Bushby Care Ltd

St Georges Lodge Residential Care Home

Inspection report

46 Chesswood Road
Worthing
West Sussex
BN11 2AG

Tel: 01903820633
Website: www.stgeorgeslodge.com

Date of inspection visit:
20 March 2018

Date of publication:
22 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

The inspection took place on 20 March 2018 and was unannounced.

St George's Lodge Residential Care Home is registered to provide accommodation and care for up to 26 older people with a range of health needs, including people in the early stages of dementia. At the time of our inspection, 25 people were living at the home. Communal areas include a large lounge, dining room and gardens. A lift is available between the ground and first floor. The majority of rooms have en-suite facilities, such as a toilet and sink. St George's Lodge Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

A registered manager was 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.

At the last inspection, the service was rated Requires Improvement under Effective and a requirement was made in relation to a breach of Regulation 11, need for consent. Consideration was not given in relation to people's capacity to give their consent. Capacity assessments were not always recorded for people who appeared to lack capacity. At this inspection, we found that steps had been taken to address the issue and the rating under Effective has improved to Good. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Medicines were not always managed safely. A staff member who administered medicines to people at lunchtime did not witness some people taking their medicines, but signed the Medication Administration Record to confirm they had taken them, which was inaccurate. Temperatures within the medicines storage area and in the refrigerator were consistently in excess of ideal temperatures which manufacturers recommend.

Care plans were not completed in a person-centred way and many lacked information about people's personal histories, likes and dislikes. The provider had an accessible information policy in place, but account had not been taken of people's impairments in order that adjustments could be made in line with the policy. Although some activities had been organised by care staff, these were not planned in line with people's interests and hobbies.

Systems were not effective in monitoring the home and had not identified the issues we found at inspection.

Medicines were ordered and disposed of safely. Staff were trained in the administration of medicines. Some

people were independent in taking their medicines and had been risk assessed accordingly. People felt safe living at the home and staff members had completed safeguarding training; they know what action to take if they suspected abuse. In addition to people's risks being identified and assessed, premises had been assessed and were managed safely. Staffing levels were within safe limits. Safe recruitment practices were in place. The home was clean and smelled fresh. Staff understood their duties under the Duty of Candour and the need for honest, open communication when things went wrong.

Staff completed training in a range of areas considered relevant to their job role. They had regular supervision and annual appraisals with their managers. People had sufficient to eat and drink and we observed people having their lunchtime meal, which was a sociable occasion. People had access to a range of healthcare professionals and services. When people moved to the home they were encouraged to bring any personal items and furniture that was of importance to them.

People were looked after by kind and caring staff who knew them well. People were encouraged to be involved in decisions relating to their care and they were treated with dignity and respect by staff.

Care plans provided detailed information about people's healthcare needs and the support they required. Complaints were managed in line with the provider's policy.

Audits were in place relating to the cleanliness of the home, accidents and incidents and staff files. The provider completed a monthly audit. Residents' meetings took place and actions were recorded when suggestions were made. People and relatives' questionnaires were sent out and overall the responses were positive. Notifications which the provider was required to send to us by law had been completed as needed. Staff felt well supported by the management team and staff meetings took place. Comments made by people and their relatives were positive about the quality of care at the home.

We found two breaches of Regulations. 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

Some aspects of the service were not safe.

Medicines were not always administered safely or stored at temperatures to remain effective.

Staff knew how to keep people safe and had completed safeguarding training.

Risks to people and the premises were identified, assessed and managed safely. However, risk assessments and care plans did not always reflect people's most up to date needs.

Staffing levels were within safe limits and staff were recruited appropriately.

The home was clean and odour free.

Is the service effective?

Good

The service was effective.

Staff had received training in relation to the Mental Capacity Act 2005 and associated legislation under Deprivation of Liberty Safeguards. Staff had a good understanding of the requirements and put this into practice.

Staff completed training in a range of subjects considered essential to their role and received regular supervisions and annual appraisals.

