Marantomark Limited

St George's Nursing Home (Oldham)

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

St George's Care Centre is a purpose built 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. St George's is registered to provide care and support to 77 people. At the time of our inspection there were 76 people living there.

St George's Care Centre is located in the residential area of Moorside, Oldham. It is approximately three miles from Oldham town centre and is situated close to local shops and amenities, with good access to local transport routes.

This was an unannounced inspection which took place on 22, 23 and 25 January 2019. The care Quality Commission (CQC) last inspected St George's Care Centre in November 2017, when the service was rated as 'Requires Improvement' overall. At that inspection we found the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. This was because medicines were not always managed safely. Following our inspection, the service provided us with an action plan which described how they would make improvements. At this inspection we found improvements had been made and the service was no longer in breach of any of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had an experienced registered manager, who was a registered mental health nurse. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The building was secure, clean and well maintained. There were effective infection control and prevention measures within the service. Checks and servicing of equipment, such as for the gas, electricity and fire-fighting equipment were up-to-date.

Staff had been recruited safely. The service had completed all the necessary checks to ensure that staff were suitable to work with vulnerable people. There were enough registered nurses, care workers and support staff to meet the needs of the people who currently lived at the home. There was an on-going recruitment drive with the aim of reducing the use of agency staff.

A safe system of medicine management was in place.

People had individual assessments in place which identified risks in relation to their health and wellbeing. These helped identify if people were at risk from everyday harms, such as falls. Where risks were found, there were plans in place to guide staff, so that people were kept safe.

Accidents, incidents and safeguarding concerns were recorded and managed appropriately. There was clear information detailing any remedial action taken to reduce the likelihood of similar events occurring in the future.

We observed that staff always considered people's capacity and consent when supporting them with care tasks. People were given choices when making everyday decisions. When people were being deprived of their liberty the correct processes had been followed to ensure that this was done within the current legislation

People were supported by well-trained staff. New staff received a thorough induction to the service and the training matrix showed that all staff had completed face-to-face training in a range of topics. Senior nurses and management carried out regular supervision and observation of staff. This ensured the standard of their work was monitored and gave them the opportunity to raise any concerns or worries.

During our observations we found staff treated people with dignity and respect. Staff showed patience and understanding and interacted with people in a kind and caring manner.

Staff at St George's monitored people's health. Where specific healthcare needs were identified, such as weight loss, the service liaised with health care professionals for specialist advice and support. Nursing staff were always available to undertake nursing duties, such as wound care and end of life care. People were supported to eat a well-balanced diet and were offered a choice of home-cooked meals.

People's care records were person-centred and contained detailed information about their preferred routines, likes and dislikes and how they wished to be supported. Providing person-centred care is about ensuring someone with a disability or long-term condition is at the centre of decisions about their life.

People were encouraged to provide feedback through service user meetings, an annual survey and via 'Quick Response Code' which was displayed in the reception area. This is a digital method of providing feedback.

The management team provided strong leadership of the service and was committed to maintaining and improving standards. Audits and quality checks were undertaken on a regular basis and any issues or concerns addressed with appropriate actions.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Safe recruitment processes were followed and staff understood how to keep people safe from harm.

There were systems in place for the safe management of medicines.

The home was clean and well-maintained. Equipment was regularly checked and serviced.

Is the service effective?

Good

The service was effective.

Staff received an induction, regular training and supervision.

Staff helped people make choices about their everyday routines. The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People were supported to maintain their nutrition, health and well-being. Staff worked with other health care professionals to meet people's health needs.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring.

People had their dignity, privacy and independence respected.

Is the service responsive?

Good

The service was responsive.

People were encouraged to take part in activities of their choice.

Complaints were responded to appropriately.

Staff were knowledgeable about people's needs. People's care was personalised to them.

Is the service well-led?

Good

People told us the registered manager was approachable. There was strong leadership of the home.

There were effective management systems in place to monitor and improve the quality of service people received.

People were encouraged to provide feedback on all aspect of service delivery at St Georges.

St George's Nursing Home (Oldham)

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. The 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 was an unannounced inspection which took place on 22, 23 and 25 January 2019. The inspection team on the first day of the inspection was made up of an inspection manager, an adult social care inspector and an assistant inspector. The second and third days of the inspection were carried out by an adult social care inspector.

