2 Care

St George's House

Inspection report

263 Camden Road
London
N7 0HS

Tel: 02076077989
Website: www.2care-rsl.org.uk

Date of inspection visit:
14 November 2016

Date of publication:
19 December 2016

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

This inspection was carried out on 14 November 2016 and was unannounced.

During our inspection on 12 August 2015 we found that systems in place for storing and administration of medicines were not appropriate to ensure safety and effectiveness. Support plans were not always personalised or reviewed regularly. Regular checks and audits of service quality and delivery were not being carried out effectively. The home was in breach of Regulation 9, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

St George's House provides residential care for men and women with mental health issues. The service focuses on a three phase rehabilitation programme to support people to move to more independent accommodation. There were 23 beds, and 9 people were staying at the home during the inspection.

The service had a registered manager. 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 legal requirements in the Health and Social Care Act 2008 and the associated regulations on how the service is run.

Staff were trained in safeguarding adults and had a good understanding in keeping people safe. They knew how to recognise abuse and who to report to and understood how to whistle blow. Whistleblowing is when someone who works for an employer raises a concern about harm, or a risk of harm, to people who use the service. There were policies and procedures in place for staff to follow.

There was enough staff to support people safely and to meet their individual needs.

Assessments were undertaken to assess any risks to people living at the home and steps were taken to minimise potential risks and to safeguard people from harm.

Medicines were stored, administered and recorded correctly.

Safe recruitment procedures were in place that ensured staff were suitable to work with people, as staff had undergone the required checks before starting to work at the service.

Care plans were personalised to the people using the service. People were involved in planning of care and the care plans were then signed by people to ensure they were happy with the care and support listed on the care plan.

People had access to healthcare services such as the GP and dentists.

Systems were in place to ensure staff received regular supervision and appraisal. Staff received induction

training and also received regular training to ensure that people were safe and the care provided was effective.

Complaints were managed appropriately and people were aware on how to make complaints.

People participated in a number of activities such as DVD nights, gardening and cooking workshops.

People's privacy and dignity was maintained. People were independent and we saw people moving freely around the house and were able to go to their rooms and outside without interruption.

Systems were in place for quality assurance. Regular audits were being carried out by the management team with actions listed for improvement.

Questionnaires were completed by people about the service. Outcomes were generally positive and covered important aspects on staff, safety, complaints and dignity.

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.

Staff knew how to identify abuse and report concerns or allegations of abuse.

Individual risk assessments had been prepared for people and measures put in place to minimise the risks of harm.

Safe recruitment procedures were in place to recruit staff and there were enough staff to meet people's needs.

Medicines were being managed safely.

Is the service effective?

Good

The service was effective.

Staff received induction training and relevant mandatory and specialist training to help provide people with effective support.

Staff had a good understanding of the Mental Capacity Act 2005.

Supervision and appraisals were being carried out.

People had access to healthcare professionals and services.

Is the service caring?

Good

The service was caring.

People were supported by staff that respected their dignity and maintained their privacy.

People were treated with respect and helped to maintain their independence.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were produced

with the individual. These plans were tailored to meet each individual's requirement and were reviewed on a regular basis.

People were involved in activities.

The provider had a complaints procedure and complaints were managed appropriately.

Is the service well-led?

Good

The service was well-led.

Staff told us that the manager was supportive and approachable.

There were appropriate systems in place to monitor the service and make any required changes. Regular audits had been undertaken by the management team.

The service sought feedback from people through meetings and surveys.

St George's House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 was carried out on 14 November 2016 and was unannounced. The inspection team comprised of an inspector, a bank inspector in adult social care 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.

Before the inspection we reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. We also made contact with the local authority and health and social professionals that may have had involvement with the home.

During the inspection we spoke with four people, one relative, five staff members, the registered manager and the locality manager. We observed interactions between people and staff members to ensure that the relationship between staff and people was positive and caring.

We spent some time looking at documents and records that related to people's care and the management of the home. We looked at seven people's care plans, which included risk assessments.

We reviewed five staff files which included training and supervision records. We looked at other documents held at the home such as medicine records, quality assurance audits and residents and staff meeting minutes.

Good

Is the service safe?

Our findings

People told us they were safe living at the home. One person told us when asked if they felt safe, "Yes it's okay no problems" and a relative commented, "Yes' 'security lock on the door and staff around." Another person commented, "Yes, because I feel safe." A health professional told us, "I have felt that St Georges manage [person] very well" and another health professional told us, "St George's House provided an excellent level of care and support to each client."

During our last inspection the home was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were not being managed safely. During this inspection we found improvements had been made and medicines were being managed safely.