People enjoyed the food on offer at the home and any special diets, religious or cultural preferences were catered for.

People had access to a range of healthcare professionals and services.

People's rooms were personalised. There were no restrictions on visiting times.

Is the service caring?

Good

The service was caring.

Positive, caring relationships had been developed between people and staff. Staff knew people well, including their likes, dislikes and preferences.

People and their relatives or representatives were involved in decisions relating to their care.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Care plans did not always record people's personal histories and preferences. Activities were limited and were not organised based on people's interests and hobbies.

Care plans provided information to staff on people's care and support needs. However, account had not been taken about how to cater for people's impairments or sensory needs.

Complaints were managed in line with the provider's policy.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Some parts of the provider's policy on vision, mission and values were not embedded into the running of the service. Auditing systems were in place, but had not identified the issues we found at inspection.

People and their relatives were positive about the care provided at the home and gave feedback through meetings and questionnaires.

Staff felt supported by the management team. The registered manager was a member of various networks within West Sussex to share ideas and practice.

St Georges Lodge Residential Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 20 March 2018 and was unannounced. The inspection team consisted of three 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. Their area of expertise was in older people.

Prior to the inspection we reviewed the information we held about the home. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. The registered manager had completed a Provider Information Return (PIR). The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people who lived at the home, one relative, the provider, the registered manager, head of administration, deputy manager, head of care, chef, kitchen staff and two care staff.

We spent time observing the care and support that people received and also observed a member of staff administering medicines to people.

We reviewed a range of records about people's care and how the home was managed. These included five care records and medicines records. We also looked at staff training, support and employment records,

audits, minutes of meetings, menus, policies and procedures and other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely in line with the provider's policy. We observed a member of care staff administering medicines at lunchtime. The staff member identified the medicines that each person needed to take by looking at the relevant Medication Administration Record (MAR). They then prepared the medicines and took them to the person that was due to have their medicine. On three occasions, we saw that the medicines were left with the person to take. The staff member did not ensure people had taken their medicines before leaving their rooms. However, the staff member did sign the relevant MAR to confirm the medicine had been administered. This was inaccurate since the member of staff could not know whether each person had actually taken their medicine or not since they had not witnessed it. We discussed the issue with the registered manager during feedback at the end of the inspection. The registered manager was disappointed with our findings and explained that the staff member in question would have known people well and therefore would not have questioned whether they had taken their medicines or not, but had trusted them to do so. Nevertheless, the MAR for each person should only be signed when the staff member administering the medicine witnesses the event. We saw there was a gap in the MAR for one person. They should have received a particular medicine for pain relief on a specific day, but staff had not signed the MAR to confirm whether the person had received their prescribed medicine or not. In most cases, when oral suspensions, liquids and creams were opened, the date of opening was recorded on the container. However, we saw that a bottle of drops to help with the build-up of ear wax had been opened for one person, but the date of opening had not been recorded. This meant that staff could not be assured that the bottle of drops was safe to use since they did not know how long the bottle had been open.

We looked at the storage of medicines in an area next to the dining room and saw that temperatures in the area had been recorded. To ensure that medicines maintain their effectiveness, drugs manufacturers recommend that a temperature of 25 degrees Celsius should not be exceeded over time. The temperatures of the area where medicines were stored were routinely around 25 degrees Celsius or sometimes 26 degrees Celsius. This would have affected a particular medicine that was stored and rendered it potentially unstable and ineffective. We saw that one medicine of this type was dated January 2016 and had been stored at potentially higher temperatures than was recommended by the manufacturer for over two years. The registered manager agreed that safe temperature was an ongoing issue and that a fan could be used when the temperature increased above 25 degrees Celsius. However, this was not in use on the day of inspection, when the temperature was 25.5 degrees Celsius. We looked at the temperature of the refrigerator. Ideally medicines should be stored at a temperature of between 3 degrees Celsius and 7 degrees Celsius. We looked at the record of the refrigerator temperatures for March 2018 and found that every recording was either 8 or 9 degrees Celsius at the top end and 6 degrees Celsius at the lower end. This meant that medicines were not stored within normal temperature range. The registered manager told us that the fridge was relatively new and they would contact the manufacturer to sort out the problem.