To help us plan our inspection we reviewed information we held about the service. This included the inspection report from our last inspection in November 2017 and the home's action plan following that inspection. We also reviewed the statutory notifications the CQC had received from the provider. Notifications provide information on changes, events or incidents that the provider is legally obliged to send to us without delay

During our visit we spoke with the registered manager, the provider's operations manager, the training coordinator, three nurses and four care assistants. We talked with two people who used the service and five relatives. We also spoke with three relatives on the phone to ask their opinion of the service. We looked around the home, checking on the condition of the communal areas, toilets, bathrooms and some bedrooms. On the first day of our inspection we observed lunch being served on three of the units. We also observed how staff interacted and spoke with people.

As part of the inspection we looked in detail at seven sets of care records. These included care plans and risk assessments. We reviewed the medicine administration records (MARs) for people living on Haven and Brookdale units. We also looked at other information about the service, including training and supervision

records, staff personnel files, audits, maintenance and servicing records.

Good

Is the service safe?

Our findings

All the relatives we spoke with were happy with the way staff cared for their family members. Comments made included, "I've never heard anyone speak to him in a nasty way"; "I go home and I have peace of mind. I know he's being looked after"; "They are doing a remarkable job" and "They know how to care for people here."

There was a safe system in place for the management of medicines. At our last inspection in November 2017 we found that medicines were not always managed safely and the service was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the service was no longer in breach of this regulation. Everyone prescribed medicines had a medicines administration record (MAR). We checked the MARs on Haven and Brookdale units and found they had been completed accurately. The appropriate documentation (prn protocol) was in place for people who received medicines 'when required', such as medicines for the treatment of anxiety. However, on both units the protocols were kept separately from the corresponding MAR sheet. It is best practice to keep them together. We were assured they would be filed together in future. Staff had completed medicines training and had their competency checked before they were allowed to administer medicines.

At our last inspection in November 2017 we found that some concerns around the safe use of fluid thickeners. These are powders which are mixed into peoples' drinks to thicken them. They are used when people have been assessed as being at risk of choking on fluids. At this inspection we found a safe system in place for the management of fluid thickeners. Staff followed speech and language therapy (SALT) guidance to ensure people's fluids were thickened accurately to the correct consistency. Each unit had a dietary information file which contained details about each person's dietary requirements, including any special diets and the amount of thickener to be added to people's drinks. Dietary information was also discussed during the staff handover meetings and recorded on the handover information sheet. This ensured all staff knew how much thickener to add to peoples' drinks to minimise the risk of choking. This was particularly important for agency staff, who might not be familiar with different people's requirements. The service had recently arranged training for staff and relatives about the safe use of fluid thickeners. This was to ensure everyone was familiar with revised international guidelines about how drinks should be thickened to prevent choking.

The service had systems in place to protect people from the risk of avoidable harm or abuse. Staff received training in safeguarding adults and those we spoke with were knowledgeable about what was meant by safeguarding and whistleblowing and knew how to report any concerns they had about people's safety. All safeguarding incidents were recorded and investigated by the home and reported to the local authority safeguarding team. Records confirmed that the registered manager had taken the appropriate action following safeguarding incidents. There was one on-going safeguarding investigation which was being looked at by the local authority and has yet to be reported on. Following the incident, the registered manager met with the family and sent a letter of apology.

The service had a safe system in place for the recruitment of new staff. We reviewed five staff files which contained the required documentation, including references and a disclosure and barring service (DBS) check. DBS checks help employers make safe recruitment decisions as they identify if a person has had any criminal convictions or cautions.

The home was well maintained, clean and free from any unpleasant odours. The paintwork in some corridors was chipped and skirting boards needed repainting. However, there was a programme of redecoration in place to improve these areas.

Good standards of hygiene and cleanliness were evident throughout the home. Toilets and bathrooms had adequate supplies of liquid soap and paper towels and hand washing posters showing the correct hand washing method were displayed. Antibacterial hand gel was available on all corridors. An 'infection control' notice board provided staff and visitors with a wide range of information on infection control subjects. We observed staff using personal protective equipment, such as disposable gloves and aprons when they assisted people with personal care, or handled food. These measures minimised the potential for the spread of infection.

The home had scored 96% in a recent infection control audit carried out by the local authority and had received the local authority's 'Certificate in Excellence' award in infection prevention and control, during 2018/19. This award demonstrated the provider's commitment to high standards of hygiene and infection prevention. The kitchen had achieved a rating of five stars following its last food standards agency inspection in December 2018. This meant food ordering, storage and preparation were classed as 'very good'

Regular health and safety checks were carried out to ensure the premises, environment, services and specialist equipment were safe for people and staff. These included weekly fire safety checks and annual servicing of the passenger lift, gas and electricity supplies and hoists. The service had an up-to-date legionella risk assessment. Legionella is a type of bacteria that can develop in water systems and cause legionnaire's disease that can be dangerous, particularly to vulnerable groups such as older adults.