Medicines were stored safely and securely in a locked cabinet. One staff member carried the keys for the shift and we heard how this responsibility was allocated during a staff handover we observed. There were no controlled drugs at the home at the time of this inspection and the member of staff we spoke with was able to demonstrate their knowledge of how controlled drugs should be stored and administered safely.

We reviewed the records of two people who were self-administering medicines. The records were organised and contained a signed and dated self-administration medicines consent form, which included details of dosage and clarification that the person understood what their medicine was for. There was correspondence from the GP, which authorised the self-administration of medicines, with a recommendation that the decision was reviewed every six months, which we saw had been completed. The records of a person who self-administered medicines included weekly spot checks. A staff member told us this was to ensure that the person stored their medicines appropriately in the locked drawer provided and to ensure the remaining medicines tallied up with the medicine administration record (MAR). Where there were concerns about one person who self-administered medicines, the staff member told us their medicine were checked daily because, "They have a lot of things going on for them at the moment and we want to make sure they are safe."

We also looked at MAR records for three people who were fully supported to take their medicines. We saw completed consent forms agreeing support from staff to administer their medicines. Records showed there was a comprehensive description of the conditions under which PRN (as required) medicines was given. PRN medicines were recorded on the back of individual MARs, with reasons for taking it also recorded. People's allergies were listed or noted as 'not known' as appropriate.

We saw correspondence with a GP where staff asked advice about a person who did not always want to eat before taking their medicines. The doctor confirmed that this was safe for the person. There were no unexplained gaps on MARs for the four week cycle we looked at and our spot check of loose medicines confirmed that all medicines were accounted for. There was an up to date medicines policy, accessible to all staff on the intranet.

The fridge temperature was recorded daily, with no evident gaps on the record and recordings were within

acceptable temperature range. There were also daily medicine checks completed by a senior member of staff, with comments and concerns recorded such as a reminder to re-order medicines, which were running low.

The registered manager also completed a weekly medicine audit and action plan. Records showed recommended actions such as requesting staff to update their medicine signature and all medicines for return to be processed.

Records showed staff had completed their medicines e-learning proficiency assessment, which included new staff. Before staff administered medicine on their own they were required to complete four e-learning modules and four quizzes and be observed twice whilst they gave medicines. We saw evidence that both existing staff and newly recruited staff had completed the e-learning modules and the four quizzes and had passed. However, whilst we saw evidence that the two practical observations had been signed off as completed, this gave no indication of what those observations included. This is important to ensure that good practises or areas that may require improvements is noted and communicated to staff to ensure medicines are administered safely. We fed this back to the registered manager who told us this will be reviewed.

During our last inspection the home was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records showed that people's risk assessments were not being reviewed regularly. This meant that any changes to people's needs may not have been identified and could lead to unsafe and inappropriate care.

We found assessments were undertaken to assess any risks to people using the service. These were person centred. The risk assessments were completed for each person and these covered risks in areas of violence, suicide, self-harm, relapse and self-neglect. The plan provided information on the presenting risks that each person had and also listed symptoms, triggers, prevention strategies and interventions for each person. The plan also listed the actions that staff should take to manage or reduce risks in order to ensure people and staff were safe. People were involved in planning of these risks and the risk assessments were signed by people to ensure they agreed with the plan. Records showed that the risks assessments had been reviewed regularly since the last inspection and people's risk assessment were updated following the reviews.

Staff were aware of their responsibilities in relation to safeguarding people who used the service. Staff files contained up to date training certificates on safeguarding. Staff were able to explain what safeguarding was and who to report to. Staff also understood how to whistle blow and knew they could report to outside organisations such as the Care Quality Commission (CQC). Information was available on whistleblowing in the staff office. One staff member told us, "I would push my concerns up thorough the organisation and if that was not successful, I would not hesitate to contact the Care Quality Commission with my concerns." We looked at the provider's safeguarding and whistleblowing procedure, which provided clear and detailed information on the types and signs of abuse and how to report allegations of abuse. Records did not show who staff could report to outside the organisation such as the CQC and council. The registered manager told us this would be included.

Staff files demonstrated the provider followed safe recruitment practice. Records showed the home collected references from previous employers, proof of identity, criminal record checks and information about the experience and skills of the individual. Staff members were only offered a post when all relevant information had been received which would protect people from unsuitable staff being employed at the home.

