processes for managing creams needed to be improved. Staff had a good knowledge of risks but records in relation to risk management were not always clear.

### Is the service effective?

**Good**

The service was effective.

People received support from staff that had the knowledge and skills to provide the care they required. The provider met the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Overall people were satisfied with the food and drink provided. People were supported to access healthcare professionals to maintain their health and wellbeing when required.

### Is the service caring?

**Good**

The service was caring.

People were positive about the care they received and told us staff were caring and kind. Staff respected people's privacy and dignity and welcomed visitors to the home. People were involved in making decisions about their care.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People were supported by staff who knew them well. People took part in some activities but these were not always in accordance with people's preferences or needs such as for those people with dementia. People knew how to raise complaints, and they were addressed by the registered manager to people's satisfaction.

## Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a registered manager and deputy manager in post and staff felt supported by them. Quality monitoring systems were in place but had not been consistent in identifying areas for improvement. There was a lack of clarity in regards to senior staffing arrangements in the absence of the Registered Manager.

# St George's 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 27 March 2017 and was unannounced. The inspection team consisted of two inspectors and an expert- by- experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of our inspection, we asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Information within the PIR mostly reflected our findings.

We looked at information received from other agencies involved in people's care. We spoke with the local authority commissioning team who funded the care a number of people received. They shared information with us similar to what we already knew about the service.

We also looked at the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. These may be any changes which relate to the service and can include safeguarding referrals, notifications of deaths and serious injuries.

During the inspection we spoke with seven people who lived at the home and six visitors. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with six staff including the registered manager, the deputy manager, care staff and the cook. We reviewed four people's care plans and daily records to see how their support was planned and delivered.

We reviewed records of checks that staff and the management team made to assure themselves people

received a quality service.

Requires Improvement

# Is the service safe?

## Our findings

During our last inspection of the home on 10 March 2016 we found a number of concerns of a safeguarding nature had not been reported to the local authority safeguarding team as required. As a result of this we felt the registered manager and staff team needed to increase their understanding of safeguarding procedures to ensure any incidents that compromised people's health and safety were managed safely and effectively.

During this inspection we found some improvements had been made in that incidents related to safeguarding people had been reported to the Local Authority safeguarding team in line with their procedure. However, they had not consistently been reported to us as required. When we looked at incidents referred to the safeguarding team, we found some of these did not meet the local authority threshold for needing a safeguarding referral.

There were two different safeguarding procedures available to staff in the home. One was a policy specifically for St George's Home which had not been reviewed since 2012. This described the different types of abuse but not the processes or responsibilities of the service to keep people safe. The other was a 'West Midlands Safeguarding Procedure'. The registered manager confirmed this was the one they followed but was unable to explain what information it contained.

Staff told us they had completed training on what constituted abuse and how to respond to any potential abuse. Staff told us, "Yes, I have done that I learnt about abuse and that I need to record everything. I did that training with the council, it was really good" and "Safeguarding is any action such as neglect which causes harm." Another staff member told us, "I would write it down (the concern) and tell the manager straight away." However, during our conversations with staff, there were variances in their knowledge and understanding of safeguarding procedures and processes they should follow. For example, we showed one staff member a completed incident form that stated the person had unexplained bruising. The staff member did not feel this incident needed to be investigated because they considered these must have occurred when the person was in hospital. However, information on the incident form did not confirm if the hospital had identified any bruising on the person upon their discharge to the home. Unexplained bruising could be potential abuse, action had not been taken by the home to report this as a safeguarding concern.

Two staff we spoke with were unable to explain the difference between an accident, incident and a safeguarding referral. When we looked at records of these, some were duplicated demonstrating this lack of understanding. One staff member told us, "I don't know. It's hard. It's very confusing."

When we looked at safeguarding referral records, sometimes there were no outcomes or follow up actions recorded so it was not clear they had been appropriately managed and any risks to people's health and safety addressed. We discussed safeguarding procedures with the registered manager and they understood these were in need of review so that staff were clear what processes they were required to follow.

People who lived at the home told us they felt safe. One person told us, "I think I'm safe. You've got people here and someone to talk to. I've got dementia and can't remember much. No-one has ever upset me or

made me feel afraid. It's comfortable here; I know that much." Another person told us, "Oh yes, I'm safe. I've never had any mishaps." Relatives felt people were safe. One told us, "Yes, [Person's] safe. They always phone if there are any problems."