All accidents and incidents that occurred in the home were recorded and investigated. The accident forms were analysed monthly so that any trends or patterns could be identified, addressed and the risk of reoccurrence in the future reduced. This helped to keep people safe.

Risks to people's health and safety had been assessed and were reviewed regularly. Risk assessments included those for falls, choking, bed rails, behaviour and pressure ulcers. Where a risk had been identified, a corresponding plan was in place which guided staff on the best way to mitigate the risk to that person.

Equipment was in place to deal with clinical emergencies. Each unit had a first aid box, oxygen and a suction machine. The service had two defibrillators; one in reception and the other on the first floor. Staff had been trained to use them. A defibrillator is a device that gives an electric shock to the heart of someone who is in cardiac arrest. The majority of staff had received first aid training.

There were sufficient staff to keep people safe and meet their needs. Each unit had a lead nurse, who had clinical oversight of the staff team and there was always a nurse on duty to undertake nursing duties, such as medicines administration. Gaps in the weekly rotas due to sickness or staff leave were filled by staff from the regular care team or by agency staff. Staff told us that on occasions they were moved to work on another unit, if that unit was short staffed. There was an ongoing recruitment strategy to recruit additional permanent staff with the aim of reducing the use of agency staff.

Good

Is the service effective?

Our findings

The service supported staff to access regular training. This meant people were supported by staff who had up-to-date skills and knowledge. We talked to the training coordinator, who was committed to ensuring all staff received face-to-face training in a wide range of subject areas. They told us, "I'm passionate about training, particularly about manual handling" and it was obvious through our discussions with them that they were dedicated and knowledgeable.

There was a training matrix to show when people had completed courses, or required refresher training to keep their knowledge up to date. This was monitored regularly so that staff could be reminded that training was due. The training matrix showed that staff had completed training in a range of topics, including moving and handling, fire safety, react to red (pressure ulcer prevention), safeguarding and infection control. All staff were trained to use a defibrillator, as part of their first aid course. Staff we spoke with were complimentary about the training they had received. One person said "I prefer training face-to-face, so that I can ask if I don't understand anything."

All new staff received a two-day induction programme, which covered their mandatory training. Once this was completed, staff worked some 'shadow' shifts, where they worked alongside more experienced members of staff, until they were assessed as competent to work unsupervised. All new staff worked a three-month probationary period, during which time they were expected to become competent in different subject areas, including care documentation, personal care, policies and procedures and communication. These were based on the 'Care Certificate', which is a national set of standards that health and social care workers adhere to in their daily working life.

All staff received regular supervision and an annual appraisal. Supervision provides an opportunity for line managers to meet with staff, feedback on their performance, identify any concerns, and offer support, assurances and learning opportunities to help them develop.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The service was working within the principles of the MCA. For example, we saw that 'best interests' meetings had been held when specific important decisions had to be made for people who lacked capacity, such as decisions around end of life care. Care staff were aware of the importance of asking people for consent before undertaking any care and during our inspection we saw that this practise was always followed. Staff ensured people were given choices. For example, during lunch, people were asked what table they would like to sit at and if they would like any assistance.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In

care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Records showed relevant DoLS applications had been submitted to the local authority for authorisation. Where people were subject to a DoLS, the service followed the correct procedures for meeting the conditions of authorisation. For example, reporting on the use of restraint, where people were restrained to protect themselves, or others, from harm.

People told us they were happy with the quality of the food. We observed lunch on three of the units during the first day of our inspection and found there were sufficient staff to support people who needed assistance. Some people chose to eat their meals at the dining tables, others sat in their easy chairs. Some people remained in their bedrooms. We saw that assistance was provided appropriately, with a good use of touch to reassure people and plenty of encouragement given to people who got distracted or lost interest while they were eating.

People were assessed for risk of weight loss and malnutrition. People were weighed regularly and the Malnutrition Universal Screening Tool (MUST) used. This helped identify the level of risk and appropriate preventative measures, such as food monitoring, fortifying meals with nutritional supplements and/or referral to a dietician.

People living at St George's had access to a range of external healthcare professionals to help maintain their health and well-being. The service had good links with local GPs and other specialists, such as dietitians, social workers and speech and language therapists. Relatives told us they were kept informed about healthcare decisions affecting their family members.