At the last inspection we recommended that consideration was given to the appropriate deployment of staff, to ensure people's needs are met at all times. Staff and people had no major concerns about staffing levels. Staff told us that staffing levels had improved since the last inspection and as only nine people were staying at the home it was manageable. They said that all shifts were filled and there was little or no use of agency staff. Instead, bank staff were used to fill shifts as required. The registered manager told us they were currently in the process of recruiting additional care workers and a team leader had been recently recruited as they planned to admit further people into the home therefore staffing levels would reflect that depending on people's dependency needs. The service employed three care workers during the day, the registered manager and two care workers at night. We observed that staff were not rushed and were able to speak and offer support to people when needed.

Risk assessments and checks regarding the safety and security of the premises were up to date and had been reviewed. These included a fire safety policy, fire risk assessments, regular evacuation drills and weekly fire tests for the recovery house. We saw evidence that demonstrated appropriate gas and electrical installation safety checks were undertaken by qualified professionals. Checks were made for portable appliance testing and hot water temperature to ensure people living at the home were safe.

We reviewed the incident and accident records. Appropriate action had been taken by staff working at the time of the accident. Clear records were kept of the investigation that was carried out and any actions taken as a result.

Good

Is the service effective?

Our findings

Staff had the knowledge and skills they needed to perform their roles effectively. People we spoke with told us that staff supported them well and understood their needs. A person told us, "They do yes" when asked if staff were skilled and knowledgeable to support them and another person told us, "Staff are exceptionally good." A relative commented, "Yes in the times I've spoken with staff I think they are rather good." A social professional told us, "I have also found the front line workers [staff] in particular, to be very knowledgeable about the support they are providing."

All staff were required to complete a two week induction programme which included health and safety awareness, misuse of drugs and provider policies. Records and staff confirmed this. Staff told us that they were well prepared for their role prior to starting employment.

We saw the staff training matrix which showed that almost all staff were up to date on their mandatory training. Staff had undertaken mandatory training such as Mental Capacity Act (MCA), first aid and health and safety, safeguarding, infection controls and safeguarding's. In addition staff had received more specialists training in mental health awareness such as personality disorders, legal highs, depressions and schizophrenia.

Staff told us that there was good access to training, most of which was e-learning. In addition, we saw there had been in-house training for some staff which included peer support, group skills and personal care planning and recovery.

We spoke with staff and looked at staff files to assess how they were supported to fulfil their roles and responsibilities. Records showed that the home maintained a system of appraisals and supervision. Formal individual one-to-one supervisions were provided regularly. We saw that the content of supervision sessions recorded were relevant to individual's roles and included topics such as training needs, concerns and individual progress. Appraisals were scheduled annually and we saw that staff had received regular appraisals. One staff member told us they found this to be a good time to "step out of work and reflect on their practice."

People at the service were on a three phase programme to enable independent living and each level determined how much support they required, including assistance with preparing and cooking meals. People were independent and managed their finances, which included budgeting and purchasing their own food. Staff told us that support was provided with preparing and shopping for meals if required. The home held a cooking group for people that may require support with meals and cooking. We saw people had their own cupboards to store food in the kitchen area and there was a small supply of basic food such as cereal, bread, milk, tea coffee and fruits that was provided by the home. People had meals plans in place that was created with the support of staff. The meal plan showed that healthy eating was encouraged to ensure people had a nutritious and healthy diet. A staff member told us, "Residents generate their own menu's we help tailoring the meal it's their choice." There were two small kitchens and a communal kitchen. We observed all the kitchen were clean and tidy.

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.

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.

DoLS are put in place to protect people's liberty where the service may need to restrict people's movement both in and outside the home. The registered manager and staff had a clear understanding of DoLS and MCA. The registered manager told us people were not subject to DoLS authorisation and had capacity to make decisions by themselves about their treatment and support. We saw that people were able to go out by themselves.

People confirmed that staff asked for consent before proceeding with care or treatment. For example, a staff member asked whether people were happy to talk to the expert by experience and gained their consent before letting the expert by experience speak to them and if people did not want to speak, then this decision was respected.

Staff whom we spoke with were able to demonstrate their understanding of consent to care and treatment. They told us people who lived at the home had signed consent forms to consent to staff supporting them. Records confirmed this. Staff also told us they had annual information governance training which was around consent and sharing of information.

Records showed multi-disciplinary work with other professionals such as psychiatrist, community psychiatric nurse, social worker and dietician. In one care plan, records showed the person having attended forensic therapy on a regular basis to help with their recovery. Health professional details were recorded on people's care plans and people confirmed they had easy access to health professionals and received support from staff to access these services if needed. A relative told us, "I'm often at the annual psychiatric meetings and I'm impressed" and "Yes, [person] sees a dentist, opticians."

Good

Is the service caring?