The above evidence shows that medicines were not always administered safely and medicines were not stored within a safe temperature range. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection, the registered manager told us that a new medicines fridge had been purchased and that all medicines had now been moved to a cooler office. An air conditioning unit was to be fitted to help maintain temperatures below 25 degrees Celsius.

Medicines were ordered and disposed of safely. Only staff trained in the administration of medicines were allowed to administer them. People we spoke with confirmed they received their medicines and that pain killers would be offered if needed. One person self-administered their medicines and had been risk assessed to show they were safe to do this. One person said, "They will give you Paracetamol if you have a headache. I have no medicines in my room, only indigestion tablets". Another person told us, "I receive my medicines from the trolley and it's normally on time. They offer me tablets if I have a headache".

Following the inspection, we spoke with the registered manager who told us that the medicines trolley had been moved to another part of the home, to a room which was well ventilated and where a safe temperature could be maintained. A new refrigerator for medicines had been purchased. The registered manager told us that the staff member who had administered medicines to people had apologised for the oversight in leaving medicines with people. The registered manager felt assured this would not happen again, having discussed the issue fully with the staff member.

Policies and procedures documented the management of medicines that were taken as needed (PRN) and homely remedies, which some people chose to take, such as for constipation. Guidance informed staff of the need to ensure that homely remedies did not counteract the effect of any prescribed medicines and were safe to take.

People told us they felt safe living at the home and that their independence was encouraged. One person said, "I am a very independent person and I like to do things for myself. I push the call button if I need help and staff are quick at responding". Another person told us, "There's always someone around and we have the call bell if we need someone. We're never without help".

Staff members we spoke with had undertaken adult safeguarding training within the last year. They understood the correct safeguarding procedures should they suspect abuse. Staff were aware that a referral to an agency, such as the local Adult Services Safeguarding Team, should be made, in line with the provider's policy. One staff member said, "I would let you [CQC] know if I didn't think the manager would do something".

We observed staff assisting people to move safely using a variety of hoists and stands. There were enough staff to do this safely. Staff were competent in managing this and treated people with dignity and respect. We saw that people whose mobility was restricted, or who were cared for in bed, had access to their call bells. People's risks had been identified and assessed and care records included information and guidance for staff on how to mitigate risk.

Personal Emergency Evacuation Plans (PEEP) had been drawn up which outlined how people should be supported in the event of an emergency, such as fire or flood.

Premises were managed safely and we looked at a range of audits, maintenance records and servicing agreements. These showed that gas safety, electrical wiring, lift servicing, Legionella testing and fire safety checks had been completed. Servicing of equipment such as hoists were completed annually. Staff had completed fire safety training and knew what action to take in the event of an emergency. Contingency plans had been drawn up in relation to actions to be taken in the event of an outbreak of Norovirus for example, or when severe weather warnings were issued.

There were sufficient numbers of staff on duty to keep people safe and meet their needs. Five care staff were on duty in the morning, four during the afternoon and two waking night staff. After the inspection, we were told that three extra members of staff, plus the provider, were asked to come in on the day of inspection, to be available to the inspection team if needed. We asked staff if they thought there were enough care staff on duty to provide safe and effective care. One staff member said, "I think so. We have enough time to spend with the residents and get to know them". Another staff member told us, "I would say we do, yes. The dependency of residents went up recently and we got an extra staff member". We asked the registered manager whether there were currently any staff vacancies and whether agency staff were used to cover gaps in the rota. We were told that agency staff were not required as bank staff could cover any additional shifts. People commented on staffing levels. One person said, "Sometimes there's not enough staff later on. I use the call bell at night to use the toilet. They're pretty good as there's only two of them". Another person told us, "So far the staffing levels seem okay. There always seems to be someone if you need them and they respond quickly to the bell".