Overall people felt there were sufficient numbers of staff available to support them. One person told us, "They're very good. I can't complain. I've never had to wait for anything." Another told us, "There is enough staff." Relatives felt there were enough staff most of the time. They told us, "Sometimes they seem a bit pushed" and "Most of the time there's enough (staff)". One relative told us, "There always seems to be plenty of staff on duty …. but [Person] has mentioned they had to wait to get up."

Staff told us there were usually enough of them to support people's needs except when staff went off sick when this made it more of a challenge for them to meet people's needs in a timely way. One staff member told us, "If things don't go to plan, things snowball." Another told us, "We are very busy, we don't stop. If someone is poorly, we struggle to get things done."

The registered manager told us they used information obtained from the assessment of people's needs to determine staff numbers. We observed there were enough staff to meet people's basic needs. On the day of our visit, we were told a member of night staff had gone home during the night shift due to being unwell and this had resulted in the staff team completing their care tasks later than normal to meet people's needs.

Recruitment procedures ensured staff were safe to work with people. Prior to staff starting work at the home, the provider carried out recruitment checks. Records confirmed these checks included written references and a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions as they provide information about any criminal record a person may have. Staff told us they were not allowed to work until their recruitment checks had been completed.

Risk assessments were undertaken to identify action needed to minimise any risks to people's health and wellbeing. Staff were knowledgeable about the risks associated with people's care and knew people's support needs varied according to their abilities and preferred routines. However, risk assessments and management plans for people were not always clear enough to provide guidance to staff to minimise risks. For example, one person was assessed to be at high risk of falls and refused to use their walking frame. Staff described how they managed the risk and told us, "We hold their hand or link their arm when they are walking to keep them safe because they won't use their Zimmer frame." We saw this happened throughout our visit. However, guidance on how to reduce the risk of them falling was not detailed in their care plan. The person's risk assessment stated they had a sensor mat in place so that staff would be alerted if they got out of bed during the night. However, we observed the mat was not in place. When we asked the registered manager about this, they said the person didn't need one and it had been removed. This contradicted what two staff told us. One staff member said the person needed a sensor mat to keep them safe during the night as they had a tendency to be confused and could fall if they tried to find the toilet. Both staff members were not aware the mat was no longer in use and said they did not know where it had gone. The registered manager told us they would update the person's falls risk assessment.

Staff told us one person who had a diagnosis of dementia could be challenging towards others when they became anxious. This risk had been identified in a risk assessment which advised staff to 'offer reassurance and use distraction techniques'. However, it was unclear what distraction techniques should be used to keep the person and others safe. Despite this, staff were able to describe how they managed these behaviours. One staff member told us, "We calm [Person] by talking to them, they like reassurance so we always answer their questions and direct them to where they want to go. We avoid negative words as it can increase their anxiety, I tell them they are safe and that they are loved and that really works." We saw this

happened throughout our visit.

We looked at how people's medicines were managed. On the day of our visit, the medicines were given to people at a later time than expected. This was partially due to the unexpected absence of a night staff member, which had impacted on the duties for the day staff. A staff member told us they had to wait for two staff to be available to administer medicines so they could complete 'double checks' to reduce the risk of errors occurring. One staff member said, "It makes me more confident administering in pairs."

We saw people were offered water to take with their medicines and were verbally encouraged to take them, staff were patient and did not rush people. The Medicine Administration Records (MAR's) were signed when the person had taken medicine which was good practice.

Medicines prescribed "as required" such as pain relief were managed appropriately. For example, we saw a staff member ask one person if they wanted their tablets for their "arthritic" pain. The person responded they only wanted 'one' and this was given. Staff were aware that no more than eight tablets were to be given within a 24 hour period. They checked this amount had not been given before the tablet was administered. Another person was asked if they wanted their medicine for their "stomach acid" and the person refused. This was recorded as a refusal on the medicine record as required.

We looked at five MAR's and all were clearly signed to confirm how medicines had been managed. However, some people needed to have creams applied to their skin and the staff who were administering the medicines were signing to say creams had been administered when they had not applied them themselves. Both staff members explained care staff applied the creams when people needed them. However, they were not actually checking application had taken place. This was not good practice as staff could be signing records to confirm creams had been applied when they may have not have been.