Our findings

People and their relatives told us staff members were caring and they had good relationship with them. One person commented "Yes" and a relative told us, "A great deal of kindness and fondness" when asked if staff were caring and polite. A person told us, "Staff are very professional with their approach and manner and how they deal with you." We observed that people had a positive relationship with staff members. A health professional told us, "The staff were very supportive to each client, and I felt they even went the extra mile when assisting each client's move into supported housing projects."

It was evident that when speaking to staff, they had a good understanding of people's individual's needs and preferences and were respectful of them. Staff were able to tell us what people's background were and their support needs. Staff told us they build relationship with people by getting to know them and spending time with them. People told us they had good relationship with staff and staff knew their needs, a person told us, "They [staff] know my needs."

People were independent and staff provided support when it was needed. People at the home were living with a range of mental health conditions and were being supported to maintain their independence as much as possible. We observed people were able to move around independently and go to the lounge, dining area, toilets and hallways if they wanted to. The registered manager told us that most people went on to independent living after their stay at the home and that all the people living at the home were ready to be moved onto more independent accommodation, once accommodation became available. The people we spoke with confirmed that they were independent and did most things such as budgeting, shopping and cooking for themselves. A person told us, "I get my own breakfast" and another person commented, "Cooking, I do it on my own." A staff member told us, "We empower them, we give them budgeting money so they can do their own self-catering. If they can do things on their own, we encourage them to do it and if they have eaten and leave the plate on the table we tell them to move the plate."

Staff told us that they respected people's privacy and dignity. All bedrooms were for single occupancy. This meant that people were able to spend time in private if they wished to. People could freely go into their rooms when they wanted and close the door without interruptions from staff and people. A relative told us when asked if staff respected their family members privacy and dignity, "I am under the impression that is the case, they won't let me up to [person] room unless [person] allows me into [person] room." We observed staff knocked on people's door before entering. A staff member told us, "We knock before we enter. If we knock and there is no answer we say we are popping our heads around." We did not observe treatment or specific support being provided in front of people that would had negatively impacted on a person's dignity. Staff respected people's choice for privacy. A staff member told us, "Their own keys to their rooms, come and go as they please, when we give out medication we close the door." We observed some people preferred to take their meals in their own rooms and this was respected.

Staff gave us examples of how they maintained people's dignity and privacy not just in relation to personal care but also in relation to sharing personal information. Staff understood that personal information about people should not be shared with others and that maintaining people's privacy when giving personal care

was vital in protecting people's dignity. A person told us, "If you have any problems they always keep it confidential."

The service had an equality and diversity policy. Religious beliefs were discussed with people. Their preferences were recorded in care plans. Staff understood that racism, homophobia, transphobia or ageism were forms of abuse. They told us people should not be discriminated against their race, gender, age and sexual status and all people were treated equally according to their needs and preferences. People and relatives we spoke to had no concerns about staff approach towards them. A staff member told us, "That we don't discriminate in anyway, culture, age, sexual orientation, religion" and another staff member commented, "Everyone has the right to do anything no discrimination, respecting the persons level of understanding and their rights."

People had contact with family members and details of family members were recorded on their care plans. The relative we spoke to confirmed they were able to visit.

Good

Is the service responsive?

Our findings

Both people and relatives told us that staff listened to them and people confirmed that they received personalised care that was responsive to their needs. A person told us, "Staff are usually very supportive if they can help you they will" and another person commented, "If you need anything for your room like a chair or table if they think it is safe enough to have it, they will assist you to get that thing. I wanted a table and my worker is going to help me get it." A social professional told us, "I have always found the management and staff at St George's to be very consistent and responsive to the needs of their residents." A health professional told us, "The staff are very amenable when speaking with them and the service user that I am discussing is slowly progressing so I feel it is a suitable placement for [person]."

People were assessed before being admitted to the home in order to ensure that their needs could be catered for, which included the risks people may pose to others. People were given an induction pack by the home, which included important information about fire safety and house rules.

During our last inspection the home was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records showed that people's care plans were not person centred and had not been reviewed regularly.

During this inspection records showed the care plans were detailed, person centred, and provided guidance to staff about how people's care and support needs should be met. Care plans were being reviewed regularly. We found that people had input into the care plans and had choice in the care and support they received. People's support plans were divided into areas which included living skills, self-care, social networks, self-esteem and meaningful activity or work. One person's care plan identified ways in which their confidence could be boosted, which included being supported to improve their literacy and numeracy skills. Another care plan outlined a programme of support for a person who was at risk of financial exploitation. These plans provided staff with information so they could respond to people positively and in accordance with their needs. However, information was not always easy to locate, as the files, which were separated into individual sections, contained a lot of old information. The registered manager did acknowledge that a substantial amount of information on people's files could be archived to make more current information easier to access.