Safe recruitment systems were in place. Staff files we looked at showed that new staff had completed an application form, taken part in an interview process, two references were obtained and their suitability to work in care was checked through the Disclosure and Barring Service. The head of administration described how important it was to have staff with the right values to work at the home. They explained, "We ask new staff to come in for two trial mornings which are supervised and they get paid. This is to make sure they're safe". If new staff were considered to be suitable, then they would start the induction process.

The home was clean and smelled fresh. The provider put preventative measures in place where necessary, for example, ensured the adequate provision of personal protective equipment (PPE) for staff, such as aprons and gloves. There were individual infection control risk assessments within people's care plans. All areas of the home were clean and tidy. There were hand hygiene stations throughout the home which provided alcohol gel. Hand basins provided hot running water, soap and disposable towels. Bathrooms and toilets were clean and free of litter or debris. Staff had a good understanding of infection prevention and control issues. One staff member was the infection control champion, shared information and provided guidance to staff. We were told that an infection control nurse had recently completed an infection control audit and this provided the basis for ongoing infection control audits.

Staff had completed training and understood their responsibilities under Duty of Candour. They were able to explain the need for open and transparent communication with people and their relatives when mistakes were made. Arrangements were in place for reviewing and investigating safeguarding incidents should these occur. Following a medicines error, the home had been transparent, apologised, contacted the person's family and notified the relevant agencies of the error.

Good

Is the service effective?

Our findings

At the inspection in November 2015, we found the provider was in breach of a Regulation associated with consent to care. We asked the provider to take action because consideration of people's capacity to give consent was not considered consistently. Mental capacity assessments were not always recorded for people who appeared to lack capacity. Whilst risk assessments were in place for bed rails, people's capacity to consent to the use of bed rails or a best interests decision taken were not evidenced. Following the inspection, the provider informed us that they had contacted the local authority for advice and that authorisations under the Deprivation of Liberty Safeguards were being sought where needed. Following the inspection, the registered manager sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection, we found that sufficient improvements had been made and that this regulation was met.

At this inspection, we checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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).

Where needed, people's capacity to make specific decisions had been assessed. Where people had been identified as lacking capacity, DoLS applications had been completed and submitted to the local authority. We asked staff about issues of consent and their understanding of the MCA. Two of the three staff members we spoke with had undertaken recent training in this area. All could tell us the implications of the Act and of DoLS for the people they were supporting. Staff could tell us about people's rights to take risks when they had capacity.

We looked at care plans in the light of issues of consent and capacity and saw that capacity assessments had been completed where needed. However, we also noted some people were subject to repeated mental capacity assessments where this was not necessary. Two people had both received five assessments in the past two years. We found no evidence that there were concerns about these people's mental capacity, therefore, the principle of assumption of mental capacity had not been recognised. Another person's 'Do Not Attempt Cardio-pulmonary Resuscitation' form was out of date. It was written before the person came to live at the home and stated they did not possess mental capacity. The care plan indicated the person had since regained capacity, was able to participate in their care planning and given written consent to it. This was discussed with the registered manager who told us they would review the matter.

We asked the registered manager how they kept up to date with best practice and they told us they had signed up to the Commission's updates and other social care organisations. When new staff came to work

at the home, if they had no previous social care qualifications, they would study towards the Care Certificate. The Care Certificate is a universally recognised award which is a mixture of work based training and assessment. The head of administration explained the induction process, that new staff shadowed experienced staff until they were considered competent and confident to work more independently. Staff completed training in topics considered essential to carry out their roles, for example, in moving and handling, safeguarding, fire safety, food and hygiene, infection control and dementia awareness. Some training was delivered face to face and other training was delivered electronically. We asked staff about the training opportunities on offer. One staff member said, "Well I'm the dementia champion so I've done some training in that area and I can pass that on to the other staff". Staff confirmed that most of their mandatory training had been completed. Records showed that staff had regular supervision meetings and annual appraisals and their training needs were discussed. We asked staff about the managerial support they received. One staff member said, "We get supervision regularly and that's really good. We get to have our say". Staff confirmed that supervision and appraisal was a two-way process and felt it was honest and open.