People's creams were kept in their bedrooms and we checked them with the registered manager to see if they had been dated when opened. Three out of four creams we checked did not have an opening date recorded. This was important to ensure creams were used within acceptable timescales so they remained effective. The registered manager expressed their disappointment this had not happened and advised that staff knew this was something they should do and this would be addressed.

Training records confirmed some staff had completed medication management training. We saw those staff who administered medicines had completed training to ensure they could do safely.

Plans were in place to help ensure people were kept safe in the event of an emergency. Guidance on what staff should do if there was a power cut, gas leak or a fire included an instruction to move people to a "place of safety". However, there were three locations listed to be a place of safety but staff were not aware of these when asked and were unable to explain how they would get people to the places listed. Personal emergency evacuation plans (PEEPS) were not available in all files we viewed and not all staff knew they were in place when asked. One staff member said, "I presume so but I am not sure." The registered manager said they were in place for everyone and said they would put them in a central accessible file so they could be easily located if needed.

Good

# Is the service effective?

## Our findings

People felt their needs were met effectively by staff. One person told us, "I would recommend them to anyone." Another told us, "Everyone gets the same care as me. I don't know how they do it." Relatives told us they had confidence in staff knowledge and skills to meet their relative's needs. One relative told us, "I'm aware that staff are regularly trained. From what I see, they are competent….. [Person] was really poorly… the staff felt that [Person] would respond to antibiotics (medication). They really pushed for it and [Person] made a full recovery."

Staff confirmed they had received an induction to the service when they had started work at the home. They explained they worked alongside other staff which helped them to understand what was required of them in their role. One staff member told us, "Yes, I had an induction and a buddy who showed me the ropes, it was very welcoming and helped me find my feet." Staff told us there were plans for them to complete online training to obtain the 'Care Certificate' once this had been organised by the registered manager. To obtain this, staff are assessed against a specific set of standards. Staff have to demonstrate they have the skills, knowledge, and behaviours to ensure they provide high quality care and support.

Staff told us they had access to training to ensure their skills were updated and they felt confident in their role. One staff member told us, "We get plenty of training here." Another told us, "Training is good, but I'm a bit worried about the future." This was because the majority of training was changing to be computer based. A tablet computer had been purchased for staff to use to complete training but staff were concerned about not having enough time to do it. They told us they had not been allocated specific time to complete this. One staff member told us, "I am keen to do the training to do my job well but we are not allocated any time so I don't know if I will be able to do it." The registered manager said the new method of training was still in the process of being implemented and some staff were still to register "on line" so they could complete the training required.

Records showed staff received ongoing training the provider considered essential to meet people's needs. A training schedule helped the registered manager prioritise and plan staff training. Some staff had completed training linked to the care needs of people in the home such as dementia, nutrition and risks related to falls. Others were due to complete this.

We observed when staff carried out their duties, they put what they had learnt into practice. For example, when staff used the hoist to transfer a person from a chair into a wheelchair they talked through the process with the person so they did not get anxious. They completed the transfer in a calm and safe way. We observed a staff member say, "We're going to go in the air like we usually do, keep your knees bent. Stay nice and calm. It's okay, well done. We're going down to your chair. Well done, you've done very well." The staff member spoke to the person in a gentle and reassuring way. This demonstrated respect for the person even though the person was not able to communicate. The process was calm and the person did not appear to experience any anxiety. Once they had been transferred to the wheelchair, we saw staff moved the footrests into position so the person could be taken to another area of the home safely.

Staff said they had supervision meetings with their manager every two months to provide them with any support they needed to be effective in their role. These meetings also gave them opportunities to talk about their work performance and personal development. One staff member told us, "Supervision is every two months, they ask if we have any problems and what training we need to do. See if we are happy with things." Another staff member told us, "Meetings are supportive, I think they are a good way to say how we feel and if we need any training."

The Mental Capacity (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw most people made decisions for themselves such as what they would like to eat and drink and where they would like to sit. Staff asked people for their consent before providing assistance. This showed they understood the principles of the MCA and knew they could only provide care and support to people who had given their consent. One member of staff told us, "They either give verbal consent or you can tell by their body language. One person expresses if they do not want something. We have visual books that people can point to." The staff member explained they usually used visual aids when they asked people about the menu or when they were getting people washed and dressed.