During our inspection we looked around the home to see how it was decorated and furnished and to check that it was suitably adapted for the people living there. The home was a modern two storey purpose-built building divided into six units and set within large, well-maintained grounds. The corridors were bright, well-lit and wide, which meant there was ample space for manoeuvring wheelchairs and hoists. All units had large communal rooms, with a dining area and small kitchenette. Equipment such as electric beds and pressure relieving mattresses were of a good standard. Bedrooms were personalised with people's furniture, photographs and personal mementoes. Where appropriate, signage was in place on bedroom doors and doors to communal rooms to help people with dementia or poor sight find their way.

Good

Is the service caring?

Our findings

We received many positive and complimentary comments about St George's Care Centre. These included, "I think it's good. I think the staff are excellent"; "I love it here. The staff are great, the food is great"; "We're very happy with the home"; "They know how to care for people" and "All the staff are very nice."

People looked cared for and everyone was appropriately dressed. Staff paid attention to people's personal care, such as ensuring their nails and teeth were clean. Relatives were happy with the standard of personal care, although one person commented that staff occasionally forgot to wipe their family member's face after a meal. Another person talked to us about their family member, who spent most of their time in bed. They told us he was always nicely dressed, his hair brushed and bedclothes changed regularly. They said, "They (staff) know the standard that is expected of them."

During our observations we found staff treated people with dignity and respect. Staff showed patience and understanding and gave an explanation before a task or activity was carried out. This was particularly obvious during meal times, where staff explained to people who needed assistance, what they were doing. Where people were slow to answer questions, staff gave them time to respond and offered encouragement. One nurse told us, "It's important to speak slowly and clearly, but not patronisingly." Staff received training in dignity and respect and those we spoke with could give examples of how they promoted dignity and privacy, such as whispering to people if they needed to ask them about a personal matter.

Staff were thoughtful and attentive to people's needs. For example, when one person tried to wipe his mouth on his plastic apron during lunch, a care worker quickly brought him a napkin. One care worker talked to us about supporting people who did not receive visitors. They told us "We are their family now. You shouldn't be in this job if you don't care about how people feel." Staff used touch in an appropriate way, for example, resting a hand on someone's shoulder or arm when they needed comforting. We saw how staff responded to one person who became distressed, by offering reassurance and distracting them with conversation.

People were encouraged to maintain some independence, if they were able. For example, on the mental health unit people were supported to clean their bedrooms. One person went shopping for food and prepared their own meals. During our inspection we saw one person took a sweet trolley round to all the units.

We looked at how staff recognised and responded to people's personal preferences and how additional needs were taken into account. By looking at how information was captured in care records and through talking to staff, we were satisfied the home delivered care and support in a way that was non-discriminatory and promoted personal preferences. For people of faith, we saw the home had good links with the local religious community and people's pastoral needs were being met.

Good

Is the service responsive?

Our findings

People who wished to move into St George's had their needs assessed to ensure the service could provide the correct level of support for them. We found the registered manager, nurses and care staff were knowledgeable about people's needs. Care was person-centred. Providing person-centred care is about ensuring someone with a disability or long-term condition is at the centre of decisions about their life.

Care records contained information about people's support needs, including mobility, communication, nutrition and hydration, behaviour and end of life wishes (where appropriate). These were reviewed regularly and amended if there had been any changes in the level of support required. Care plans contained detailed information to guide staff on the care and support people needed. For example, mobility care plans included details about the use of slide sheets (equipment for moving people who are in bed) and information about the type and size of slings to be used with a hoist. This ensured staff had the correct guidance for moving people safely.

Some people who were unable to swallow, received their nutrition and medicines through a tube inserted into their stomach through their abdomen. These people had care plans which described how staff should look after the feeding tube to ensure it worked properly and did not become blocked or infected. Where people required regular monitoring, charts were in place to record the actions staff had taken. For example, turn charts were used when people needed to have their position changed to reduce the risk of pressure ulcers, and nutrition charts were used to monitor the amount of food people ate.

The service employed a qualified nurse on each unit so that 24-hour nursing care was provided. Nurses carried out a range of nursing duties, including catheterisation, wound care and end of life care. The majority of staff had completed some training in end of life care, and the home had completed the, 'Six steps to success – Northwest end of life care programme for care homes'. This gave staff the skills to support people at the end of their life. One nurse told us, "We do what the family want for them. There's no hospital admission unless it's really necessary. We can spend more time with them (residents) than in hospital."