We observed people having their lunch and this was a sociable occasion. One person said, "All the food's very nice and we have a choice, plenty of food. The puddings are wonderful". Another person told us, "The food Is very good. They always give you a choice if you don't fancy the main meal". Choices of drinks were freely available, with wine and sherry served at lunchtime for people who wanted it. People were asked what they would like to choose from the menu the day before, but could change their minds on the day if they wanted something else. Some people chose to eat their meals in their rooms, rather than in the dining room. People were assisted by staff to eat their meals when required.

Staff were knowledgeable about people's different dietary requirements. They were aware of the importance of healthy eating, special diets and of maintaining a balanced diet. Two chefs worked at the home and we asked one chef about people's likes and dislikes and any special diets. We were shown documentation that was completed when someone first came to live at the home and this contained detailed information about people's likes, dislikes, diets and cultural or religious food requirements. This information was reviewed every three months by kitchen staff. The chefs attended residents' meetings and met with people individually to ensure they were happy with the food on offer. The menu was based on a four week rota and there was a choice of freshly cooked food. Daily kitchen cleaning rotas had been completed, in addition to fridge and freezer temperatures, food probe calibration and cooking, cooling and reheating temperature recordings.

People had access to a range of healthcare professionals and services and care plans confirmed this. For example, referrals had been made on behalf of people to hospital consultants, dieticians and speech and language therapists where needed. We asked people about their health care. One person said, "I've had a bad leg and they got the doctor for me. The chiropodist comes every six weeks". Another person told us, "There's no problem getting a doctor. When I need to go to hospital for appointments I go by ambulance". A relative said, "I tend to take Mum to any appointments, but the carers will take her if I can't".

When people moved into the home, they were able to bring personal items and furniture with them. We saw there were memory boxes outside people's rooms. Memory boxes contained items that were important to people and which were reminiscent of their lives. Some people had photos of loved ones or pets which were laminated and affixed to their bedroom doors. Visitors were made welcome and there were no restrictions on visiting times. People were supported to stay in touch with people who mattered to them. For example, if relatives could not visit or lived far away, people were supported to use Skype or telephone to stay in touch. In an upstairs hallway, there was an extra small seating area that one person liked to use. One person said, "I love the garden and I like sitting out in the summer. I walk around the car park most days".

Good

Is the service caring?

Our findings

We observed care and support given to people throughout the day. The care was safe and appropriate with adequate numbers of staff present. There was good interaction between people and staff who consistently took care to ask people's permission before intervening or assisting them. Positive, caring relationships had been developed and staff were responsive to people's needs and addressed them promptly and courteously. Staff knew people really well, for example, staff knew people's food preferences without referring to documentation and who they liked to sit with. One person said, "If you get upset they will sit and talk to you. [Named registered manager] will always talk to you. Nobody makes you do anything you don't want to do". A relative told us, "All the carers are very nice and they always know if Mum's not feeling right".

We looked at people's care plans in order to find out how staff involved people and their families with their care. Care plans and risk assessments were discussed and agreed with people or their representatives and were signed in confirmation. Records of people's contact with relatives and friends were kept. One person said, "All the staff are very good, friendly and helpful". We looked at whether people's communication needs were taken account of and how staff sought accessible ways to communicate with people in relation to decision making. There was no evidence to show that this was done, however, people we spoke with were able to communicate effectively and had no specific communication needs.