Where there were restrictions on how people's care was delivered, appropriate action had been taken to complete DoLS applications to authorise these as being in the person's best interests. This demonstrated the registered manager understood their responsibility in relation to the MCA and DoLS. Mental capacity assessments had been completed to assess if people had capacity to make their own day to day decisions. For example, an MCA assessment showed one person was unable to retain and "weigh up" information to make complex decisions. A representative for the person with an advocate from Age UK had therefore been approached to make a best interests decision in relation the person's care. The person was unable to make a decision about their residential care placement. The person was at risk because they had previously fallen at their own home, and had been unable to get up following a serious injury. There were concerns about the person's ability to cope alone. Records showed a decision was made in the person's best interests to live at St Georges. A DoLS application had been made and authorised but had expired. Records showed the registered manager had made an application to renew this.

Most staff demonstrated knowledge of DoLS. One staff member told us, "Some people here can't make decisions for themselves, their family stepped in to help them make decisions about if they wanted to live here. We have to do things for people which are in their best interests and I know we can't deprive people of things like going outside."

Overall people were satisfied with the food provided and had enough to eat and drink. Two people thought the food was very good. One commented, "The food's very good. It's like a hotel. You're never frightened about drinking out of a cup. It's spotless." Other comments included, "I like it pretty much" and "Sometimes the dinners aren't always that good but I've always been a fussy eater. We have sandwiches most days for

tea." Relatives said they were satisfied with the food provided to their family member. One relative told us, "The food I think is pretty good. [Person] eats well on the whole." Another relative told us, "[Person] has always been a fussy eater. There are so many things they won't eat but they have actually put weight on since being here. They always have a jug of water or juice."

The Provider Information Return told us, "Service users make their choices of what they like to eat and every meal time is a social event where they enjoy their food, and chat at the dining table. We were able to confirm it was a social event with people chatting to each other and enjoying the company of others. During the morning, a staff member asked each person what they would like for their lunch. Two choices were given. Lunch was organised over two sittings and staff told us this was so staff could spend the time they needed to support people to eat. Overall, people ate well and if they did not want the main hot choice, care staff were careful to ensure that they ate something else they liked. One person ate all of their meal and asked "Where's the rest of it?" A staff member responded "You've eaten it all. Would you like some more?" The person said yes and a second helping was quickly provided which showed people were able to have more food if needed.

We noted at lunchtime a person who usually ate independently using an adapted plate had not been provided with the plate to assist them to do this. Staff told us the plate they usually used had "gone missing". The person asked for assistance and staff supported the person to eat. This was done in a respectful way. They explained, "[Person] your lunch is here. It's chicken. Would you like me to cut it up for you? Do you need a hand? The staff member explained in detail to the person what they were doing to help enhance the person's enjoyment of their meal. The staff member said, "Here's some potato and vegetables. It smells nice; it's making me hungry. If I'm going too fast, just let me know….. One moment, I'm just cutting the sprouts up." This demonstrated staff understood the person's needs and how to support them in a respectful way.

The staff and the cook were aware of those people with special dietary needs such as those people with diabetes or who were at risk of losing weight. The cook told us they fortified (added calories) foods for those people at risk of poor nutrition. A list of these people was kept on the wall in the kitchen to remind kitchen staff of this. The cook told us, "I add butter, double cream and cheese to some people's foods to get extra calories into their diet. I add extra milk powder to hot chocolate."

People and relatives told us people were able to access healthcare professionals when they needed. One person told us, "My teeth are loose and getting on my nerves. They've arranged for me to see the dentist." A relative told us, "The GP came a fortnight ago. [Person] was having hallucinations associated with their [health condition]… but it's subsided now." Other comments from relatives included, "The district nurse comes in and they've got [Person] walking again" and "The physiotherapist has been in to help [Person] with their mobility."

There was good communication between staff about people's healthcare needs. We attended a handover meeting that took place at the beginning of the shift when staff on duty changed over. The health and well-being of each person was discussed. Where staff had noted changes in a person's health, they advised the relevant healthcare professionals such as the GP had been contacted. On the day of our visit, a GP visited a person regarding a health complaint that staff had reported to them earlier. A visiting health professional we spoke with told us, "They are very good here at contacting us if they need us." This showed staff took action to access healthcare professionals when they identified a need.