A range of group activities were provided on all units. The service normally employed two full-time and one part-time activities coordinators. However, due to sickness and one person leaving the service, there was only one activity coordinator working at the time of our inspection. The registered manager told us they were currently recruiting to fill the post of full-time activities coordinator. In the meantime, staff were supporting people with activities. Some people were able, with the support of staff, to access the local community, visiting local shops or travelling further afield into Manchester. Two people visited a local community centre where they had lunch and played bingo.

Good communication between staff was promoted through handover meetings, which took place on all units at the start of each shift. These gave staff the opportunity to discuss people's care and support needs and ensured any changes in their health or welfare were understood and shared confidentially. Each unit produced a handover sheet, which gave brief details of people's particular needs, such as their mobility and dietary needs or their behaviour. This was particularly useful for new and agency staff.

The service had a complaints procedure which explained how to make a complaint and how it would be dealt with. This was displayed throughout the home. All complaints that were received were logged and responded to. We reviewed the most recent complaints and found that the appropriate action had been taken. For example, one complaint was in relation to a person not being supported correctly with their meal. The service had responded by offering a written apology, retraining the member of staff concerned, and informing staff through a memo about best practice. People we spoke with told us they felt able to raise matters of concern with staff.

The Accessible Information Standard (AIS) was introduced by the Government to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS. Through our review of people's care and support records, we were satisfied that if people required information in an accessible format, this would be provided. For example, one person's communication care plan suggested that staff use a white board to display relevant information such as the date, time, weather and staff on duty. The training coordinator told us that if needed, she could make flash cards (cards containing a small amount of information) to help staff communicate with people.

Good

Is the service well-led?

Our findings

The service had a well-defined and effective management structure which ensured there was constant oversight of the home, its staff and the care that was provided. Since our last inspection a new operations manager had been employed and they provided valuable support and guidance to the registered manager through their regular visits to the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Clinical leadership was provided by the registered manager, who was a mental health nurse, and by the lead nurses on each of the six units. The service was in the process of advertising for a clinical lead, to provide further clinical support to the nurses.

Relatives and staff were complimentary about the way the service was run and told us the management team and lead nurses were approachable and supportive. One relative told is, "If I need to see someone, I see them pretty quickly." Two members of staff told us that when their personal circumstances had changed, the registered manager had found ways to ensure they could continue working safely at the home. To help promote good communication the registered manager visited each unit at least once a day. This gave her the opportunity to talk to staff and residents, observe staff interactions with residents, provide advice and check that the environment was suitably clean and maintained.

The registered manager worked collaboratively with the local authority and with professionals involved in people's care. This included raising safeguarding alerts and liaising with social work teams and healthcare professionals when appropriate. This ensured people's ongoing welfare and safety. The management team and staff acknowledged the importance of being open and transparent when mistakes were made, so that the appropriate action could be taken in an atmosphere of support. One nurse told us "I feel safe working here. If I made a mistake I could go to the manager."

The registered manager had met their regulatory responsibilities. Providers are required by law to notify the CQC of certain events in the service, such as serious injuries, deaths and safeguarding concerns. Records we looked at confirmed that the CQC had received all the required notifications from the service. The rating from our last inspection was displayed in the home's reception area and on the provider's website. This meant people had been informed of our judgement of the service.

We found there was a robust system of quality assurance and governance processes. These systems help providers monitor the safety and quality of their service and ensure people receive a good, safe standard of care. Each unit carried out a range of audits, two to three times per month, which looked at areas including the environment and cleanliness, completion of diet and fluid charts and MAR charts. Where these highlighted areas for improvement these had been dealt with. For example, one audit of the MARs had identified some errors around signatures and this problem had been addressed with staff. An additional level of quality monitoring was provided through a monthly audit which had been introduced by the

operations manager. This looked at a whole range of areas, including weight management, infections, falls, complaints and incidents. The operations manager discussed the findings of this monthly quality check with the registered manager, so that prompt action could be taken to address any issues identified.

Each unit held staff meetings two or three times a year. These were an important way of communicating information about the service, discussing concerns and gathering feedback from staff. Minutes from recent meetings showed that topics discussed included moving and handling, completing diet and fluid charts and staff rotas.

The provider sought feedback from people and their relatives through service user meetings and an annual survey. The service had received a good response to the most recent survey, which had been carried out in October 2018. Topics covered by the survey included quality of care, staffing, food, activities, complaints and accommodation. Analysis of the survey had yet to be completed, although many good comments had been received. People visiting the home could also provide feedback by using the 'Quick Response Code' which was displayed in the reception area. This is a digital method of providing feedback.