We observed staff interacting with people throughout the day. Staff were respectful and kind to people and we observed many instances of warmth between staff and people. On these occasions, staff took time to explain their actions in order to minimise people's anxiety. The atmosphere at the home was calm and inclusive. Staff were knowledgeable about the people they cared for and explained people's individual needs and requirements. One staff member said, "A lot of the staff, as well as residents, have been here a long time, so we know them really well". Another staff member felt the home was a caring place and told us, "I think so, definitely. I wouldn't stay if it wasn't". People were treated with dignity and respect. We observed staff knocked on people's doors and obtained their permission before entering. People were encouraged to do as much as they could for themselves, but staff were readily available if needed. One person said, "I am a very independent person. I like to do things for myself but I push the call bell if I need help".

Requires Improvement

Is the service responsive?

Our findings

We looked at people's care plans and they were legible and securely stored. However, they were not always completed in a person-centred way. People's choices and preferences were not always documented and there were very limited personal and social histories contained within the plans. However, care staff we spoke with were knowledgeable about the people they cared for. Daily records we looked at were staff focused and task orientated. For example, one person's daily records contained a repeated entry stating, 'All care given as per plan'. In some care plans we saw several examples of people receiving treatment where no rationale to do so was present. One person had their weight checked every month for 16 months. There was no indication in the care plan why this was necessary, particularly as their weight remained constant throughout. Other people were undergoing regular blood pressure and pulse readings without any rationale for doing so. We were told this was done at the request of people's GPs, but staff were unable to tell us why.

We were shown the provider's accessible information policy. This described the need for information to be provided in an accessible format and stated, 'The Accessible Information Standard is of particular relevance to people who are blind or have some visual loss'. Two people at the home were registered blind, but no special arrangements were made to show how account was taken of their visual impairments For example, documents to be written in large print. The provider's policy was not effective in terms of identifying people's sensory needs or disability needs and how these would be met. It was not clear how information could be presented in an accessible format or communicated in a way that was tailored to meet people's individual needs. One person said, "There's not enough for me to do because I can't see and hear, but things are offered. Nobody makes me do anything". We looked at a care plan which included an assessment of the person's care needs. This showed they had an impairment, but no thought had been given on what arrangements might be made, for example, a referral to an appropriate health professional, to address their specific needs.

A noticeboard at the home showed activities on offer which was mostly music or group entertainment. Care staff organised some structured activities, but these were not based on people's preferences or interests. Activities were not on offer daily, for example, during February, according to the notice, ten activities were planned, including a visit from a hairdresser. We were told approximately three minibus outings took place in the year, but people were not taken out on regularly an individual basis. One person said, "I don't do activities. I don't like to join in. I did try once, but found it too childish". Another person told us, "I love the music but the new people won't join in. We have activities every Thursday afternoon". On the day of our inspection there were no organised activities taking place. We were told that people could play Bingo and cards twice a week.

The above evidence shows that care plans were not written in a person-centred way. Activities were not organised based on people's interests or hobbies. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst care records were not always written in a person-centred way, this did not impact on the care people

received since staff knew people well. People were involved in reviewing their care and records confirmed this. Care plans were detailed and provided guidance for staff on how to meet people's needs. For example, information on support one person required with their diabetes, the need for regular check-ups from a chiropodist and eye tests. A care plan we looked at for one person with insulin dependent diabetes showed their blood glucose levels had been taken and recorded appropriately. Guidance in their care plan aided staff in the management of possible emergencies. For example, the care plan described the symptoms and management of hypoglycaemia and hyperglycaemia. Some care plans included information in relation to people's religious or cultural needs at the end of their lives. They stipulated whether a person's preference was to stay at the home or would rather be transferred to hospital for end of life care.

The complaints procedure was readily available and on display in communal areas of the home. This contained information about how and to whom people and/or their representatives should make a formal complaint. There were also contact details for external agencies. Staff were clear about their responsibilities in the management of complaints. People told us they would speak with a member of the management team if they had any concerns. One person said, "If I wanted to grumble about anything I would talk to the manager, but I never have complained about anything". Another person told us, "I would be happy to approach [named registered manager] with a complaint". Complaints were logged, actions taken and outcomes recorded to the satisfaction of the complainant.