Good

# Is the service caring?

## Our findings

People were positive about their experiences of living at St George's and of the staff that supported them. One person commented, "I'd say they're kind. No-one has upset me." A visitor told us, "The staff are all very caring, they do their best to keep people calm and they explain what is happening …. They have a good approach and know people well." Other comments from visitors included, "It's definitely caring…. I don't know how they do it" and "The staff are absolutely fantastic. The care here is very, very good."

We observed many caring interactions between staff and people. Staff were cheery when going about their duties and it was clear they had developed positive and genuine relationships with people. For example, when we were talking with one person, about their family, they were struggling to remember the names of their family members. A staff member was able to tell them the names straight away, without checking any paperwork. This level of detailed knowledge demonstrated care staff knew the person well.

We asked staff if they felt the service was caring towards people. One staff member told us, "It's a nice home and the staff care. I like working with people that show they care. The carers are good they really care." Another told us, "It's lovely and homely here, it's a caring and warm atmosphere."

We saw staff carried handbags when they assisted some people to move which was a caring gesture people were thankful for and appreciated. When people became upset, staff supported them. For example, when one person showed signs of becoming anxious, a staff member started to sing a tune to them which they responded to and this made them smile. Another person who was sleepy was approached by a staff member to ask if they were okay. The staff member asked them if they would like a drink and held a drink in front of them to see if they wanted it. The person was not quite ready to take the drink so the staff member sat with them for a while and offered the drink again which they then drank. This showed the staff member knew the person would respond if given time.

We saw staff treated people with dignity and respect. Staff addressed people by their preferred names and spoke with people at a pace that was suitable to them so they could understand. People told us staff were respectful when supporting them. One person told us, "You can't rush things like showers or baths….. I get up first and they put the curtain across when they're helping me to get dressed. They knock before they come in to the room." A relative told us, "[Person] is always shaved. He sees the chiropodist and his nails are always clean." Another told us, "They always knock on [Person's] door and alert them to who it is [coming in]. They respect [Person's] privacy and dignity."

People were encouraged to maintain relationships with people important to them. Relatives were encouraged to be involved in their family member's care and confirmed communication with staff was good. Visitors were seen throughout the day and sat with people in the lounge areas. Many told us they visited every day which indicated they felt welcome and comfortable in the service. Staff clearly knew visitors well and made them feel welcome by offering drinks and involving them in conversations.

The manager told us telephone points were in bedrooms if people wished to keep in touch with friends and

relatives by telephone. There was one person who had used "Skype" to contact a relative who lived overseas.

Staff told us they regularly celebrated people's birthdays with a cake, birthday cards and sung 'happy birthday' to celebrate their day. Staff told us they also recognised other occasions such as Mother's day and Easter and involved people by recognising these occasions in some way.

Requires Improvement

# Is the service responsive?

## Our findings

During our last inspection we identified improvements were needed to the environment as some people living with dementia became agitated when noise levels were high in the communal lounge. We identified during this inspection, those people were no longer at the home. The registered manager told us in their action plan following the last inspection they had reverted to two sittings at mealtimes. They told us had resulted in a positive effect in that people who were confused did not find it too busy or noisy during this period. We did not observe any people with anxiety as a result of noise during this time.

People felt they were looked after well and their care needs were met. One person told us, "They're absolutely out of this world. They can't do enough for you." A relative said, "They're very approachable. Everything is focussed on the clients."

The registered manager told us people and relatives were involved in care reviews by holding individual meetings with them when they visited the home during the week. They advised people and relatives were asked to sign care plans to show they agreed with them.

We observed people were usually well-presented and wore clean clothes and spectacles and had clean nails. Some ladies wore skirts, others wore trousers. Some wore make-up, others did not, as was the case for jewellery. This indicated that peoples' choices were respected. We noted some people were not wearing socks or tights. When we asked staff about this they were not clear why this was but suggested the people may not have wanted to wear them. One person told us they were not happy at being assisted out of bed early. They said "This morning they got me out of bed early for no reason." Staff told us they did not get people up early unless they wanted to.

We saw people were mostly relaxed in the lounge areas, and people did not show any anxiety in response to any noise as identified at our last inspection. During the day we saw some people stimulated with activities such as visitors arriving or participating or watching a soft ball game that was played during the morning. At other times people were not engaged or stimulated in any activities.