There were support plans that covered issues on the support people required such as going back to work and moving on to independent living which included the steps to be taken for people to move on from the home. A staff member told us, "Someone wanted to read before they were 30, [person] enrolled in college it was too much for [person][so we did it in house and [person] did very well."

Daily progress notes provided an overview of what people had done on the day such as if people went out for a visit, stayed in the home or attended any appointments. There was a keyworker system in place which meant people had a designated staff member assigned to them to support them with day to day tasks as well as achieving longer terms goals and aspirations. Each person had a key worker and regular meeting were held with people to talk about their journey and if additional support was required.

We sat in during a staff handover and observed the staff team worked well together and information was shared amongst them effectively.

Staff told us they did room checks to ensure that people were safe and their rooms were in a hygienic state. These checks were usually weekly and we saw consent forms which people had signed. A member of staff showed us one person's record where they had consented to their room being checked on a daily basis. Staff told us this was in response to the person's current state of mind and their increased risk of suicide.

People were able to participate in activities if they wanted to. A person told us, "I go for walks and shopping." Another person commented, "Once a month we go out for a meal, special occasions they will take us to a restaurant for a big meal. We went to the Imperial War museum. We do groups for meals or coffee."

There was a programme of activities such as cooking support, art groups, DVD nights and social clubs. We saw where a person had expressed a wish to learn to cook healthy meals in an effort to lose weight and they had drawn up a weekly timetable of cooking and walking with their keyworker. In another person's daily note we noted that a staff had encouraged a person to rent a DVD for people at the home to watch together. The registered manager told us that people would use vegetables they planted in the garden to cook healthy meals. Staff confirmed that people could participate in activities, a staff member told us, "We have gardening, art room, go out with them, cooking group" and another staff member commented, "Breakfast club, gardening group, was a London in Bloom award, living skills, go out for coffee."

There were procedures in place to handle complaints. The policy provided people who used the service and their representatives with clear information about how to raise any concerns and how they would be managed. We saw formal complaints had been received and these had been investigated and resolved appropriately to the satisfaction of the complainant. We saw a letter of apology from the registered manager to a person who stayed at the home whose bedroom radiator was broken. The letter explained the timeframe within which the problem would be resolved. Complaints leaflets were kept at the entrance of the home. Records showed complaints were analysed, reviewed and shared across the providers other homes for learning and improvement.

Good

Is the service well-led?

Our findings

Staff, relatives and people told us that there was a good atmosphere within the home. A health professional told us, "I have felt that St Georges manage this person very well, they are very clear with boundaries and formalise this in a helpful way which is then fed back to me."

We observed the environment to be relaxed where people were free to chat and interact with each other and staff members. For example, people were able to freely move around the house and go into different parts of the house and sit down if they wanted privacy. People were also able to go in and out of the home freely.

Staff told us they felt well supported by management. One staff member told us, "New manager is really good" and another staff commented, "She's the best thing that could of happened, she has already brought in some new changes." The interaction between staff and the registered manager was professional and respectful. Staff told us that there was an organised management structure and they knew what to do when starting work, a staff member commented, "Yes, there is a good structure in the house, you get delegated tasks and I have my own notebook."

Regular staff and residents meetings enabled people who used the service and staff members to provide a voice and express their views. Resident meeting minutes showed people discussed house rules, activities and food. Staff meeting minutes showed staff discussed training needs, CQC inspections, medicines, safety, and information exchange about the people living at the home.

The service had a system in place for quality assurance. We saw that recent audits were carried out on the home by the locality manager, the previous registered manager who had recently left and the quality team. The audits carried out by the locality manager and previous registered manager was based around the CQC Key Lines of Enquiries, which were Safe, Effective, Caring, Responsive and Well-Led. Actions were listed to complete. Checks included care plans, building safety and staffing and fire safety. Records showed that the previous registered manager had also regularly audited care plans since the last inspection and actions were listed for improvements. The registered manager told us that audits would be a reoccurring theme to ensure continuous improvements and that it is also sustained.

The service had a quality monitoring system which included questionnaires for people. We saw the results of the questionnaires for 2015, which were generally positive and covered important aspects on staff, safety, complaints and dignity. One comment from the survey included, "The service was able to support and understand the ups and downs of recovery. I was shown empathy and patience at the same time as positive, consistent encouragement." Records showed that the survey were analysed and action in place to make improvements to ensure high quality care was being delivered.