Requires Improvement

Is the service well-led?

Our findings

Some systems were in place to measure and monitor various aspects of the home. However, they were not effective in finding issues we found of concern at this inspection. Some aspects of medicines management were not safe, such as the competency of a staff member to administer medicines safely and the temperature at which medicines were stored. Care records were not personalised and did not always include information about people's personal histories, likes and dislikes. Activities were not planned to take account of people's interests and hobbies.

We looked at audits in relation to the cleanliness of the home, analysis of accidents and incidents and staff files. Monthly audits and reviewing of notifiable incidents took place to identify any trends or patterns, so that learning took place. Staff understood their responsibilities under the Duty of Candour and the principles of this were on display on the staff noticeboard and included at induction for new staff. We were told that the provider completed a monthly audit when they visited the home which included spot checks for people, whether they were happy and their rooms cleaned. Residents' meetings took place every other month. The head of administration said, "We try and include everyone and put posters up. The meetings are held in the lounge or dining room. For people who can't come, we go to their rooms and ask for their feedback". Records confirmed that residents' meetings took place and documented any actions arising from each meeting so these could be followed up. For example, a result from one of the residents' meetings was how much people enjoyed a Pets as Therapy (PAT) dog and arrangements were made to make this a more regular occurrence. People and relatives' questionnaires were sent out and we saw positive responses to these. Where actions needed to be taken, these were clearly documented and followed up. A monthly newsletter was published, St George's Gazette, a copy of which was given to each person and sent or emailed to relatives. People were involved in the selection of new staff.

We were given a copy of the provider's vision, mission and values. This stated the vision as, 'St George's Lodge vision is of a care home that ensures a person-centred approach to all service users, which enables individuals with support, to enjoy a healthy, engaging and independent life'. The document also stated, 'We believe in the right of every service user to realise and maintain personal aspirations, abilities and social connections'. However, these values were not embedded into the culture of the service to ensure that people received person-centred care.

We were told that the providers were, "Very much present and visible, visit usually every Wednesday and were always on the 'phone". The providers owned two other care homes in the south and, "The homes work together to bounce ideas of each other". The provider was in the process of ensuring that people's confidential information was protected under Government Data Protection Requirements which would come into force from May 2018.

Notifications which the provider was required to send to us by law, had been completed as required and the rating gained at the last inspection was displayed on the home's website.

We asked staff if they thought the home was well-led. One staff member said, "A lot of staff have been here a

long time; I think we're a good team". Another staff member told us, "The manager and deputy are really supportive and the door is always open". A third staff member said, "I think it's a very caring place and a lot of that comes from the manager". Staff meetings took place quarterly and staff said these were useful and that they felt listened to. People were happy living at St George's Lodge Residential Care Home. One person said, "I'm happy here, my daughter made a good choice". Another person told us, "It's as good as you can get. I wouldn't want to be anywhere else". Compliments from people and their relatives were collected in a compliments folder. A 'thank you' card from a relative said, 'Thank you. I could not have found a nicer place for my Mum to regain her confidence after her falls'. A relative visiting the home at the time of the inspection said they were very happy with the care, that the home was very tidy and clean and they would give the care 10 out of 10. Reviews from an external website provided positive feedback from people and their relatives.

The registered manager was a member of various managers' forums in West Sussex and attended meetings to network and share good practice. Links had been forged in the local community with the involvement of local schools and nurseries. For example, people visited the local secondary school for a Christmas concert and children from a nearby nursery came to visit people at the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person-centred. Activities were not organised in a way that reflected people's interests and hobbies. Regulation 9 (1) (3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff did not follow policies and procedures in the management of medicines and medicines were not always administered safely. Regulation 12 (1) (2)(a)(g)