Staff told us, people's basic needs were met but because of the high dependency levels of some people, they were not able to spend as much time with people as they would like. They explained this was because most of their time was taken up meeting people's basic needs such as moving them safely or helping them to get washed and dressed. This meant there was limited time for people's interests and hobbies to be supported. One staff member told us, "We don't always get the time we want to spend with people. It would be nice to have more quality time to spend with them. I think if we had an activities person there would be more stimulation for people. There is not always a lot going on for people, more activities would be great."

Staff said people were supported on outside visits when this was possible. One staff member said, "I took [Person] to Sainsbury's so they could choose some new clothes. I took [Person] to Boots so they could pick toiletries." We saw there were some outside visits that took place. At the time of our visit no organised trips

had been planned. The registered manager told us in the Summer, people would be taken out more.

When we asked people about the activities provided at the home they told us these were limited and sometimes not of interest to them. One person told us, "We don't have much in the way of entertainment. I love dancing." Another said, "I speak the truth, I do get bored." Visitors felt this was an area that could be improved by ensuring they were more focused on people's wishes and preferences. One visitor told us, "Activities may be one thing that's a bit lacking but it's difficult to get responses from them [the residents]. Someone came in to do some flower arranging but people didn't seem that interested. They do sit around doing not much." Another said "[Person] will not engage in anything to do with the modern world. They do not really want to engage in activities. [Person] just watches. I think [Person] might miss out on a bit of conversation."

We saw staff were responsive to people's care needs and did their best to ensure people's requests were met in a timely manner. For example, one person was offered a blanket when they said they felt "chilly" and staff quickly provided a blanket. We saw staff noticed another person looked unwell and they asked them if they were okay. The staff member took hold of the person's hand and asked the person if they were tired and wanted to go to their room. This showed staff recognised signs the person may not be well. Another person asked to go to the toilet four times within a 40 minute period, each time they asked, staff responded and the person was assisted. However, the consequences of this meant that on one occasion, another person had to wait to be hoisted from their wheelchair to an armchair and a third person had to wait for staff to help them to have a drink. At lunchtime, one person asked for a special drinking glass. This was quickly provided and the person responded positively by smiling and they said, "That's it (the glass), you know me."

Information was detailed in care plans about people's faiths as well as any support they needed. Staff told us about one person who was a practising Roman Catholic and how they supported this person. They confirmed the person received Holy Communion approximately once a month from a local priest.

At the time of our visit there were approximately half of the people in the home identified to have dementia. We did not see that specific activities suited to their individual needs had been fully assessed, identified and provided. However, some staff responded positively to people's dementia needs. For example, one person with dementia asked staff on numerous occasions throughout the day if it was 'Monday'. Each time they asked, staff reminded them it was Monday. There was no visual aid in view of the person to help remind them. However, we saw three staff members write the word 'Monday' on a piece of paper which the person put into their pocket. We asked staff about this and they told us the person had a clock in their bedroom which displayed the time and day but it was the person's preference to have it written on a piece of paper. They explained if they did not write it down, the person could become tearful and cry. The staff actions showed they were responsive to this person's needs.

Signage varied around the home with some of this being in a picture format and number and others not. Picture signage is known to support people with dementia to locate areas of the home more easily.

We saw that prior to people's admission to the home, assessments were carried out to identify people's needs. This helped to identify people's preferences and wishes in regards to how they wished to receive their care. This information was then transferred into care plans. However, one staff member told us, "We don't really use care plans, they are in the office. Care plans viewed were not always clear about how staff should support people to ensure a consistent approach. For example, we looked at a care plan for a person who could experience seizures. We saw there was no plan in place to manage these. However, staff told us they would call an ambulance if the person had a seizure. The manager told us the person had not experienced any seizures for several years. The person was also known to have behaviours that challenged

staff. Guidance in the person's care plan stated that staff should distract the person although it was not clear how. Staff told us they felt the person's behaviours were due to the person's frustration and they knew the person could be calmed by talking with them and asking what was wrong. Another care plan instructed staff to assist the person with a shave. It did not document if the person liked a wet or dry shave or how often they liked to shave. Staff knew this and one said, "He uses an electric shaver, he does what he can but he needs a bit of help to get all of the whiskers."

We looked at a care plan for a person who had sore areas on their skin and noted they had received the support of a healthcare professional. The records were not sufficiently detailed to show if the person's sore areas had improved or were deteriorating so that staff knew the care being provided was effective.

Despite care records not always being clear, staff knew people well. Staff were patient when supporting people and were able to tell us in detail about people's needs and their preferred routines. One staff member told us, "We know people really well and pass on messages during handover (meetings at the beginning of each shift)." Another staff member said, "We need to know all of the small things about people so we can care for them well. Everyone is different. That information is not always recorded in their care plans." They explained they got to know people by talking to them, observing their behaviours and by staff sharing information.

Care plans contained people's life history and staff knew about people's backgrounds. One staff member told us, "[Person] talks fondly about the children they used to care for. I talk to them about children, they tell me about their happy memories." We saw staff placed a toy cat on one person's lap and they began to stroke it. It was clear staff knew this would bring comfort to the person.

The Provider Information Return completed by the provider told us, "The service users are encouraged to participate in their care planning and care reviews through quality assurance and key work systems." People spoken with did not always remember or recognise this happened, however, we saw everyone who lived at the home had a care plan and relatives told us they were involved in care plan reviews. There was a keyworker system that ensured people were supported by a named worker to help provide some consistency for them. A staff member explained being a keyworker meant they built up a relationship with the person and they "kept a close eye on them and made sure they were happy".

Visitors told us if they had any concerns they would go to the registered manager which demonstrated they felt confident their concerns would be addressed. One visitor commented, "There are some complaint forms by the door but I'd go straight to the manager if I had cause." Another told us, "I'm not aware of the complaints procedure but if I was worried, I'd speak to the manager."

Staff were aware of their responsibilities to ensure any complaints were reported to management. One staff member told us, "I would listen to what the problem was and advise them to speak to manager."

A complaints procedure was available to people but this was not sufficiently detailed with information of the Local Authority and Ombudsman should people wish to escalate their concerns further. This was reported to the registered manager so action could be taken to address this. We saw complaints received had been recorded and responded to and areas for staff learning had been identified to help prevent them from happening again.

Requires Improvement

# Is the service well-led?

## Our findings

At our last inspection we identified improvements were needed in relation to "Safe", "Responsive" and "Well Led". We found during this inspection there continued to be improvements needed in these areas.

People spoke positively of St Georges and said they were happy living at the home. Relatives were equally positive about the home. One told us, "We're very pleased. We couldn't have made a better decision. [Person] is very happy. The staff are marvellous. The manager is firm which is needed." A second visitor told us, "I always promised [Person] that I wouldn't put them in a care home. At first, we were reluctant because it's not the poshest place but it's been brilliant. We love all the staff and residents. The manager has the best intentions of everyone at heart. Staff have been here a long time and care for [Person] the way that they'd care for their own."

Staff told us they enjoyed working at the home. Some had worked at the home for many years and all staff said they felt well supported by the management staff. One staff member told us, "If we have a problem I feel I can go to her (registered manager). We asked them if their problems were always resolved, they told us, "Yes they are resolved, she is pretty good, she is one of the best I have had."

The management team consisted of a registered manager and a deputy manager. The registered manager was experienced and had worked at the home for 31 years. It was evident from speaking with the registered manager they were committed to the ongoing quality of care and improvement of the home. They told us they met with the provider regularly to keep them informed of what was happening in the home and to discuss any changes needed.

Staff knew what was expected of them in regards to delivering care to people but it was less clear who took the lead when management staff were not in the home. When we arrived at the home, we were unable to establish who was in charge of the shift. Care staff and the registered manager told us 'senior' care staff did not necessarily always work in that role and it was dependent on which staff were on duty as to whether they worked in that capacity. Care staff told us assumptions were made as to who was in charge during shifts when the registered manager and deputy manager were not in the home. The registered manager told us the person in charge of a shift was indicated on the duty rota with an asterisk but not all staff were aware of this. We found duty rotas did not show when the deputy manager worked as part of the shift. This meant we could not determine sufficient care staff hours were provided consistently. The deputy manager was named on the duty rota as a "senior carer" which was not accurate. No other staff were listed as senior care staff but some told us they worked in this capacity.

The Provider Information Return stated, "We have a good communication …. before every shift staff discuss the wellbeing of each service user, also a communication book." We found this to be the case. We saw good team work and communication between the staff team and the managers during the visit. There was a staff handover meeting at the beginning of each shift and we attended one of these where staff discussed the welfare of each person. There was a communication book in use where staff recorded any appointments people needed to attend. This showed us staff could pass on information and receive important messages

from the management team.

Staff meetings were held to give staff the opportunity to comment on issues related to the running of the home. This helped to ensure staff were involved in decisions that impacted on them and others. One staff member told us, "We have meetings, we are listened to here." Another said, "We can put things on the agenda, we can have our say." Staff had also been asked to complete quality questionnaires and of the three returned, all were positive about working at the home.

The provider had systems to monitor the quality of the service provided and encouraged feedback from people and relatives. We saw since January 2017 three people had completed quality questionnaires. Two of them stated they were happy and one had said their room needed a "tidy up". The registered manager said this had happened. Five relatives had completed questionnaires and four of the five stated they were happy with the service. One had commented they were not happy about odours in the home. The registered manager explained this had been due to toilets being blocked and had been resolved. There was no information seen to confirm feedback from questionnaires was analysed to identify any areas of improvement so they could be acted upon and communicated to people.

In addition to quality questionnaires there was a suggestion box in the foyer of the home and forms were available for people to add their comments. The registered manager explained the box was opened monthly but people rarely completed the forms.

The registered manager said meetings regularly took place with people to check they were happy with the care and services provided. When we looked at the notes of these meetings, it was not always clear what had been discussed and agreed to show people's views had been listened to and acted upon. For example, one person had said the quality of the food needed to be improved and suggested more potatoes were put on the menu, but we could not see any planned action to address this.

The provider had a system of internal checks to ensure the quality of service was maintained and the home ran in line with the provider's policies and procedures. For example, the registered manager carried out audits of medicines on a weekly and monthly basis to make sure medicines were managed safely. However, some audits were not effective as the medicine audit did not include checks of prescribed creams which meant we could not be sure people's creams were always applied as directed. Audit checks completed in January 2017 had not identified the dates creams were opened had not been recorded. Audit records stated "all liquids, eye drops and creams are dated when opened" and the "no concerns" box had been ticked. The registered manager confirmed visual checks of creams in people's bedrooms did not form part of the audit but stated, "I can see they are being applied as bottles are being used up, I trust the carers."

Other audits included checks on sensor mats to ensure they were working for those people at risk of falls. However, there were contradicting messages from the registered manager and staff as to whether one person needed a mat or not. Records stated a mat should be used but we observed it was not.

There were food and fluid records to monitor what people at risk of poor nutrition consumed but we noted when viewing one person's records there were no targets detailed to indicate to staff what they needed to aim for. For example, the person had consumed 900mls of fluid one day and 1100mls the next. Staff did not know what the target fluid amount should be. The registered manager told us this should be in excess of 1100mls but it was not evident any action had been taken to audit records and act upon the results when the amount was below this.

We found safeguarding systems and processes were not sufficiently clear to ensure risks to people's health

and safety were effectively managed. Accident, incident and safeguarding information was also sometimes duplicated. Staff found it difficult to differentiate between these records because systems in place were not clear enough to support their understanding.

The registered manager had submitted most of the notifications we required by law about important events in the home. However, they had failed to notify us when potential safeguarding incidents had occurred. The registered manager assured us this would be addressed in the future. It is important that the CQC receives all necessary notifications so we can monitor the service and take action when required.

We saw there had been some improvements to the environment following our last inspection. This included a new assisted bath and refurbishment of the bathroom on the first floor. Some of the bedrooms had also been redecorated. We saw most areas of the home were visibly clean and tidy but some areas were in need of refurbishment. For example, some corridor carpets were threadbare and paintwork was chipped. We were told there was a refurbishment programme which included the corridor carpets being replaced and all bedrooms eventually being refurbished. The registered manager explained they had been without a maintenance person for two months which had put back the homes refurbishment plans. We were told there were also plans to change two bathrooms into wet rooms to benefit people.

The registered manager had completed our Provider Information Return (PIR). The information provided on the return mostly reflected what we saw during the inspection. The PIR also included areas which had been identified to need improvement to benefit people. For example, more staff training linked to people's needs such as autism and dementia. Also, an increase in the number of staff and service user meetings. We identified these were in progress.